State of Utah

Division of Medicaid and Health Financing

Bureau of Managed Health Care

Annual External Quality Review Report of Results

March 2024

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1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) require states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) ensure that a qualified external quality review organization (EQRO) conduct an annual external quality review (EQR) and prepare a detailed annual technical report of results that summarizes findings on the quality and timeliness of, and access to care. In May 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Medicaid and Children's Health Insurance Program (CHIP) managed care regulations. In February 2018 CHIP was reauthorized via House Bill 195 and the Bipartisan Budget Act of 2018 and in December 2022, the Consolidated Appropriations Act extended federal funding for CHIP for an additional two years and made permanent a state option to provide 12 months of postpartum coverage in Medicaid and CHIP. HSAG developed this EQR technical report to comply with 42 Code of Federal Regulations (CFR) §438.364 as articulated in the May 2016 regulations with revisions released in November 2020, effective December 2020. The Utah Department of Health and Human Service (DHHS), formerly the Utah Department of Health, is the Utah State agency responsible for the administration of Utah's Medicaid and CHIP programs. DHHS has contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare this report.

To provide medical services in calendar year (CY) 2023, DHHS contracted with accountable care organizations (ACOs) and prepaid mental health plans (PMHPs) that are PIHPs to serve the Medicaid population and contracted with MCOs to serve the Medicaid and CHIP populations. To provide dental services, DHHS contracted with two dental PAHPs—one serving the Medicaid population and one serving both the Medicaid and CHIP populations. Throughout this report, these entities are referred to as "health plans" unless there is a need to distinguish a particular health plan type. DHHS does not exempt any of its health plans from EQR.

The Utah Managed Care Delivery System

Table 1-1—Summary of Health Plans in CY 2023 by Type and Operating Authority

Health Plan Type	Operating Authority
Four Medicaid ACOs	1915(b) Choice of Health Care Delivery (CHCD) waiver
One Medicaid mental and physical health MCO	1915(a) contracting authority
Four Medicaid mental and physical health MCOs	1115 Demonstration waiver
Eleven PMHPs (PIHPs)	1915(b) PMHP waiver
Two CHIP MCOs	CHIP authority

Health Plan Type	Operating Authority
Two Medicaid dental PAHPs	1915(b) Choice of Dental Care Delivery Program waiver
One CHIP dental PAHP	CHIP authority

Four ACOs Operating Under the 1915(b) CHCD Waiver

DHHS has been operating the 1915(b) CHCD waiver program since 1982. Under this waiver, DHHS provided physical health care through MCOs. Since 1995, enrollment in an MCO has been mandatory for members living in Utah's urban counties. Effective January 1, 2013, the MCOs began administering the Medicaid pharmacy benefit for their members with the exception of mental health, substance use disorder (SUD), hemophilia, and transplant immunosuppressant drugs. In 2015, DHHS expanded mandatory ACO enrollment to include nine rural counties. During CY 2023, DHHS contracted with the following ACOs:

Health Choice Utah (Health Choice)

Healthy U

Molina Healthcare of Utah (Molina)

SelectHealth Community Care (SelectHealth CC)

One MCO Operating Under 1915(a) Contracting Authority

In 2001, DHHS implemented a specialty MCO, Healthy Outcomes Medical Excellence (HOME), under 1915(a) contracting authority. HOME provides both physical health and mental health services using a medical home model of care for members dually diagnosed with a developmental disability and a mental illness. Enrollment into HOME is voluntary. In 2006, DHHS transformed HOME into a risk-based, capitated MCO.

Four MCOs Operating Under an 1115 Demonstration Waiver

On January 1, 2020, DHHS launched its Utah Medicaid Integrated Care (UMIC) plans providing both physical health and behavioral health services to Utah's adult Medicaid expansion population in Davis, Salt Lake, Utah, Washington, and Weber counties. During CY 2023, DHHS continued to contract with four UMIC plans:

Health Choice Utah (Health Choice UMIC)

Healthy U (Healthy U Integrated)

Molina Healthcare of Utah (Molina UMIC)

SelectHealth Community Care (SelectHealth CC UMIC)

Eleven PMHPs Operating Under the 1915(b) Prepaid Mental Health Plan Waiver

DHHS has been operating the 1915(b) PMHP waiver program since 1991. Under this waiver, DHHS provides behavioral health care through the PMHPs. Enrollment in the PMHPs is mandatory.

Bear River Mental Health (Bear River)

Central Utah Counseling Center (Central)

Davis Behavioral Health (Davis)

Four Corners Community Behavioral Health (Four Corners)

Healthy U Behavioral

Northeastern Counseling Center (Northeastern)

Optum (Optum/Tooele)

Salt Lake County Division of Behavioral Health Services (Salt Lake)

Southwest Behavioral Health Center (Southwest)

Wasatch Behavioral Health (Wasatch)

Weber Human Services (Weber)

Two MCOs Operating Under Title XXI Authority

Created in 1997 under Title XXI of the Social Security Act, CHIP provides low-cost health insurance coverage for children in working families who do not qualify for Medicaid. Utah began operating its CHIP program in 1997. In CY 2023, DHHS contracted with the following CHIP MCOs:

Molina Healthcare of Utah CHIP (Molina CHIP)
SelectHealth CHIP

Two Medicaid Dental PAHPs Operating Under the 1915(b) Choice of Dental Care Delivery Program Waiver

Premier Access (Premier)

MCNA Dental [MCNA Insurance Company and Managed Care of North America, Inc.] (MCNA)

One CHIP Dental PAHP Operating Under Title XXI Authority

Premier Access

The State of Utah Managed Care Quality Strategy

Consistent with CMS recommendations, the DHHS Quality Strategy[1-1] provides a blueprint for advancing the State's commitment to improving quality health care delivered through the contracted health plans. Utah designed its primary system of health care delivery and payment to improve the quality of care that Utah's Medicaid and CHIP members receive. The DHHS Quality Strategy outlines goals designated as the Triple Aim to achieve better care, better health, and better value for members enrolled in Utah's managed Medicaid and CHIP health plans. Based on results from CY EQR-related activities, HSAG offers observations and recommendations related to the following targeted goals.

Goals and Objectives

Goal 1: Improve the Quality of Care for Members

OBJECTIVES

- Conduct semi-annual meetings with the Quality Improvement Council and Care Coordination Committee.
- Evaluate health plan quality assessment and performance improvement program (QAPIP) impact.

RECOMMENDATIONS

HSAG recommends that DHHS continue leveraging its Quality Improvement Council and Care Coordination Committee to engage with the health plans and identify innovations and interventions to improve QAPIP outcomes not limited to the Healthcare Effectiveness Data and Information Set (HEDIS)[1-2] measures that remain below the current national average. HSAG also recommends that the Division of Integrated Healthcare (DIH) medical director continue to have an active role in the direction, implementation, and facilitation of the health plans as they collaborate to improve outcomes. HSAG suggests that DHHS consider a focus on achieving the following objectives:

- Through collaboration between the health plans and DHHS, discuss common barriers and best practices to drive improvement on measures and collaboratively develop statewide initiatives.
- Support and encourage the health plans to continuously evaluate and improve quality programs.
- Evaluate and improve member experience of care.
- Leverage DHHS' EQRO to share and describe upcoming changes in regulations or requirements.

[1-1] Division of Medicaid and Health Financing: Bureau of Managed Health Care. State of Utah Managed Care Quality Strategy. Available at: Utah Managed Care Quality Strategy 2021.pdf. Accessed on: Dec 8, 2022.
[1-2] HEDIS® is a registered trademark of NCQA.

Goal 2: Improve the Health of Members

OBJECTIVES

- Improve health plan performance on quality measures

RECOMMENDATIONS

HSAG noted that all of the ACOs and five of the 11 PMHPs fell below the statewide average for *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up* and *30-Day Follow-Up*. In addition, the ACOs scored below the National Committee for Quality Assurance (NCQA) Quality Compass[1-3] average for several measures, including *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up.* HSAG recommends that DHHS work with the ACOs and PMHPs to discuss and identify innovative approaches for improving these measures.

Additionally, the MCOs and ACOs continued to score below the measurement year (MY) 2022 NCQA Quality Compass average for *Breast Cancer Screening.* HSAG recommends that DHHS work with the ACOs and MCOs to develop intervention strategies for improving this measure.

Goal 3: Improve the Value of Healthcare

OBJECTIVES

- Reduce emergency department utilization rates through better management of chronic conditions in the primary care environment.

RECOMMENDATIONS

HSAG noted continued low performance rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* by the PMHPs. HSAG recommends that DHHS consider implementing a PMHP and HOME joint innovation task force to determine innovations for addressing this ongoing concern. DHHS could also collaborate with the PMHPs and HOME to determine benchmark performance levels to be achieved.

Purpose of the Report

This report provides the results of the four mandatory EQR activities HSAG completed in CY 2023. DHHS contracted with HSAG to conduct validation of performance improvement projects (PIPs) following CMS' *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related*

[1-3] Quality Compass® is a registered trademark of NCQA.

Activity, February 2023 (EQR Protocol 1)[1-4]; validation of performance measures following CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 2)[1-5]; an assessment of compliance with Medicaid managed care regulations following CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 3)[1-6] (i.e., compliance review); and validation of network adequacy (protocol not yet released) for all health plans. This report also presents health plan-specific and statewide assessments of strengths and weaknesses (listed as opportunities for improvement throughout this report) regarding health care quality and timeliness of, and access to care furnished by the health plans; conclusions drawn; and recommendations for performance improvement with statewide recommendations in this section (Section 1. Executive Summary) and health plan-specific recommendations in Section 2. Evaluation of Utah Medicaid and CHIP Health Plans.

HSAG used the following definitions to evaluate and draw conclusions about the performance of the health plans in each of these domains.

Quality

CMS defines "quality" in the 2016 federal health care regulations at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM [primary care case management] entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and through interventions for performance improvement.[1-7]

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https:// www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 16, 2024.

[1-5] 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/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 16, 2024.

[1-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https:// www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Jan 16, 2024.

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Timeliness

NCQA defines “timeliness” relative to utilization decisions as “the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”[1-8]

NCQA further states that the intent of utilization management (UM) standards is to minimize any disruption in the provision of health care. HSAG extends this definition of “timeliness” to include other managed care provisions that impact services to members and that require timely response by the MCO or PIHP, such as processing grievances and appeals, and providing timely follow-up care.

Access

CMS defines “access” in the 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care health plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services).[1-9]

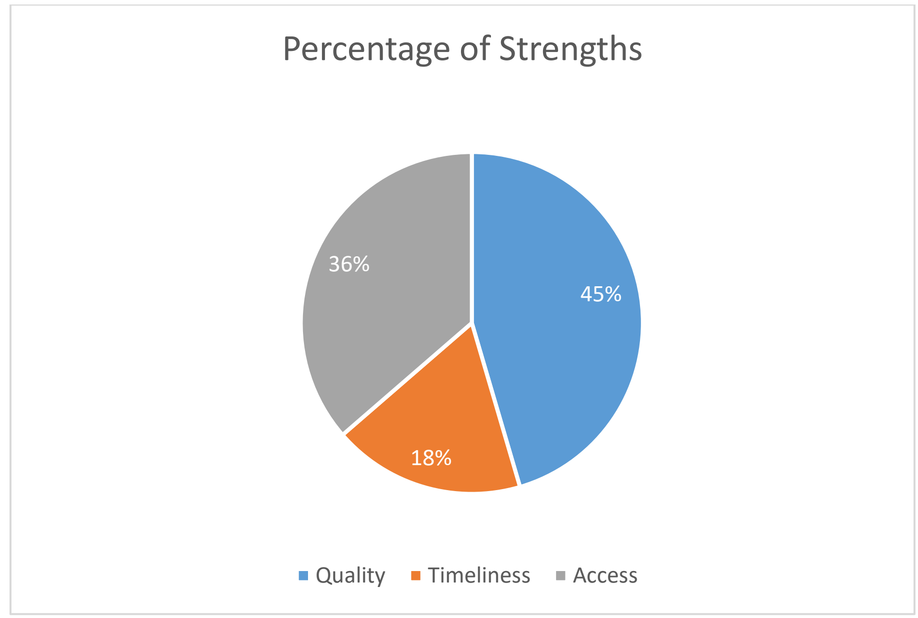
Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities

Figure 1-1 and Figure 1-2 provide an overall assessment of the percentages of strengths and weakness (opportunities for improvement) that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. HSAG derived these percentages from the results of all mandatory activities conducted during CY 2023. Of note, NAV outcomes are not included in the figures below, as all strengths and opportunities relate to the Access domain.

[1-8] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

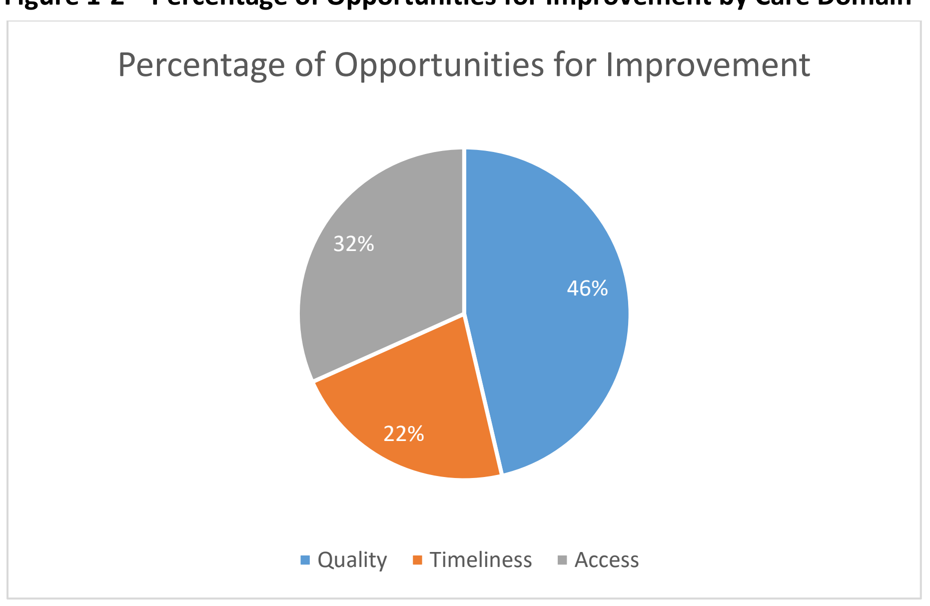
[1-9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Figure 1-1—Percentage of Strengths by Care Domain*



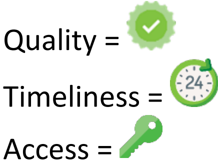
*Each strength may impact one or more domains of care (quality, timeliness, or access).

Figure 1-2—Percentage of Opportunities for Improvement by Care Domain*



*Each recommendation may impact one or more domains of care (quality, timeliness, or access).

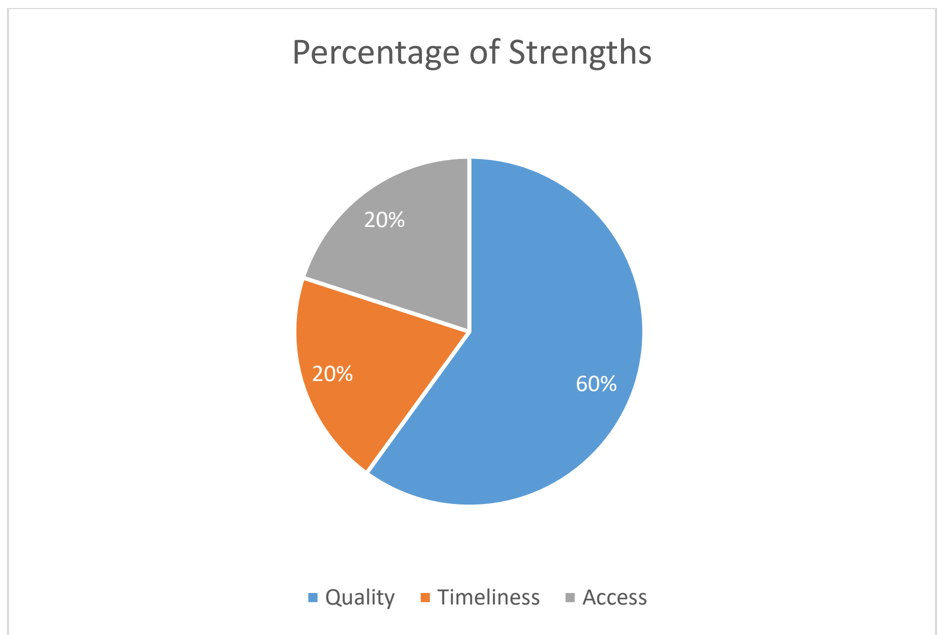
The following are statewide strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Validation of Performance Improvement Projects

Figure 1-3 provides an overall assessment of the percentages of strengths and opportunities for improvement that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. HSAG derived these percentages from the results of PIP activities conducted during CY 2023. For health plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

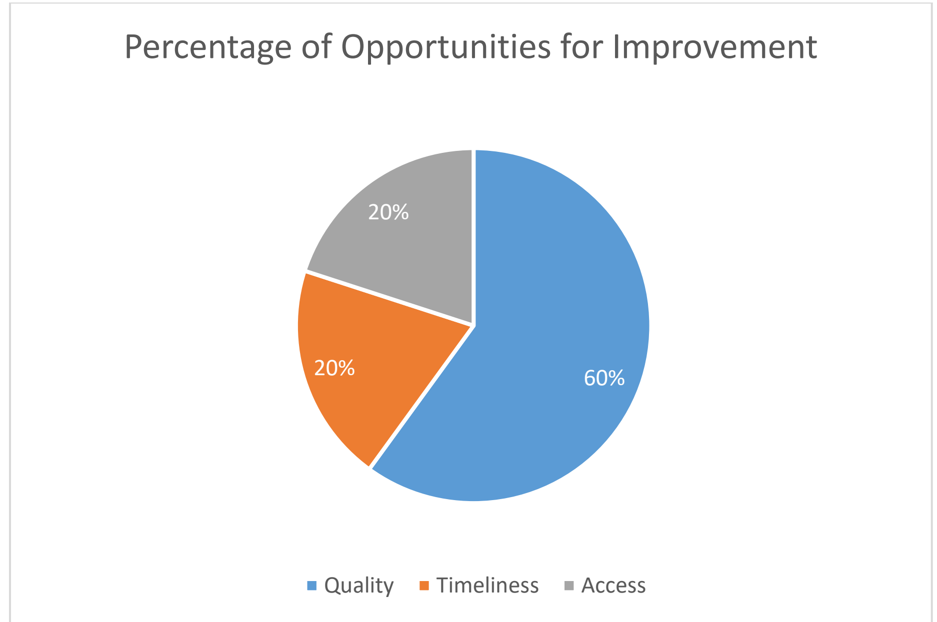
Figure 1-3—Percentage of Strengths by Care Domain for PIPs Statewide*



*Each strength may impact one or more domains of care (quality, timeliness, or access).

Figure 1-4 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality and timeliness of, and access to care and services related to PIPs.

Figure 1-4—Percentage of Opportunities for Improvement by Care Domain for PIPs Statewide*



*Each recommendation may impact one or more domains of care (quality, timeliness, or access).

Statewide Strengths Related to Validation of PIPs

HSAG identified the following statewide strengths related to PIP validation:

- Of the 25 PIPs HSAG validated, 23 PIPs received an overall *Met* validation status.
- The health plans and dental PAHPs demonstrated a thorough application of the PIP design principles and use of appropriate quality improvement (QI) activities to support improvement of PIP outcomes.
- Five (two UMIC plans and three PMHPs) of the 16 health plans that reported remeasurement data demonstrated statistically significant improvement in all the performance indicator rates over the baseline in the most recent remeasurement period.

Statewide Opportunities for Improvement Related to Validation of PIPs

HSAG identified that statewide opportunities for improvement related to PIP validation existed primarily in:

- Narrative interpretation of data.

- Evaluation of the effectiveness of each intervention.
- Achievement of improvement in performance indicator rates and outcomes.

Statewide Recommendations Related to PIPs

For CY 2023, HSAG received 25 PIPs for validation. The PIPs were in varying stages. One health plan (Four Corners) reported the PIP study design only; eight health plans (the four ACOs, Salt Lake, Wasatch, Weber, and SelectHealth CHIP) reported baseline results; four health plans (Bear River, HOME, Optum, Southwest) and one dental PAHP (Premier Access) reported Remeasurement 1 results; six health plans (Central, Health Choice UMIC, Healthy U, Healthy U UMIC, Molina UMIC, and Select Health CC UMIC) and one dental PAHP (Premier Access CHIP) submitted Remeasurement 2 results; two health plans (Davis and Northeastern) and one dental PAHP (MCNA) reported Remeasurement 3 results; and one health plan (Molina CHIP) reported Remeasurement 4 results. HSAG evaluated the health plans submitting remeasurement data for achievement of statistically significant, significant clinical, and significant programmatic improvement in processes and outcomes.

Of the 25 PIPs HSAG validated, 23 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles and the use of appropriate QI activities to support improvement of PIP outcomes. The remaining two PIPs received an overall *Partially Met* validation status. The opportunities for improvement existed primarily in the narrative interpretation of data, documentation of intervention evaluation data, and achievement of improvement in outcomes. More specific information about the PIP validation results for CY 2023 for each health plan and dental PAHP is included in Section 2 of this report.

For the next annual PIP submissions, HSAG recommends that the health plans:

- Ensure that all information in the PIP Submission Form is documented correctly and completely to address each applicable evaluation element.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis during each measurement period.
- Consider using QI science-based tools, such as process mapping and failure modes and effects analysis (FMEA), for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care, in addition to other stakeholders' input.
- Implement interventions in a timely manner to impact the remeasurement rates.
- Document an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from

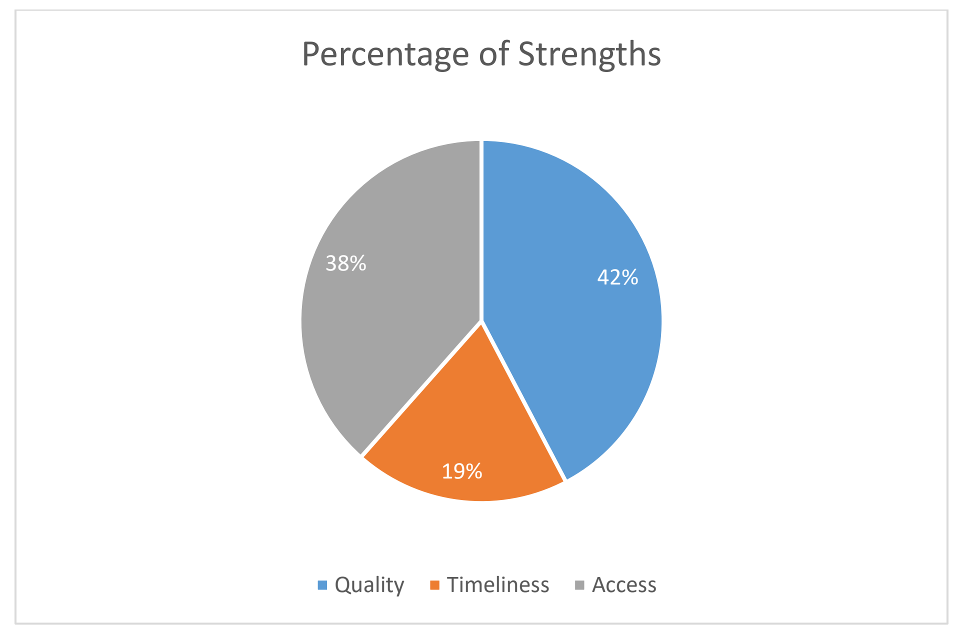
the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation results should be provided in the PIP submission.

- Intervention-specific evaluation results should guide next steps for each individual intervention.
- Ramp up and adopt health plan-wide interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles in order to impact the entire eligible population in the next measurement period.
- Include an executive sponsor (e.g., medical director, chief medical officer, or CEO) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
- Seek technical assistance from HSAG, if needed.

Validation of Performance Measures

Figure 1-5 provides an overall assessment of the percentages of strengths and opportunities for improvement that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. HSAG derived these percentages from the results of performance measure activities conducted during CY 2023. For health plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

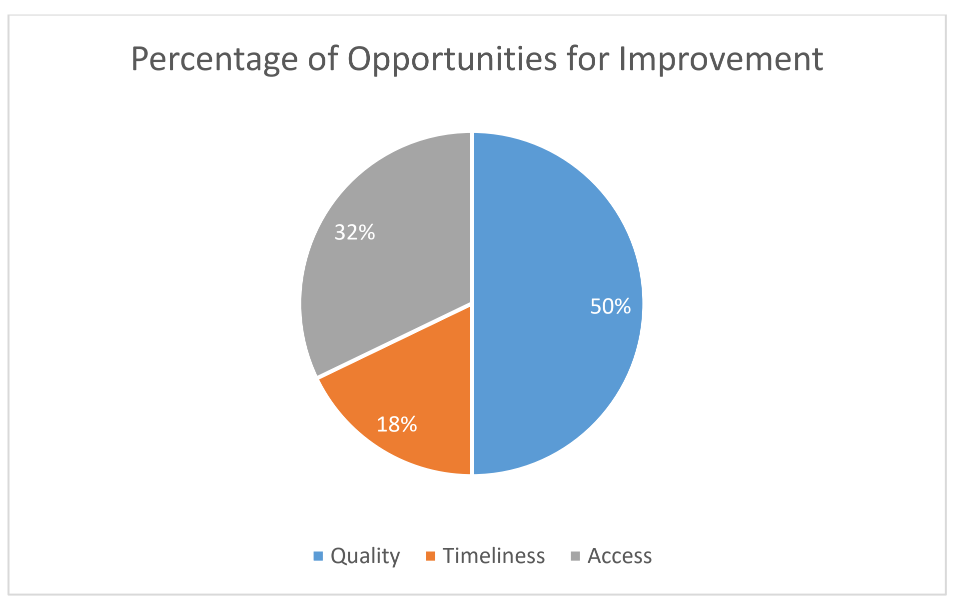
Figure 1-5—Percentage of Strengths by Care Domain for Performance Measures Statewide*



*Each strength may impact one or more domains of care (quality, timeliness, or access).

Figure 1-6 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality and timeliness of, and access to care and services related to performance measures.

Figure 1-6—Percentage of Opportunities for Improvement by Care Domain for Performance Measures Statewide*



*Each recommendation may impact one or more domains of care (quality, timeliness, or access).

Statewide Strengths Related to Validation of Performance Measures

At least three of the four ACOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Upper Respiratory Infection (URI)—3 months–17 years*
- *Controlling High Blood Pressure*
- *Use of Imaging Studies for Low Back Pain*

At least three of the four UMIC plans exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*

- *Controlling High Blood Pressure*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total*

Both CHIP MCOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for URI—3 months–17 years*
- *Immunizations for Adolescents—Combination 1*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

Both Medicaid dental PAHPs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*
- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—Total*

Based on performance measure outcomes, four PMHPs exceeded the statewide PMHP average for both *Follow-Up After Hospitalization for Mental Illness* measure indicators.

Statewide Opportunities for Improvement Related to Validation of Performance Measures

At least three of the four ACOs fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—3 to 11 years*
- *Immunizations for Adolescents—Combination 2*

- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

At least three of the four UMIC plans fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Eye Exam (Retinal) Performed*
- *Follow-Up ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

One of the two CHIP MCOs fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

One Medicaid dental PAHP fell below the MY 2022 NCQA Quality Compass average for the following performance indicator:

- *Annual Dental Visit—19–20 Years*

Based on performance measure outcomes, five PMHPs fell below the statewide PMHP average for both *Follow-Up After Hospitalization for Mental Illness* measure indicators.

Statewide Recommendations Related to the Validation of Performance Measures

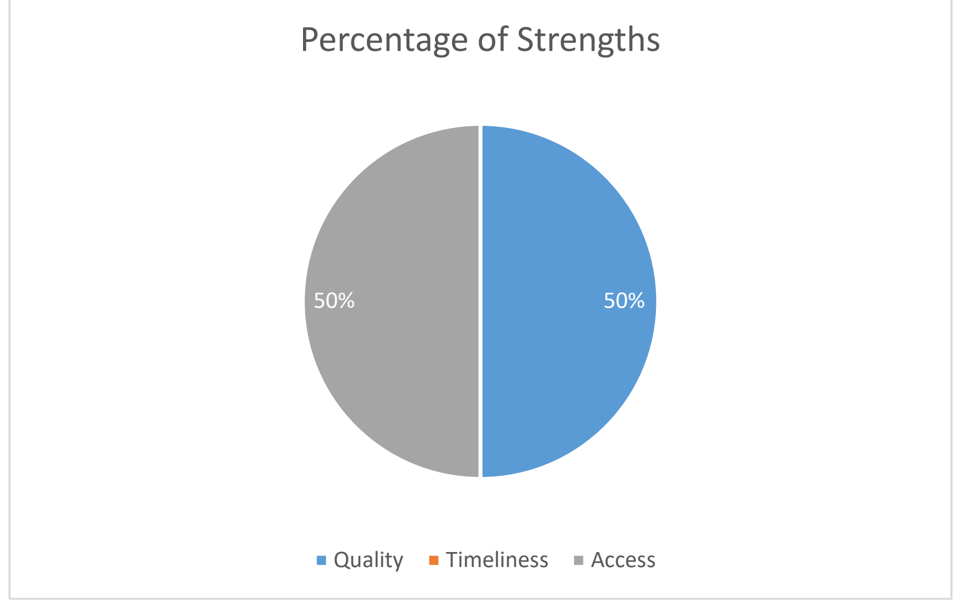
Based on MY 2022 performance, HSAG recommends that Medicaid ACOs, UMIC plans, and CHIP health plans perform a segmentation analysis on the eligible populations for measures that fell below the national average to determine subgroups of members that represent the biggest area of opportunity to improve performance. The health plans can tailor interventions that will meet the needs of noncompliant subgroups (e.g., by age, race, gender, geography, primary care provider [PCP]) once they

understand the unique barriers and behavior patterns of these subgroups. It is also recommended that all Utah Medicaid health plans focus on member programs that address the specific needs and barriers of women to health care since they are the key to performance across a large number of low-performing scoring indicators. HSAG recommends that the PMHPs and HOME ensure adequate validation against measure inclusion and exclusion criteria is performed prior to rate calculation and perform an analysis of noncompliant members to better understand the remaining barriers to follow-up care.

Compliance Monitoring

Figure 1-7 provides an overall assessment of the percentages of strengths and opportunities for improvement that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of compliance activities conducted during CY 2023. For health plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

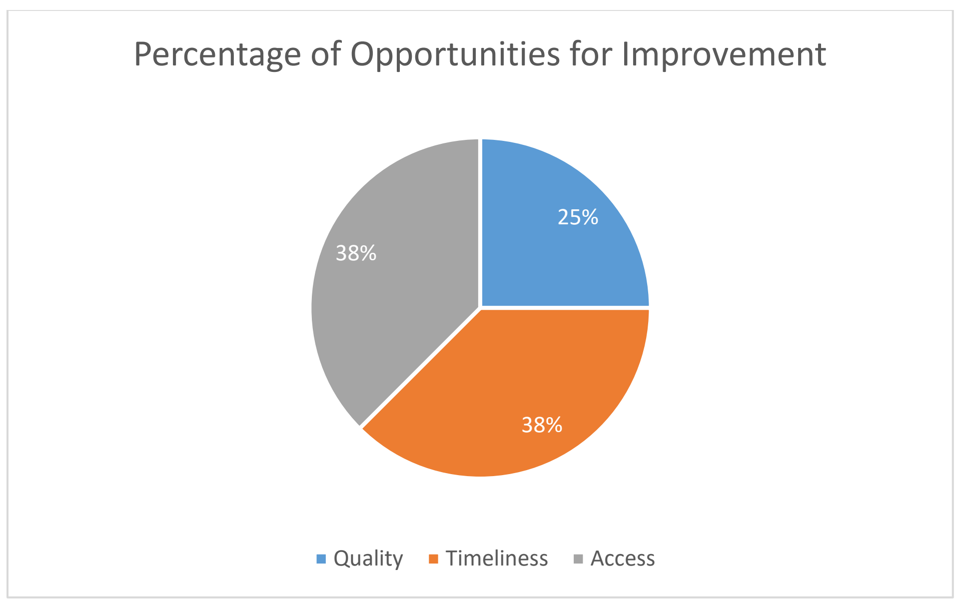
Figure 1-7—Percentage of Strengths by Care Domain for Compliance Monitoring Statewide*



*Each strength may impact one or more domains of care (quality, timeliness, or access).

Figure 1-8 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality and timeliness of, and access to care and services related to compliance monitoring.

Figure 1-8—Percentage of Opportunities for Improvement by Care Domain for Compliance Monitoring Statewide*



*Each recommendation may impact one or more domains of care (quality, timeliness, or access).

Table 1-2 lists the number of health plans for which HSAG identified findings resulting in required actions for each standard as a result of the CY 2023 compliance review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 1-2—Number of Health Plans (Statewide) With Findings in CY 2023

Standard	Number of Health Plans (of 25 total) With At Least One Required Action
Standard I—Enrollment and Disenrollment	5
Standard II—Member Rights and Confidentiality	16
Standard IV—Emergency and Poststabilization Services	13
Standard VII—Coverage and Authorization of Services	16
Standard X—Practice Guidelines	2
Standard XIII—Grievance and Appeal System	29

Statewide Strengths Related to Compliance Monitoring (Standards Wherein Five or Fewer Health Plans Had Ongoing Findings)

For compliance monitoring, HSAG identified statewide strengths related to the following standards:

- Standard I—Enrollment and Disenrollment

- Standard X—Practice Guidelines

Statewide Opportunities for Improvement Related to Compliance Monitoring

HSAG identified statewide opportunities for improvement related to the following standards:

- Standard II—Member Rights and Confidentiality
- Standard IV—Emergency and Poststabilization Services
- Standard VII—Coverage and Authorization of Services
- Standard XIII—Grievance and Appeal System

Statewide Recommendations Related to Compliance Monitoring

HSAG offers the following statewide recommendations related to compliance monitoring:

- Health plans should consider conducting an audit of their internal policies and procedures reconciled with the federal requirements and State contract language to ensure accurate definitions and timelines.
- After conducting a policy audit, health plan leadership should ensure that adverse determination and appeal processes align with internal policies.

Validation of Network Adequacy

While the network adequacy validation (NAV) process may be used to analyze different aspects of provider networks and members' access to care, the CY 2023 NAV focused on time/distance and provider capacity analyses for specified provider types using member enrollment and provider data files. DHHS and each respective health plan submitted these files to HSAG.

For services that require members to travel to the provider (e.g., dental care), each health plan must ensure that it contracts with an adequate number of providers to meet urbanicity-specific time or distance network requirements. However, a health plan's failure to meet a time/distance standard does not necessarily reflect a network concern, as the health plan may have DHHS' approval to use alternate methods to ensure members' access to care (e.g., community services). Additionally, a health plan's ability to meet the minimum network standard does not guarantee all facets of access to care for all members. Regardless of each health plan's ability to meet the established time/distance standards, the scope of the CY 2023 NAV did not analyze other potential barriers members may encounter when attempting to access Medicaid services. For example, factors such as members' access to transportation, health status and needs related to disability accommodations, and

appointment/service availability could account for inadequate access to care despite the CY 2023 NAV results.

Overall, the Utah CY 2023 NAV results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider types (e.g., pediatric specialists). Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards. HSAG determined that all strengths and opportunities for improvement relate to the access domain and as such domain tables have not been presented for this activity. For health plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

For the NAV activity, all identified strengths and opportunities for improvement relate to the access domain; therefore, no pie charts are included in this section.

Statewide Strengths Related to NAV

There are several statewide strengths related to the health plans' provider networks:

- All applicable health plans met 100 percent of the time/distance standards for pediatric and adult PCPs.
- All applicable health plans met 100 percent of the time/distance standards for prenatal care and women's health providers.
- The Medicaid PAHPs and CHIP PAHP were able to provide 100 percent of members in rural and urban areas with access to general dental providers within the time/distance standards.
- Across nearly all health plan types, one or more health plans had at least one provider category that met time/distance standards in CY 2023 after not meeting the time/distance standards in CY 2022.

Statewide Opportunities for Improvement Related to NAV

There were still statewide areas for improvement related to the health plan provider networks:

- Most health plans were unable to meet time/distance standards for the Behavioral Health—Facilities provider category. It may be helpful for DHHS to collaborate with the health plans to determine if this is due to a lack of providers, an unwillingness of available providers to contract with the health plans, or the inability to identify these providers with available data.
- Provider saturation analysis showed that for many provider categories, the health plans could improve the number of members with access by contracting with additional available providers in the area.

Statewide Recommendations Related to Validation of Network Adequacy

Based on the results and conclusions presented in this report, HSAG recommends the following for DHHS and the health plans to strengthen the Medicaid and CHIP managed care provider networks and ensure members' timely access to health care providers:

- As planned by DHHS, HSAG recommends continuing to work with the health plans to require health plan reporting of NAV metrics and conducting validation of those metrics. Along with health plan metric reporting, HSAG recommends that DHHS and HSAG continue annual follow-up with the health plans to assess their approaches and steps to improve member access to providers for categories that do not meet the time/distance standard.
- As the provider ratios and geographic distribution represent the potential capacity and distribution of contracted providers and may not directly reflect the availability of providers at any point in time, DHHS should consider the use of appointment availability and utilization analyses to evaluate providers' availability and members' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- In addition to assessing the number, distribution, and availability of providers, DHHS may wish to consider reviewing patient satisfaction survey results and grievance and appeal data to evaluate the degree to which members are satisfied with the care they have received.
- DHHS may wish to consider designing and implementing a focus study to investigate selected topics regarding access to care among Medicaid members by geographic region. Depending on available resources, study topics may include evaluating health disparities affecting access to care or the potential for providers in the network who are not providing services to Medicaid members (i.e., phantom provider network assessment).
- DHHS and the health plans should consider investigating the addition of uncontracted providers to assess if those providers are willing to contract. Further, DHHS and the health plans should assess the reasons that the providers are unwilling to contract with the health plans, if applicable.

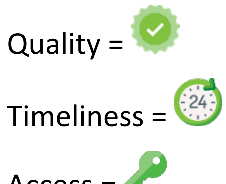
2. Evaluation of Utah Medicaid and CHIP Health Plans

Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—Medicaid

Medicaid ACOs Providing Only Physical Health Services

Health Choice Utah (Health Choice)

Following are Health Choice's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Health Choice continued its clinical PIP topic: *Well-Child Visits in the First 30 Months of Life.* This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-1 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-1—CY 2023 Performance Improvement Project Validation Results for Health Choice (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	5	0	0
	Implementation Total	**8/8**	**0/8**	**0/8**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2023, Health Choice submitted the PIP Design and Implementation stages. Health Choice had not progressed to the point of reporting outcomes during this validation cycle.

Table 2-2 displays the data for Health Choice's PIP.

Table 2-2—PIP Outcomes—*Well-Child Visits in the First 30 Months of Life* for Health Choice

Performance Indicator Results					
Performance Indicators	**Baseline (01/0/2022–12/31/2022)**		**Remeasurement 1 01/01/2023–12/31/2023**		**Sustained Improvement**
The percentage of eligible members who received six or more well-child visits with a PCP by 15 months of age.	N: 455 D: 958	46.5%			
The percentage of eligible members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	N: 637 D: 1106	59.8%			

N–Numerator; D–Denominator

The baseline rate for the percentage of members with six or more well-child visits on different dates of service on or before the child's 15-month birthday was 46.5 percent. The baseline rate for the percentage of members with two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday was 59.8 percent. HSAG will assess the health plan for achievement of improvement in the next annual submission when Remeasurement 1 data are reported.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. The health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to its overall success in achieving the desired outcomes for the PIP.

For the PIP, Health Choice used staff feedback and data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-3—PIP Barriers/Interventions for Health Choice

Barriers	Interventions
Incomplete well-child visits; not having at least six visits between 0–15 months of age or at least two visits between 15–30 months of age.	Well-child visit schedule cards sent to members 0–30 months of age to educate on the well-child visit schedule and used as a tracker for the dates of the well-child visits.
Parental confusion as to how many well-child visits children need between 0–30 months of age.	Conduct member outreach to remind parents of well-child visit gaps in care and answer questions related to well-child visits.

Health Choice—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Health Choice:

- The PIP topic addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Health Choice designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Health Choice.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP progresses, HSAG offers the following recommendations:

- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Develop an evaluation process and determine evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Implement intervention-specific evaluation results to guide the next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the final audit report (FAR) for the HEDIS MY 2022 showed that Health Choice's HEDIS compliance auditor found Health Choice's information systems (IS) and processes to be compliant with the applicable IS standards and reporting requirements for HEDIS MY 2022. Health Choice contracted with an external software vendor with HEDIS Certified Measures℠,[2-1] for measure production and rate calculation. HSAG's review of Health Choice's FAR revealed that Health Choice's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to performance measure validation (PMV) results.

Performance Measure Outcomes

Table 2-4 shows Health Choice's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

[2-1] HEDIS Certified Measures ℠ is a service mark of the NCQA.

Table 2-4—Health Choice HEDIS MY 2022 Results

HEDIS Measure	Health Choice MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	**71.87%**	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	67.82%	60.91%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	94.81%	92.60%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**35.74%**	52.43%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**50.12%**	55.92%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	**60.83%**	63.16%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients with Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**50.61%**	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	75.28%	60.86%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**26.28%**	35.55%

HEDIS Measure	Health Choice MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	**72.42%**	82.95%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**72.68%**	76.96%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	73.83%	73.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**72.75%**	76.75%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**46.45%**	56.76%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**46.36%**	56.50%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*
**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.[2-2]*

Health Choice—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Health Choice exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for URI—3 months–17 years*
- *Controlling High Blood Pressure*

[2-2] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Health Choice fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 2*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

Health Choice fell below the MY 2022 NCQA Quality Compass average for 11 of the 15 performance indicators (73.33 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.

- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending schedule appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claims data, addressing missing services, or partnering with the health plan on initiatives.
  - The health plan has the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the health plan's QAPIP program is aligned with performance goals.
- Implementing programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Health Choice measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Health Choice—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-5 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-5—Summary of Scores for the Standards for Health Choice

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	19	17	2	0	0	95%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	26	2	0	0	96%
	Totals	**75**	**75**	**71**	**4**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services

- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Health Choice:

- Develop a process to ensure that member correspondence is written in easy-to-understand language.
- Update its policy on grievances to include all requirements.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

VALIDATION OF NETWORK ADEQUACY

Health Choice—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-6 displays the number and percentage of provider categories by provider domain wherein Health Choice met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-6—Compliance With Time/Distance Standards by Provider Domain—Health Choice

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	15	88.2%	
Specialists—Pediatric	17	2	11.8%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	5	71.4%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-7 displays the provider domains and categories wherein Health Choice failed to meet the time/distance standards at the statewide level.

Table 2-7—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Laboratory; Outpatient Dialysis	
Hospitals	Hospital—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	
Specialists—Adult	Endocrinology; Infectious Disease	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

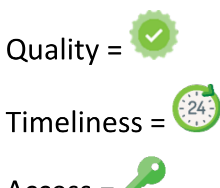
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Health Choice did not meet the time/distance standard, HSAG recommends that Health Choice assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Health Choice should ensure all providers are appropriately identified in future data submissions.

Healthy U

Following are Healthy U's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Healthy U continued its clinical PIP topic: *Improving Access to Well Visits in the First 15 and 30 Months of Life*. This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-8 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-8—CY 2023 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	5	0	0
	Implementation Total	**8/8**	**0/8**	**0/8**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2023, Healthy U submitted the PIP Design and Implementation stages. Healthy U had not progressed to the point of reporting outcomes during this validation cycle.

Table 2-9 displays data for Healthy U's PIP.

Table 2-9—PIP Outcomes—Improving Access to Well Visits in the First 15 and 30 Months of Life for Healthy U

Performance Indicator Results					
Performance Indicators	**Baseline (01/0/2022–12/31/2022)**		**Remeasurement 1 01/01/2023–12/31/2023**		**Sustained Improvement**
The percentage of eligible members who received six or more well-child visits with a PCP by 15 months of age.	N: 864 D: 1,966	44.0%			
The percentage of eligible members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	N: 1,504 D: 2,359	63.8%			

N–Numerator; D–Denominator

The baseline rate for the percentage of members with six or more well-child visits with a PCP by 15 months of age was 44.0 percent. The baseline rate for the percentage of members with two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday was 63.8 percent. The health plan will be assessed for achievement of improvement in the next annual submission when Remeasurement 1 data are reported.

Barriers/Interventions

For the PIP, Healthy U used a fishbone diagram and conducted root cause analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-10—PIP Barriers/Interventions for Healthy U

Barriers	Interventions
Parents who are not aware of the recommended frequency of well-child visits and are not aware of the importance of obtaining timely well-child visits for young children. In addition, staying current with the frequent number of well-child visits can be a challenge for busy parents.	In partnership with DHHS and other Medicaid ACOs, Healthy U developed a "Well Child Visit Record Card" to educate parents on the importance of obtaining timely well-child visits. The physical card also serves as a reminder to parents of the child's upcoming well visits by including a space to write the child's name, the child's doctor, and the date of well visit between birth and 30 months of age. The card is available in both English and Spanish. The card was finalized at the end of June 2023 and will be sent to parents with children in the target age group in July 2023.

Healthy U—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Healthy U:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Healthy U designed a scientifically sound project that was supported by using key research principles.
- The PIP topic addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG did not identify opportunities for improvement.

Recommendations

HSAG recommends that Healthy U consider:

- Implementing interventions in a timely manner to impact the Remeasurement 1 rates.
- Revisiting its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Including an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Intervention-specific evaluation results to guide the next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Healthy U's HEDIS compliance auditor found Healthy U's IS and processes to be partially compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Healthy U contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of the FAR revealed that Healthy U's HEDIS compliance auditor documented several strengths including:

- Healthy U used a National Drug Code (NDC) to CVX (vaccine administered codes) crosswalk for immunizations and loaded all prior year supplemental data sources which helped to augment specific HEDIS rates.
- Healthy U's oversight of its certified HEDIS vendor continues to improve every year.

The HEDIS compliance auditor also identified one opportunity for improvement along with a recommendation: Healthy U experienced performance issues with multiple reviews for the *Eye Exam (Retinal) Performed* measure and CDC exclusions, so HSAG strongly recommended that Healthy U review the abstraction approach for CDC to ensure its interpretation of the HEDIS technical specifications is accurate. The auditor further recommended that Healthy U submit all grey charts as part of its convenience sample review for next year.

Performance Measure Outcomes

Table 2-11 shows Healthy U's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-11—Healthy U HEDIS MY 2022 Results

HEDIS Measure	Healthy U MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	74.15%	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	63.82%	60.91%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	95.72%	92.60%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**38.42%**	52.43%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**52.07%**	55.92%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	66.18%	63.16%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	52.31%	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	67.84%	60.86%

HEDIS Measure	Healthy U MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**34.55%**	35.55%
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	85.67%	82.95%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	77.78%	76.96%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**68.81%**	73.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	80.89%	76.75%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**43.95%**	56.76%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**47.70%**	56.50%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*
**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.[2-3]*

Healthy U—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Healthy U exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

[2-3] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for URI—3 months–17 years*
- *Childhood Immunization Status—Combination 3*
- *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

Opportunities for Improvement

Healthy U fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Immunizations for Adolescents—Combination 2*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

Healthy U fell below the MY 2022 NCQA Quality Compass average for six of the 15 performance indicators (40 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization

data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.

- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the health plan's QAPIP is aligned with performance goals.
- Implementing programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Healthy U measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Healthy U—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-12 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-12—Summary of Scores for the Standards for Healthy U

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VII	Coverage and Authorization of Services	19	19	19	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**74**	**1**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System

Recommendations

HSAG offers the following recommendation:

- HSAG recommends that Healthy U update its policy on grievances and appeals to include all requirements.

VALIDATION OF NETWORK ADEQUACY

Healthy U—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-13 displays the number and percentage of provider categories by provider domain wherein Healthy U met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-13—Compliance With Time/Distance Standards by Provider Domain—Healthy U

Provider Domain	Number of Provider Categories in the Domain	Number of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Specialists—Pediatric	17	9	52.9%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	7	100.0%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-14 displays the provider domains and categories wherein Healthy U failed to meet the time/distance standards at the statewide level.

Table 2-14—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Hospitals	Hospital—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Otolaryngology, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

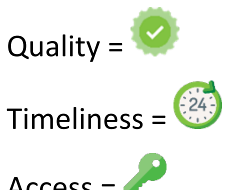
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Healthy U did not meet the time/distance standard, HSAG recommends that Healthy U assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U should ensure all providers are appropriately identified in future data submissions.

Molina Healthcare of Utah (Molina)

Following are Molina's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Molina continued its clinical PIP topic: *Well-Child Visits in the First 30 Months of Life.* This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-15 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-15—CY 2023 Performance Improvement Project Validation Results for Molina (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

<table>
<tr><th rowspan="2">Stage</th><th rowspan="2">Step</th><th colspan="3">Number/Percentage of Applicable Elements</th></tr>
<tr><th>Met</th><th>Partially Met</th><th>Not Met</th></tr>
<tr><td>Outcomes</td><td>9. Assess the Likelihood that Significant and Sustained Improvement Occurred</td><td colspan="3">Not Assessed</td></tr>
<tr><td colspan="2">Outcomes Total</td><td colspan="3">Not Assessed</td></tr>
<tr><td colspan="2">Percentage Score of Applicable Evaluation Elements Met</td><td colspan="3">100%</td></tr>
<tr><td colspan="2">Percentage Score of Applicable Critical Evaluation Elements Met</td><td colspan="3">100%</td></tr>
<tr><td colspan="2">Validation Status</td><td colspan="3">Met</td></tr>
</table>

Indicator Outcomes

For CY 2023, Molina submitted the PIP Design and Implementation stages. Molina had not progressed to the point of reporting outcomes during this validation cycle.

Table 2-16 displays data for Molina's PIP.

Table 2-16—PIP Outcomes—*Well-Child Visits in the First 30 Months of Life* for Molina

<table>
<tr><th colspan="6">Performance Indicator Results</th></tr>
<tr><th>Performance Indicators</th><th colspan="2">Baseline
(01/0/2022–12/31/2022)</th><th colspan="2">Remeasurement 1
01/01/2023–12/31/2023</th><th>Sustained Improvement</th></tr>
<tr><td rowspan="2">The percentage of members who had six or more well-child visits with a PCP during the first 15 months of life.</td><td>N: 1,084</td><td rowspan="2">46.6%</td><td></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>D: 2,206</td><td></td></tr>
<tr><td rowspan="2">The percentage of members who had two or more well-child visits with a PCP between ages 15–30 months.</td><td>N: 1,500</td><td rowspan="2">62.1%</td><td></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>D: 2,417</td><td></td></tr>
</table>

N–Numerator; D–Denominator

The baseline rate for the percentage of members with six or more well-child visits with a PCP during the first 15 months of life was 46.6 percent. The baseline rate for the percentage of members who had two or more well-child visits with a PCP between ages 15–30 months was 62.1 percent. HSAG will assess the health plan for achievement of improvement in the next annual submission when Remeasurement 1 data are reported.

Barriers/Interventions

For the PIP, Molina used data analysis and a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-17—PIP Barriers/Interventions for Molina

Barriers	Interventions
Low health literacy—members seek medical care only when ill.	Partner with a vendor to provide outreach, education, service attestation, and gift card fulfillment for completing well-child visits. Provide a report of members missing well-child visits to the vendor.
Members lack education on importance of well-child visits.	Collaborate with other Medicaid ACOs to disseminate well-child visit card and tracker. The card includes information on the importance of well-child visits and lists required visits/time frames with space to track visits.
Providers lack understanding of the Well-Child Visits in the First 30 Months of Life (W30) measure and requirements.	Missing services lists disseminated to providers who opt-in to pay-for-quality (P4Q) program, showing which members need well-child visits. Providers are offered a bonus for closing gaps.

Molina—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Molina:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Molina designed a scientifically sound project that was supported by using key research principles.
- The PIP topic addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement

HSAG did not identify opportunities for improvement.

Recommendations

HSAG recommended that Molina:

- Continually work on its PIP throughout the year.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan should consider including data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Use intervention-specific evaluation results to guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Molina contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of Molina's FAR revealed that Molina's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-18 shows Molina's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-18—Molina HEDIS MY 2022 Results

HEDIS Measure	Molina MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	73.95%	72.74%
Antidepressant Medication Management		

HEDIS Measure	Molina MY 2022 Rate	MY 2022 NCQA Quality Compass Average
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	70.10%	60.91%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	94.77%	92.60%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**34.39%**	52.43%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**44.04%**	55.92%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	**41.36%**	63.16%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**46.72%**	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	**40.88%**	60.86%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**23.11%**	35.55%
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	**76.40%**	82.95%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**72.02%**	76.96%

HEDIS Measure	Molina MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	74.19%	73.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**54.99%**	76.75%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**46.60%**	56.76%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**47.45%**	56.50%

Rates in ***red*** *font indicate the rate fell below the Quality Compass average.*

**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[2-4]

Molina—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Molina exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for URI—3 months–17 years*
- *Use of Imaging Studies for Low Back Pain*

[2-4] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

Opportunities for Improvement

Molina fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 2*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

Molina fell below the MY 2022 NCQA Quality Compass average for 11 of the 15 performance indicators (73.33 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:

  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the QAPIP is aligned with performance goals.
- Implementing programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Health Choice measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Molina—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-19 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-19—Summary of Scores for the Standards for Molina

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	6	1	0	0	93%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	19	17	2	0	0	95%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
	Totals	**75**	**75**	**70**	**5**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Emergency and Poststabilization Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Molina:

- Update its policies regarding disenrollment and member rights to include all requirements.
- Update its policies and provider manual to include the applicable time frame for making pharmacy decisions.
- Update its policies to include applicable time frames for making expedited authorization decisions and requesting State fair hearings.

VALIDATION OF NETWORK ADEQUACY

Molina—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-20 displays the number and percentage of provider categories by provider domain wherein Molina met the time/distance standards at the statewide level. HSAG presented detailed current and

speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-20—Compliance With Time/Distance Standards by Provider Domain—Molina

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Specialists—Pediatric	17	7	41.2%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-21 displays the provider domains and categories wherein Molina failed to meet the time/distance standards at the statewide level.

Table 2-21—Provider Categories That Failed to Meet Time/Distance Standards—Molina*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology; Mammography; Outpatient Infusion/Chemotherapy**	
Hospitals	Hospital—Pediatric	

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric**; Endocrinology, Pediatric; Gastroenterology, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric**; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

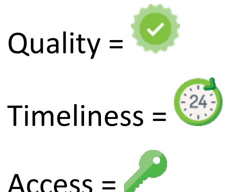
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Molina did not meet the time/distance standard, HSAG recommends that Molina assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina should ensure all providers are appropriately identified in future data submissions.

SelectHealth Community Care (SelectHealth CC)

Following are SelectHealth CC's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, SelectHealth CC continued its clinical PIP topic: *Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members.* This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-22 summarizes the validation findings for each stage validated for CY 2023. Overall, 86 percent of all applicable evaluation elements received a score of *Met.*

Table 2-22—CY 2023 Performance Improvement Project Validation Results for SelectHealth CC (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	1	1	1
	8. Assess the Improvement Strategies	3	0	0
	Implementation Total	**4/6**	**1/6**	**1/6**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**86%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2023, SelectHealth CC submitted the PIP Design and Implementation stages. SelectHealth CC had not progressed to the point of reporting outcomes during this validation cycle.

Table 2-23 displays data for SelectHealth CC's PIP.

Table 2-23—PIP Outcomes—*Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* for SelectHealth CC

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2022—12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Sustained Improvement**
The percentage of eligible members who received six or more well-child visits with a primary care provider by 15 months of age.	N: 2,657 D: 4,524	58.7%			
The percentage of eligible members who received two or more well-child visits with a primary care provider on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	N: 3,810 D: 5,663	67.3%			

N–Numerator; D–Denominator

The baseline rate for the percentage of members who received six or well-child visits with a PCP by 15 months of age was 58.7 percent. The baseline rate for the percentage of members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday was 67.3 percent. The health plan will be assessed for

achievement of improvement in the next annual submission when Remeasurement 1 data are reported.

Barriers/Interventions

For the PIP, SelectHealth CC documented one barrier and intervention that were identified as a collaborative discussion with DHHS and other ACOs. The health plan had not initiated the intervention at the time of the PIP submission. The health plan documented that its QI team internally will conduct a causal/barrier analysis and determine additional PIP interventions.

Table 2-24—PIP Barriers/Interventions for SelectHealth CC

Barrier	Intervention
Member's lack of knowledge regarding well-child visits.	Health plan developed a well-child visits card mailing to remind members to schedule a well-child visit.

SelectHealth CC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for SelectHealth CC:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 86 percent of overall evaluation elements across all steps completed and validated.
- SelectHealth CC designed a scientifically sound project that was supported by using key research principles.
- The PIP topic addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for SelectHealth CC:

- Lack of timely initiation of intervention(s) in the remeasurement period.

Recommendations

HSAG recommends that SelectHealth CC consider:

- Ensuring that all documentation in the PIP Submission Form is documented correctly and completely to address each applicable evaluation element.
- Beginning intervention testing in a timely manner to impact the Remeasurement 1 rates.
- Documenting the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. In addition to other stakeholders, SelectHealth CC should also consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Having an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation data must be included in the PIP submission.
- Intervention-specific evaluation results to guide next steps for each individual intervention.
- Improvements in the narrative interpretation of data and reporting of factors affecting the validity of the data should be addressed in the next annual PIP submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that SelectHealth CC's HEDIS compliance auditor found SelectHealth CC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. SelectHealth CC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of SelectHealth CC's FAR revealed that SelectHealth CC's HEDIS compliance auditor documented the following key findings and recommendations:

- The auditor commended SelectHealth CC again for reporting nearly all Electronic Clinical Data Systems (ECDS) measures for some submissions and suggested that SelectHealth CC continue to explore possible source systems of record it may access and use for future continuation and expansion of ECDS reporting.

- Several of SelectHealth CC's initiatives, incentives, and forward-thinking updates to processes have resulted in notable increases in rates. For example:
  - For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, SelectHealth CC's increase in education handouts attached to the visit in the electronic health record (EHR) enabled verification that anticipatory guidance for nutrition was given to the patient via the education handout.
- The supplemental data impact report included events for measures that were not included in the events list used for primary source verification (PSV) selection for nonstandard data sources. These events were immaterial to reporting for the measures that were affected. HSAG recommends that SelectHealth CC ensure that all measures are included in the events list submitted for PSV for all nonstandard data sources used for future HEDIS reporting.
- During review of the HEDIS Record of Administration, Data Management and Processes (Roadmap) Section 5: Supplemental Data, multiple discrepancies were noted across numerous data sources. SelectHealth CC was able to successfully address these discrepancies in every Section 5 where they occurred. HSAG recommends that SelectHealth CC develop a process to reconcile all questions in Roadmap Section 5 against the designed supplemental data reporting strategy.

Performance Measure Outcomes

Table 2-25 shows SelectHealth CC's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-25—SelectHealth CC HEDIS MY 2022 Results

HEDIS Measure	SelectHealth CC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	79.76%	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	72.82%	60.91%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	96.07%	92.60%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**46.98%**	52.43%

HEDIS Measure	SelectHealth CC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	63.29%	55.92%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	70.07%	63.16%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	58.95%	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	72.24%	60.86%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**34.94%**	35.55%
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	92.75%	82.95%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	82.13%	76.96%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	75.73%	73.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	86.79%	76.75%

HEDIS Measure	SelectHealth CC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	58.73%	56.76%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**53.44%**	56.50%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[2-5]

SelectHealth CC—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth CC exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for URI—3 months–17 years*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*

[2-5] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

Opportunities for Improvement

SelectHealth CC fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Immunizations for Adolescents—Combination 2*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

SelectHealth CC fell below the 2022 NCQA Quality Compass average for three of the 15 performance indicators (20 percent), indicating a few areas of opportunity for improvement. Targeted improvement efforts could be focused on the following:

- Using results from data analysis (including segmentation analysis), survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the QAPIP is aligned with performance goals.
- Implementing programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since all of the SelectHealth CC measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

SelectHealth CCs—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-26 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-26—Summary of Scores for the Standards for SelectHealth CC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	8	3	0	0	86%
VII	Coverage and Authorization of Services	19	19	19	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**70**	**5**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Coverage and Authorization of Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Select Health CC:

- Update its policy regarding member rights to include all requirements.
- Revise its policy regarding emergency and poststabilization services to clarify SelectHealth CC's financial responsibility for these services.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

VALIDATION OF NETWORK ADEQUACY

SelectHealth CC—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-27 displays the number and percentage of provider categories by provider domain wherein SelectHealth CC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and SelectHealth CC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-27—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CC

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	17	3	17.6%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	5	71.4%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-28 displays the provider domains and categories wherein SelectHealth CC failed to meet the time/distance standards at the statewide level.

Table 2-28—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CC*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology**; Outpatient Infusion/Chemotherapy	
Hospitals	Hospital—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric**; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	

* To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Select Health CC did not meet the time/distance standard, HSAG recommends that Select Health CC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CC should ensure all providers are appropriately identified in future data submissions.

Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services

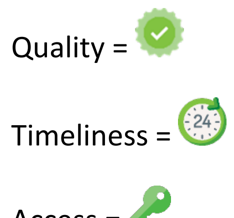
Health Choice Utah (Health Choice UMIC)

Following are Health Choice UMIC's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Health Choice UMIC continued its clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness.* This PIP aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Validation Results and Interventions

Table 2-29 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-29—CY 2023 Performance Improvement Project Validation Results for Health Choice UMIC

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3	0	0
	Outcomes Total	**3/3**	**0/3**	**0/3**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

Health Choice UMIC reported Remeasurement 2 data in the CY 2023 submission. Health Choice UMIC achieved statistically significant improvement in the Remeasurement 2 rates of both performance indicators over the baseline.

Table 2-30 displays the data for Health Choice UMIC's PIP.

Table 2-30—PIP—*Follow-Up After Hospitalization for Mental Illness* for Health Choice UMIC

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2020–12/31/2020)**		**Remeasurement 1 (01/01/2021–12/31/2021)**		**Remeasurement 2 (01/01/2022–12/31/2022)**		**Sustained Improvement**
1. Follow-Up After Hospitalization for Mental Illness within 7 Days	N: 22	12.0%	N: 55	24.4%*	N: 36	20.3%*	*Yes*
	D: 184		D: 225		D: 177		
2. Follow-Up After Hospitalization for Mental Illness within 30 Days	N: 44	23.9%	N: 91	40.4%*	N: 69	39.0%*	
	D: 184		D: 225		D: 177		

* Represent statistically significant improvement in the performance indicator rate over the baseline. N–Numerator; D–Denominator

The baseline rate for the percentage of eligible members 6 years of age and older who had a follow-up visit with a mental health provider within seven days after discharge was 12.0 percent. For Remeasurement 2, Health Choice UMIC reported a Performance Indicator 1 rate of 20.3 percent, which represents a statistically significant improvement ($p < 0.05$) of 8.3 percentage points over the baseline.

The baseline rate for the percentage of members six years of age and older who had a follow-up visit with a mental health provider within 30 days after discharge was 23.9 percent. For Remeasurement 2, Health Choice UMIC reported a Performance Indicator 2 rate of 39.0 percent, which represents a statistically significant improvement ($p < 0.05$) of 15.1 percentage points over the baseline.

Health Choice UMIC sustained statistically significant improvement over the baseline in both performance indicator rates for two consecutive remeasurement periods.

Barriers/Interventions

For the PIP, Health Choice UMIC used staff feedback and data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-31—PIP Barriers/Interventions for Health Choice UMIC

Barriers	Interventions
Inability to reach members due to poor contact information.	The behavioral health case manager used discharge documents with face sheets and the clinical health information exchange (cHIE) to find better contact information for the member and made three attempts to reach out and encourage follow-up care. Additionally, a member portal was developed to contact members identified as meeting the criteria for the *FUH* measure.
Lack of member engagement and follow through on appointment attendance.	The performance improvement coordinator (PIC) team works with the case management team to encourage outreach to the member or the member's inpatient case manager prior to discharge to ensure a discharge plan was in place and also to update member contact information.
Inability to receive timely notification for measure-eligible discharges to identify members for necessary case management outreach.	Obtaining admit, discharge, and transfer alerts from the cHIE will help to identify measure-eligible discharges. A process flow was created for review and execution of outreach based on this new data.

Health Choice UMIC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Health Choice UMIC:

- The PIP received an overall *Met* validation status with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.

- The health plan sustained statistically significant improvement in performance indicators' rates over the baseline for two consecutive measurement periods.
- The PIP topic that Health Choice UMIC selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Health Choice UMIC.

Recommendations

HSAG identified the following recommendations for Health Choice UMIC:

- Health Choice UMIC has demonstrated sustained improvement in this PIP for two consecutive remeasurement periods. The health plan should determine a new PIP topic for next year's submission with consultation and approval from DHHS.
- Health Choice UMIC should apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Health Choice UMIC should reach out to HSAG for technical assistance as it determines and designs the new PIP for next year's submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Health Choice UMIC's HEDIS compliance auditor found Health Choice UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Health Choice UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Health Choice UMIC's FAR revealed that Health Choice UMIC's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-32 shows Health Choice UMIC's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-32—Health Choice UMIC HEDIS MY 2022 Results

HEDIS Measure	Health Choice UMIC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**56.60%**	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	80.00%	60.91%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**35.36%**	52.43%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	75.95%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**31.39%**	55.92%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**42.09%**	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	62.03%	60.86%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	**71.57%**	79.00%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.94%

HEDIS Measure	Health Choice UMIC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Follow-Up After ED Visit for Mental Illness		
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up—Total)	**26.45%**	41.53%
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up—Total)	**36.36%**	55.19%
Follow-Up After ED Visit for Substance Use		
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up—Total)	28.38%	25.00%
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up—Total)	**35.31%**	36.43%
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up—Total)	**20.34%**	36.61%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up—Total)	**38.98%**	57.05%
Initiation and Engagement of SUD Treatment		
Initiation of SUD Treatment: Adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. (Initiation of SUD Treatment—Total)	48.87%	45.01%
Engagement of SUD Treatment: Adults who initiated treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit. (Engagement of SUD Treatment—Total)	15.86%	14.91%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	75.21%	73.35%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*
NA indicates that the rate was not presented because the denominator was less than 30.
**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[2-6]

[2-6] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

Health Choice UMIC—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Health Choice UMIC exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Controlling High Blood Pressure*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total*
- *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Health Choice UMIC fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Eye Exam (Retinal) Performed*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

Recommendations

Health Choice UMIC fell below the MY 2022 NCQA Quality Compass average for 10 of the 18 performance indicators (55.55 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the QAPIP is aligned with performance goals.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and value-based reimbursement [VBR] contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Health Choice UMIC care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Health Choice UMIC—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-33 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-33—Summary of Scores for the Standards for Health Choice UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	19	17	2	0	0	95%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	26	2	0	0	96%
	Totals	**75**	**75**	**71**	**4**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Health Choice UMIC:

- Develop a process to ensure that member correspondence is written in easy-to-understand language.
- Update its policy on grievances to include all requirements.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

VALIDATION OF NETWORK ADEQUACY

Health Choice UMIC—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-34 displays the number and percentage of provider categories by provider domain wherein Health Choice UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Health Choice UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-34—Compliance With Time/Distance Standards by Provider Domain—Health Choice UMIC

Provider Domain	Number of Provider Categories	Count of provider Categories Within Time Distance Standard*	Percent of Provider Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	4	4	100.0%	

Provider Domain	Number of Provider Categories	Count of provider Categories Within Time Distance Standard*	Percent of Provider Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	7	5	71.4%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	3	100.0%	
Behavioral Health—Facilities	4	2	50.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-35 displays the provider domains and categories wherein Health Choice UMIC failed to meet the time/distance standards at the statewide level.

Table 2-35—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice UMIC*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Mammography; Outpatient Dialysis	
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Health Choice UMIC did not meet the time/distance standard, HSAG recommends that Health Choice UMIC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Health Choice UMIC should ensure all providers are appropriately identified in future data submissions.

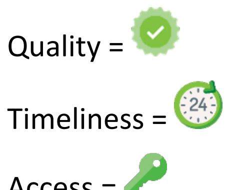
Healthy Outcomes Medical Excellence (HOME)

Following are HOME's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, HOME continued its clinical PIP topic: *Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic.* The goal of this PIP is to improve outcomes of members' health through focus on increasing the percentage of members receiving at least one preventive annual physical examination.

Validation Results and Interventions

Table 2-36 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-36—CY 2023 Performance Improvement Project Validation Results for HOME (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	2
	Outcomes Total	**2/2**	**0/2**	**0/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For this year's validation, HOME reported Remeasurement 1 results. The health plan documented a statistically significant improvement in the Remeasurement 1 rate over the baseline performance indicator rate.

Table 2-37 displays data for HOME's PIP.

Table 2-37—PIP—*Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic* for HOME

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2021–12/31/2021)**		**Remeasurement 1 (01/01/2022–12/31/2022)**		**Remeasurement 2 (01/01/2023–12/31/2023)**		**Sustained Improvement**
Percentage of HOME enrollees (20 years and older) who received at least one annual physical examination during measurement year.	N: 497	51.1%	N: 740	68.3%*			
	D: 973		D: 1,084				

*Rate represents statistically significant improvement over the baseline. N–Numerator; D–Denominator
N–Numerator D–Denominator

The baseline rate for the percentage of eligible members who received at least one annual physical examination during CY 2021 was 51.1 percent. For Remeasurement 1, HOME reported a rate of 68.3 percent, which represents a statistically significant improvement of 17.2 percentage points over the baseline. The health plan will be assessed for sustained improvement in the next annual validation cycle.

Barriers/Interventions

For the PIP, HOME used data analysis and a cause-and-effect diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-38—PIP Barriers/Interventions for HOME

Barriers	Interventions
Lack of patient compliance to schedule a physical examination. HOME serves unique population with high acuity who may need repeated crisis visits. This is likely to push routine visits to low priority for the members. In addition, the members are dependent on their caregivers or group home coordinators to arrange for non-crisis visits.	The case managers and providers explain the importance of annual physical examination for timely management of concerns that may exacerbate to critical presentation of issues. The front desk staff and case managers use the non-routine encounters as an opportunity to speak with the members and schedule annual physical examination, if due for one.
Inaccurate billed codes to capture preventative visits (<2%)	HOME coder met with the providers to educate them on the importance of correct coding and billing for annual physical visits to capture services delivered.

HOME—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for HOME:

- The PIP received an overall *Met* validation status with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- The health plan achieved statistically significant improvement in the performance indicators' rates over the baseline.
- The PIP topic that HOME selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for HOME.

Recommendations

HSAG provided the following recommendations for HOME:

- Continue with its improvement efforts to sustain the improvement achieved in PIP outcomes.

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Identify intervention-specific evaluation results to guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found HOME's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-39 presents HOME's MY 2022 performance measure results.

Table 2-39—HOME MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	HOME Rate*
Follow-Up Within 7 Days	48.39%
Follow-Up Within 30 Days	90.32%

*Rates with a small denominator are likely to be subject to wild swings in performance, and interpretations should be made with caution.

HOME—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for HOME:

- HOME demonstrated overall strength in its coordination of care between group homes and case management. Patient goals, discharge plans, and group home engagement were initiated at the beginning of hospital admissions to reduce the length of hospital stays and ensure timely follow-up care after discharge.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for HOME:

- During the review, HSAG noted that HOME did not have a process in place to ensure that all paper claims submitted to the vendor Smart Data Solutions (SDS) for translation into electronic data interchange (EDI) files were accounted for in the EDI files.

Recommendations

HSAG offered the following recommendations for HOME:

- HSAG recommends that HOME enhance its current vendor oversight to include tracking of all paper claims prior to scanning in order to ensure that all claims are transformed into EDI files.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

HOMES—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-40 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-40—Summary of Scores for the Standards for HOME

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	17	0	0	0	100%
X	Practice Guidelines	3	3	2	1	0	0	83%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
	Totals	**73**	**73**	**72**	**1**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard area:

- Practice Guidelines

Recommendations

HSAG recommends that HOME:

- Update its practice guidelines to ensure there is reference to American Society of Addiction Medicine (ASAM) level of care placement criteria.
- Review the practice guidelines on its website to ensure hyperlinks direct to the appropriate guideline.

VALIDATION OF NETWORK ADEQUACY

HOME—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-41 displays the number and percentage of provider categories by provider domain wherein HOME met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and HOME in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-41—Compliance With Time/Distance Standards by Provider Domain—HOME

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Specialists—Pediatric	17	17	100.0%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	6	85.7%	
Hospitals	2	2	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-42 displays the provider domains and categories wherein HOME failed to meet the time/distance standards at the statewide level.

Table 2-42—Provider Categories That Failed to Meet Time/Distance Standards—HOME*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

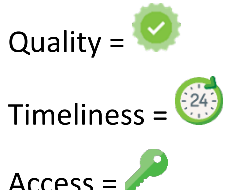
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which HOME did not meet the time/distance standard, HSAG recommends that HOME assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, HOME should ensure all providers are appropriately identified in future data submissions.

Healthy U Integrated

Following are Healthy U Integrated's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Healthy U Integrated continued its clinical PIP topic: *Improving Adults' Access to Preventive/Ambulatory Care Services*. The PIP submitted by Healthy U Integrated aims to increase the percentage of adult members receiving annual ambulatory or preventive care visits with a physician.

Validation Results and Interventions

Table 2-43 summarizes the validation findings for the PIP validated for CY 2023. Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-43—CY 2023 Performance Improvement Project Validation Results for Healthy U Integrated (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
Design Total		**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
Implementation Total		**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	0	1
Outcomes Total		**1/2**	**0/2**	**1/2**
Percentage Score of Applicable Evaluation Elements *Met*		**95%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

Healthy U Integrated reported Remeasurement 2 data. There was a decline in the performance indicator rate, and the health plan did not document achievement in significant clinical or programmatic improvement during Remeasurement 2.

Table 2-44 displays data for Healthy U Integrated's PIP.

Table 2-44—PIP—*Improving Adults' Access to Preventive/Ambulatory Care Services* for Healthy U Integrated

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2020–12/31/2020)**		**Remeasurement 1 (01/01/2021–12/31/2021)**		**Remeasurement 2 (01/01/2022–12/31/20221)**		**Sustained Improvement**
The percentage of members 20 years of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	N: 3,218	71.3%	N: 7,292	68.5%	N: 9,156	64.0%	*Not Assessed*
	D: 4,516		D: 10,642		D: 14,310		

N–Numerator D–Denominator

The baseline rate for the percentage of eligible members 20 years of age and older who received one or more ambulatory or preventive care visits during the measurement year was 71.3 percent. For Remeasurement 2, Healthy U Integrated documented a 7.3 percentage point decrease in performance over the baseline for a Remeasurement 2 rate of 64.0 percent. The health plan noted a large increase in its Integrated Care membership as the likely reason for a negative impact on members seeking nonurgent primary or ambulatory care visits.

Barriers/Interventions

For the PIP, Healthy U Integrated used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-45—PIP Barriers/Interventions for Healthy U Integrated

Barriers	Interventions
The Medicaid expansion population may be new to health insurance and unsure of how to navigate the health system or find a primary care provider (PCP).	The health plan is conducting a phone outreach campaign to educate members on the importance of identifying a PCP and making an appointment to see that provider annually. Members who do not have an attributed PCP are the target of both the letter and phone outreach.
Due to the large increase in the Medicaid membership coupled with limited resources in staffing, the health plan does not have the capability to conduct personalized outreach calls to each member via text or interactive voice response (IVR).	The health plan has signed a contract with a new member engagement vendor that has the capability to conduct text messaging and IVR campaigns. The first text messaging campaign was launched in the third quarter of 2022 and served two purposes: • Gain members' consent to contact them via text messaging. • Provide additional messaging in the IVR call about the importance of having a PCP for members who do not have an attributed PCP. In addition, these members are asked if they would like to receive a follow-up email with additional resources for finding a PCP. If a member respond "yes," an email is sent to the member.

Healthy U Integrated—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Healthy U Integrated:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- Healthy U Integrated conducted appropriate processes to identify the barriers, and it implemented interventions that were logically linked to the barriers.
- The PIP topic that Healthy U Integrated selected addressed CMS' requirements related to quality outcomes—specifically, the quality and access to care and services.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Healthy U Integrated:

- There was a decline in the performance indicator rate, and the health plan did not document achievement of significant clinical or programmatic improvement during Remeasurement 2.

Recommendations

HSAG offered the following recommendations for Healthy U Integrated:

- Continually work on the PIP throughout the year.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions. Due to lack of improvement in performance indicator rate, the health plan should consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. Healthy U Integrated should also consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Conduct an evaluation process and document evaluation results for each intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Identify intervention-specific evaluation results to guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Healthy U Integrated's HEDIS compliance auditor found Healthy U Integrated's IS and processes to be partially compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Healthy U Integrated contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of the FAR revealed that Healthy U Integrated's HEDIS compliance auditor documented several strengths including:

- Healthy U Integrated used an NDC to CVX (vaccine administered codes) crosswalk for immunizations and loaded all prior year supplemental data sources which helped to augment specific HEDIS rates.
- Healthy U Integrated's oversight of its certified HEDIS vendor continues to improve every year.

The HEDIS compliance auditor also identified one opportunity for improvement along with a recommendation: Healthy U Integrated experienced performance issues with multiple reviews for the *Eye Exam (Retinal) Performed* measure and *CDC* exclusions, so HSAG recommended that Healthy U Integrated review the abstraction approach for *CDC* to ensure its interpretation of the HEDIS technical specifications is accurate. The auditor further recommended for Healthy U Integrated to submit all grey charts as part of its convenience sample review for next year.

Performance Measure Outcomes

Table 2-46 shows Healthy U Integrated's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-46—Healthy U Integrated HEDIS MY 2022 Results

HEDIS Measure	Healthy U MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**63.98%**	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	63.08%	60.91%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**36.25%**	52.43%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	75.95%

HEDIS Measure	Healthy U MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**45.74%**	55.92%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**47.45%**	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	68.81%	60.86%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NA	79.00%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.94%
Follow-Up After ED Visit for Mental Illness		
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up—Total)	**23.26%**	41.53%
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up—Total)	**36.05%**	55.19%
Follow-Up After ED Visit for Substance Use		
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up—Total)	25.25%	25.00%
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up—Total)	**34.50%**	36.43%
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit,	**24.19%**	36.61%

HEDIS Measure	Healthy U MY 2022 Rate	MY 2022 NCQA Quality Compass Average
an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up—Total)		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up—Total)	**44.19%**	57.05%
Initiation and Engagement of SUD Treatment		
Initiation of SUD Treatment: Adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of SUD Treatment—Total)	49.71%	45.01%
Engagement of SUD Treatment: Adults who initiated treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit. (Engagement of SUD Treatment—Total)	**13.48%**	14.91%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**69.27%**	73.35%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.

**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[2-7]

Healthy U Integrated—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Healthy U Integrated exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Controlling High Blood Pressure*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total*

[2-7] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

Opportunities for Improvement

Healthy U Integrated fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Eye Exam (Retinal) Performed*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Healthy U Integrated fell below the MY 2022 NCQA Quality Compass average for 11 of the 18 performance indicators (61.11 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.

  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the QAPIP is aligned with performance goals.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Healthy U Integrated care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Healthy U Integrated—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-47 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-47—Summary of Scores for the Standards for Healthy U Integrated

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	19	19	0	0	0	100%
X	Practice Guidelines	3	3	2	1	0	0	83%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**73**	**2**	**0**	**0**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Practice Guidelines
- Grievance and Appeal System

Recommendations

HSAG recommends that Healthy U Integrated:

- Update its practice guidelines to ensure there is reference to ASAM level of care placement criteria.
- Review the practice guidelines on its website to ensure hyperlinks direct to the appropriate guideline.
- Update its policy on grievances and appeals to include all requirements.

VALIDATION OF NETWORK ADEQUACY

Healthy U Integrated—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-48 displays the number and percentage of provider categories by provider domain wherein Healthy U Integrated met the time/distance standards at the statewide level. HSAG presented detailed

current and speculative time/distance results to DHHS and Healthy U Integrated in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-48—Compliance With Time/Distance Standards by Provider Domain—Healthy U Integrated

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	4	4	100.0%	
Additional Physical Health—Facilities	7	7	100.0%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	3	100.0%	
Behavioral Health—Facilities	4	3	75.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-49 displays the provider domain and categories wherein Healthy U Integrated failed to meet the time/distance standards at the statewide level.

Table 2-49—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U Integrated*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

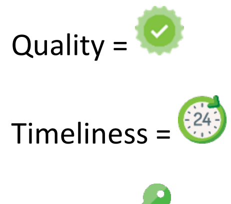
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Healthy U Integrated did not meet the time/distance standard, HSAG recommends that Healthy U Integrated assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U Integrated should ensure all providers are appropriately identified in future data submissions.

Molina (Molina UMIC)

Following are Molina UMIC's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023 validation, Molina UMIC continued its clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness*. The goal of this PIP is to improve the percentage of integrated Medicaid members receiving a follow-up visit with a mental health practitioner within 30 days of a hospital discharge for mental illness or intentional self-harm diagnoses. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of rehospitalization.

Validation Results and Interventions

Table 2-50 summarizes the PIP validation findings for each stage validated for CY2023. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-50—CY 2023 Performance Improvement Project Validation Results for Molina UMIC (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	8. Assess the Improvement Strategies	6	0	0
Implementation Total		**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	0
Outcomes Total		**2/2**	**0/2**	**0/2**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Molina UMIC progressed to reporting Remeasurement 2 results. Molina UMIC reported a decline in the Remeasurement 2 performance indicator rate as compared to the baseline; however, the health plan reported achievement of significant programmatic improvement related to the Care Connections gap closure intervention.

Table 2-51 displays data for Molina UMIC's PIP.

Table 2-51—PIP—*Follow-Up After Hospitalization for Mental Illness* for Molina UMIC

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2020–12/31/2020)**		**Remeasurement 1 (01/01/2021–12/31/2021)**		**Remeasurement 2 (01/01/2022–12/31/2022)**		**Sustained Improvement**
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a 30-day follow-up visit with a mental health practitioner.	N: 104	45.8%	N: 136	49.1%	N: 149	43.6%	*Not Assessed*
	D: 227		D: 277		D: 342		

N–Numerator; D–Denominator

For the baseline measurement period, Molina UMIC reported that for 45.8 percent of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, there was a 30-day follow-up visit with a mental health practitioner.

For Remeasurement 2, the performance indicator rate was 43.6 percent, which represents a decrease of 2.2 percentage points below the baseline rate.

Barriers/Interventions

For the PIP, Molina UMIC used a fishbone diagram and staff feedback to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-52—PIP Barriers/Interventions for Molina UMIC

Barriers	Interventions
No established behavioral health provider.	Partner with Molina Care Connections to offer members an opportunity to meet telephonically with a licensed clinical social worker (LCSW) and complete a follow-up visit within 30 days of hospitalization.
Poor outpatient treatment prior to inpatient care—no/poor patient/doctor relationship.	
Due to coronavirus disease 2019 (COVID-19), some patients may not feel comfortable going into an office setting.	

Molina UMIC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Molina UMIC:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- Molina UMIC conducted appropriate processes to identify the barriers, and it implemented interventions that were logically linked to the barriers.
- Molina UMIC reported significant programmatic improvement related to the Care Connections gap closure intervention.
- The PIP topic that Molina UMIC selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Molina UMIC:

- Molina UMIC reported a decline in the Remeasurement 2 performance indicator rate as compared to the baseline.

Recommendations

HSAG identified the following recommendations for Molina UMIC:

- Consider retiring this PIP and initiating a new PIP topic for next year's submission with consultation and approval from DHHS.
- Continue to expand the successful intervention to realize improvement in the overall performance indicator rate.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Reach out to HSAG for technical assistance as Molina UMIC determines and designs the new PIP.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Molina UMIC's HEDIS compliance auditor found Molina UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Molina UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Molina UMIC's FAR revealed that Molina UMIC's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-53 shows Molina UMIC's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-53—Molina UMIC HEDIS MY 2022 Results

HEDIS Measure	Molina UMIC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**64.66%**	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	62.69%	60.91%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**32.18%**	52.43%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	75.95%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**37.71%**	55.92%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**40.39%**	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	**45.01%**	60.86%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	83.33%	79.00%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.94%

HEDIS Measure	Molina UMIC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Follow-Up After ED Visit for Mental Illness		
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up—Total)	**24.38%**	41.53%
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up—Total)	**33.75%**	55.19%
Follow-Up After ED Visit for Substance Use		
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up—Total)	25.27%	25.00%
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up—Total)	40.13%	36.43%
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up—Total)	**24.27%**	36.61%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up—Total)	**43.57%**	57.05%
Initiation and Engagement of SUD Treatment		
Initiation of SUD Treatment: Adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of SUD Treatment)	46.33%	45.01%
Engagement of SUD Treatment: Adults who initiated treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit. (Engagement of SUD Treatment)	**14.29%**	14.91%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**69.23%**	73.35%

Rates in ***red*** *font indicate the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.

**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[2-8]

[2-8] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

Molina UMIC—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Molina UMIC exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total*

Opportunities for Improvement

Molina UMIC fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Molina UMIC fell below the MY 2022 NCQA Quality Compass average for 11 of the 18 performance indicators (61.11 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the QAPIP is aligned with performance goals.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Molina UMIC care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Molina UMIC—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-54 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance

score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-54—Summary of Scores for the Standards for Molina UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	6	1	0	0	93%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	19	17	2	0	0	95%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**70**	**5**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Emergency and Poststabilization Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Molina UMIC:

- Update its policies regarding disenrollment and member rights to include all requirements.
- Update its policies and provider manual to include the applicable time frame for making pharmacy decisions.
- Update its policies to include applicable time frames for making expedited authorization decisions and requesting State fair hearings.

VALIDATION OF NETWORK ADEQUACY

Molina UMIC—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-55 displays the number and percentage of provider categories by provider domain wherein Molina UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Molina UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-55—Compliance With Time/Distance Standards by Provider Domain—Molina UMIC

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	4	4	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	3	100.0%	
Behavioral Health—Facilities	4	2	50.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-56 displays the provider domains and categories wherein Molina UMIC failed to meet the time/distance standards at the statewide level.

Table 2-56—Provider Categories That Failed to Meet Time/Distance Standards—Molina UMIC*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology; Mammography; Outpatient Infusion/Chemotherapy**	
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

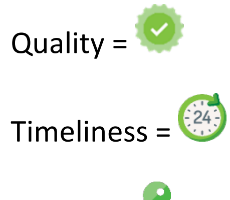
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Molina UMIC did not meet the time/distance standard, HSAG recommends that Molina UMIC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina UMIC should ensure that all providers are appropriately identified in future data submissions.

SelectHealth CC (SelectHealth CC UMIC)

Following are SelectHealth CC UMIC's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, SelectHealth CC UMIC continued its clinical PIP topic: *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members.* The goal of this PIP is to improve the percentage of integrated Medicaid members receiving a follow-up visit with a mental health practitioner within 30 days of a hospital discharge for mental illness or intentional self-harm diagnoses.

Validation Results and Interventions

Table 2-57 summarizes the validation findings for each stage validated for CY 2023. Overall, 85 percent of all applicable evaluation elements validated received a score of *Met.*

Table 2-57—CY 2023 Performance Improvement Project Validation Results for SelectHealth CC UMIC (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement(s)	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicator(s)	1	0	0
	6. Review the Data Collection Procedures	4	0	0
Design Total		**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	4	2	0
	Implementation Total	**7/9**	**2/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	0	1
	Outcomes Total	**1/2**	**0/2**	**1/2**
Percentage Score of Applicable Evaluation Elements *Met*		**85%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**90%**		
Validation Status		***Partially Met***		

Indicator Outcomes

For this year's validation, SelectHealth CC UMIC progressed to reporting Remeasurement 2 results. The health plan documented a decrease in the Remeasurement 2 rate over the baseline performance indicator rate.

Table 2-58 displays the data for SelectHealth CC UMIC's PIP.

Table 2-58—PIP—*7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* for SelectHealth CC UMIC

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2020–12/31/2020)**		**Remeasurement 1 (01/01/2021–12/31/2021)**		**Remeasurement 2 (01/01/2022–12/31/2022)**		**Sustained Improvement**
Percentage of Medicaid Integration members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within 7 days after discharge.	N: 110	36.5%	N: 182	38.2%	N: 197	33.5%	*Not Assessed*
	D: 301		D: 476		D: 589		

N–Numerator D–Denominator

The baseline rate for the percentage of eligible members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within seven days after discharge was 36.5 percent. For Remeasurement 2, the performance indicator rate

was 33.5 percent, which demonstrates a non-statistically significant decrease of 3.0 percentage points from the baseline.

Barriers/Interventions

For the PIP, SelectHealth CC UMIC completed a cause-and-effect diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-59—PIP Barriers/Interventions for SelectHealth CC UMIC

Barriers	Interventions
Lack of member care coordination before discharge.	Care manager identifies admitted members and works with patient navigator to connect with the member and to verify that a seven-day follow-up appointment has been scheduled before discharge. (Discontinued)
Due to an increase in the eligible member population, difficulty for members trying to access seven-day follow-up appointments.	Monthly interdisciplinary care team meetings were established to talk about individual cases and find solutions to access issues. (Discontinued)
Basic needs (i.e., transportation) not being met impacts members attending their seven-day follow-up appointment.	Health plan is working to develop an option to expand the Travel Safety Net.
Behavioral health (BH) provider refusal to see a member based on the member's history (e.g., no show or financial debt) impacts the scheduling of the member's seven-day follow-up appointment.	Developed a process so that if the BH Navigator encounters a SelectHealth CC UMIC BH provider refusing to schedule a seven-day follow-up appointment, they can notify SelectHealth CC UMIC to address the issue.
Members cannot remember the date of their follow-up appointment.	The hospital BH Navigators call the members within 24 hours of discharge to go over the appointment date and any barriers that may have arisen. The BH Navigators make three attempts to call the members.
Members unable to schedule/attend convenient follow-up appointments due to BH hours of operation.	A subgroup led by a physician is looking at expanding the BH network with new BH providers who have the availability to offer different care delivery options such as in home services, telehealth, and clinic hours.
Members are unaware of resources.	SelectHealth CC UMIC care managers go onsite weekly to meet with the BH Navigators and see the members to discuss the care management process and assist with any barriers that could impact the members attending their follow-up appointments.

SelectHealth CC UMIC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for SelectHealth CC UMIC:

- SelectHealth CC UMIC documented a sound PIP design and used appropriate QI processes to identify barriers and implement interventions.
- The PIP topic that Select Health CC UMIC selected addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for SelectHealth CC UMIC:

- The PIP received an overall *Partially Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 85 percent of overall evaluation elements across all steps completed and validated.
- SelectHealth CC UMIC had opportunities for improvement in capturing appropriate data to evaluate interventions for effectiveness and improving PIP outcomes.
- SelectHealth CC UMIC documented a decrease in the Remeasurement 2 performance indicator rate from the baseline rate. Additionally, SelectHealth CC UMIC documented the formation of the FUH Steering Committee and the FUH Workgroup as achievement of significant programmatic improvement. Having a quality improvement team is a requirement to conduct a PIP for documenting achievement of significant programmatic improvement.

Recommendations

HSAG offered the following recommendations for SelectHealth CC UMIC:

- Consider retiring this PIP and initiating a new PIP topic for next year's submission in consultation with and approval from DHHS.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Reach out to HSAG for technical assistance as SelectHealth CC UMIC determines and designs the new PIP.
- Provide appropriate intervention evaluation data linked to programmatic improvement.

If SelectHealth CC UMIC continues with the current PIP for next year's submission after receiving approval from DHHS, HSAG has the following recommendations:

- Revisit the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Conduct an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation data must be included in the PIP submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that SelectHealth CC UMIC's HEDIS compliance auditor found SelectHealth CC UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. SelectHealth CC UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of SelectHealth CC UMIC's FAR revealed that SelectHealth CC UMIC's HEDIS compliance auditor documented the following key findings and recommendations:

- The auditor commended SelectHealth CC UMIC again for reporting nearly all ECDS measures for some submissions and suggested that SelectHealth CC UMIC continue to explore possible source systems of record it may access and use for future continuation and expansion of ECDS reporting.
- Several of SelectHealth CC UMIC's initiatives, incentives, and forward-thinking updates to processes have resulted in notable increases in rates.
- The supplemental data impact report included events for measures that were not included in the events list used for PSV selection for nonstandard data sources. These events were immaterial to reporting for the measures that were affected. HSAG recommends that SelectHealth CC UMIC ensure that all measures are included in the events list submitted for PSV for all nonstandard data sources used for future HEDIS reporting.
- During review of Roadmap Section 5: Supplemental Data, multiple discrepancies were noted across numerous data sources. SelectHealth CC UMIC was able to successfully address these discrepancies in every Section 5 where they occurred. HSAG recommends that SelectHealth CC UMIC develop a process to reconcile all questions in Roadmap Section 5 against the designed supplemental data reporting strategy.

Performance Measure Outcomes

Table 2-60 shows SelectHealth CC UMIC's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table 2-60—SelectHealth CC UMIC HEDIS MY 2022 Results

HEDIS Measure	SelectHealth CC UMIC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	73.20%	72.74%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	**59.36%**	60.91%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**49.94%**	52.43%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	75.95%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	58.31%	55.92%
Hemoglobin A1c (HbA1c) Testing		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—
Eye Exam for Patients With Diabetes		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	55.61%	51.47%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	72.50%	60.86%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an	**74.42%**	79.00%

HEDIS Measure	SelectHealth CC UMIC MY 2022 Rate	MY 2022 NCQA Quality Compass Average
antipsychotic medication and had a diabetes screening test during the measurement year.		
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.94%
Follow-Up After Emergency Department Visit for Mental Illness		
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up—Total)	**36.43%**	41.53%
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up—Total)	**47.21%**	55.19%
Follow-Up After Emergency Department Visit for Substance Use		
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up—Total)	25.78%	25.00%
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up—Total)	39.59%	36.43%
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up—Total)	**33.45%**	36.61%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up—Total)	**54.50%**	57.05%
Initiation and Engagement of SUD Treatment		
Initiation of SUD Treatment: Adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of SUD Treatment—Total)	48.31%	45.01%
Engagement of SUD Treatment: Adults who initiated treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit. (Engagement of SUD Treatment—Total)	16.26%	14.91%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**72.66%**	73.35%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.
**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.[2-9]*

SelectHealth CC UMIC—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth CC UMIC exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Cervical Cancer Screening*
- *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total*
- *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total*

Opportunities for Improvement

SelectHealth CC UMIC fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Breast Cancer Screening*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*

[2-9] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

SelectHealth CC UMIC fell below the MY 2022 NCQA Quality Compass average for eight of the 18 performance indicators (44.44 percent), indicating some areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the QAPIP is aligned with performance goals.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.

- Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the SelectHealth CC UMIC care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

SelectHealth CC UMIC—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-61 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-61—Summary of Scores for the Standards for SelectHealth CC UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	8	3	0	0	86%
VII	Coverage and Authorization of Services	19	19	19	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**70**	**5**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Coverage and Authorization of Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Grievance and Appeal System

Recommendations

HSAG recommends that SelectHealth CC UMIC:

- Update its policy regarding member rights to include all requirements.
- Revise its policy regarding emergency and poststabilization to clarify SelectHealth CC UMIC's financial responsibility for these services.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

VALIDATION OF NETWORK ADEQUACY

SelectHealth CC UMIC—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-62 displays the number and percentage of provider categories by provider domain wherein SelectHealth CC UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and SelectHealth CC UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-62—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CC UMIC

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	4	4	100.0%	

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	7	5	71.4%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	3	100.0%	
Behavioral Health—Facilities	4	1	25.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-63 displays the provider domains and categories wherein SelectHealth CC UMIC failed to meet the time/distance standards at the statewide level.

Table 2-63—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CC UMIC*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology**; Outpatient Infusion/Chemotherapy	
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit**; Substance Abuse Facility	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Select Health CC UMIC did not meet the time/distance standard, HSAG recommends that Select Health CC UMIC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CC UMIC should ensure that all providers are appropriately identified in future data submissions.

Medicaid PIHP PMHPs Providing Mental Health and Substance Use Disorder Services

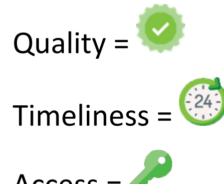
Bear River Mental Health Services (Bear River)

Following are Bear River's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Bear River continued its clinical PIP topic: *Youth Outcome Questionnaires (YOQ) or Outcome Questionnaires (OQ).* The goal of this PIP is to improve processes and outcomes of members' mental health care, by using outcome measurement instruments to increase clinician awareness of each member's current level of well-being or distress, which will provide a way to calibrate treatment interventions based on feedback as well as measure progress in treatment. The outcomes measurement instruments used in the PIP are Outcome Questionnaires (OQ 30.2) for adults 18 years and older, and Youth Outcome Questionnaires (YOQ 30.2) for members 5–18 years of age.

Validation Results and Interventions

Table 2-64 summarizes the validation findings for each stage validated for CY 2023. Overall, 80 percent of all applicable evaluation elements received a score of *Met.*

Table 2-64—CY 2023 Performance Improvement Project Validation Results for Bear River (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9**	**0**	**0**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	3	1	2
	Implementation Total	**6/9**	**1/9**	**2/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	1	0
	Outcomes Total	**2/3**	**1/3**	**0/3**
	Percentage Score of Applicable Evaluation Elements *Met*	**80%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**90%**		
	Validation Status	***Partially Met***		

Indicator Outcomes

For this year's validation, Bear River progressed to reporting Remeasurement 1 results. Bear River achieved statistically significant improvement in the Remeasurement 1 rate for one (frequency of YOQ completed by each member in a year) of the four performance indicators.

Table 2-65 displays data for Bear River's PIP.

Table 2-65—PIP—*YOQ or OQ* for Bear River

Performance Indicator Results					
Performance Indicators	**Baseline (01/0/2021–12/31/2021)**		**Remeasurement 1 01/01/2022–12/31/2022**		**Sustained Improvement**
1a. Frequency of OQ completed by each member in a year.	N: 5,662	36.5%	N: 7,524	36.0%	
	D: 15,525		D: 20,894		
1b. Frequency of YOQ completed by each member in a year.	N: 3,806	42.0%	N: 4,631	48.9%*	
	D: 9,052		D: 9,469		
2a. Percentage of OQ reports reviewed by clinician within three days.	N: 4,354	76.9%	N: 5,544	73.7%	
	D: 5,662		D: 7,524		

Performance Indicator Results					
Performance Indicators	**Baseline (01/0/2021–12/31/2021)**		**Remeasurement 1 01/01/2022–12/31/2022**		**Sustained Improvement**
2b. Percentage of YOQ reports reviewed by clinician within three days.	N: 2,527	66.4%	N: 2,752	59.4%	
	D: 3,806		D: 4,631		

*Rate indicates statistically significant improvement over the baseline rate. N–Numerator; D–Denominator

The baseline rate for the percentage of eligible members who completed an OQ in a year was 36.5 percent. For Remeasurement 1, the Performance Indicator 1a rate was 36.0 percent, which represents a decrease of 0.5 percentage points from the baseline. The baseline rate for the percentage of eligible members who completed a YOQ in a year was 42.0 percent. For Remeasurement 1, the Performance Indicator 1b rate was 48.9 percent, which represents a statistically significant ($p<0.05$) increase of 6.9 percentage points over the baseline. The baseline rate for the percentage of OQ reports reviewed by a clinician within three days of OQ administration was 76.9 percent. For Remeasurement 1, the Performance Indicator 2a rate was 73.7 percent, which represents a decrease of 3.2 percentage points from the baseline. The baseline rate for the percentage of YOQ reports reviewed by a clinician within three days of YOQ administration was 66.4 percent. For Remeasurement 1, the Performance Indicator 2b rate was 59.4 percent, which represents a decrease of 7.0 percentage points from the baseline.

Barriers/Interventions

For the PIP, Bear River used data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-66—PIP Barriers/Interventions for Bear River

Barriers	Interventions
OQ/YOQ are not being opened by the clinician.	Training clinicians on opening the OQ/YOQ in the electronic health record every time they meet with a member. This will be done during monthly staff meetings and on an individual basis if the clinician is not applying the training given during the staff meetings.
Member is given OQ/YOQ only once per month.	The process was changed to include OQ/YOQ during each individual or family therapy session.

Bear River—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Bear River:

- Bear River designed a scientifically sound project that was supported by using key research principles.
- The PIP topic that Bear River selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.
- Bear River achieved statistically significant improvement in the Remeasurement 1 rate for one of the four performance indicators.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Bear River:

- The PIP received an overall *Partially Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 80 percent of overall evaluation elements across all steps completed and validated.
- There were opportunities to improve the documentation of the interventions and reporting of intervention evaluation processes, evaluation data, and next steps.
- Three of the four performance indicators had a decline in performance as compared to the baseline.

Recommendations

HSAG provided the following recommendations for Bear River:

- Continually work on the PIP throughout the year.
- Ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- Revisit the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.

- Implement an evaluation process and document evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. For example, for the staff training intervention initiated in January 2023, the health plan must provide data about how many trainings were completed and how the health plan determined whether the trainings were effective.
- Implement intervention-specific evaluation results must guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Bear River's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-67 presents Bear River's MY 2022 performance measure results.

Table 2-67—Bear River MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Bear River Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**51.04%**	51.93%
Follow-Up Within 30 Days	69.71%	68.20%

The red font indicates that the health plan scored below the State average for this measure.

Bear River—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Bear River:

- Bear River addressed the health care needs of its members across various scenarios. Members in need of care could meet with Bear River providers in person or remotely via telehealth. Bear River operated a receiving center for members in need of urgent substance use or behavioral health services, as well as a Mobile Crisis Outreach Team (MCOT) to facilitate rapid response to health

care crises involving members. Bear River also worked with schools to address the behavioral health needs of children.

- Bear River monitored its performance on the *Follow-Up After Hospitalization for Mental Illness* measure and confirmed the decrease in its *7-Day Follow-Up* rate between MY 2021 and MY 2022. Bear River implemented steps to ensure timely follow-up for members and improve its performance on this indicator.

Opportunities for Improvement

HSAG identified the following opportunity for improvement for Bear River:

- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

Recommendations

HSAG offered the following recommendations related to PMV:

- Consider conducting a root cause analysis to determine potential interventions to improve the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Bear River—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-68 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-68—Summary of Scores for the Standards for Bear River

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	5	2	0	0	86%
IV	Emergency and Poststabilization Services	11	11	10	1	0	0	95%
VII	Coverage and Authorization of Services	17	17	16	1	0	0	97%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**71**	**71**	**67**	**4**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Practice Guidelines
- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services

Recommendations

HSAG recommends that Bear River:

- Update its policies on member rights and poststabilization services to include all requirements.
- Include all applicable information regarding advance directives in a member-facing document or platform, such as its website.
- Update is notice of adverse benefit determination documents to indicate correct time frames for resolving standard and expedited appeals.

VALIDATION OF NETWORK ADEQUACY

Bear River—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-69 displays the number and percentage of provider categories wherein Bear River met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-69—Compliance With Time/Distance Standards by Urbanicity—Bear River*

		Frontier		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Bear River	10	4	40.0%	4	40.0%	

*Analyses were restricted to counties and urbanicities within Bear River's service area.

Opportunities for Improvement

Table 2-70 displays the provider domains and categories wherein Bear River failed to meet the time/distance standards.

Table 2-70—Provider Categories That Failed to Meet Time/Distance Standards—Bear River*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**; General Hospitals with a Psychiatric Unit**	
Behavioral Health—Providers	Behavioral Medical - Adult**; Behavioral Medical—All**; Behavioral Medical—Pediatric**; Behavioral Therapist—Pediatric**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).
** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Bear River did not meet the time/distance standard, HSAG recommends that Bear River assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons.

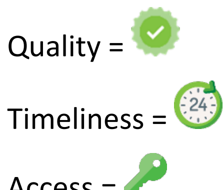
Central Utah Counseling Center (Central)

Following are Central's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Central continued its clinical PIP topic: *Inpatient Readmission Rates*. The goal of this PIP is to improve processes and outcomes of members' mental health care and decrease readmission to inpatient psychiatric hospitals.

Validation Results and Interventions

Table 2-71 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-71—CY 2023 Performance Improvement Project Validation Results for Central (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	4	0	0
	Design Total	**10/10**	**0/10**	**0/10**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	0
	Outcomes Total	**2/2**	**0/2**	**0/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

Central progressed to reporting Remeasurement 2 results. The health plan documented an increase in the Remeasurement 2 rate over the baseline performance indicator rate; however, the improvement was not statistically significant. The health plan documented implementation of the mobile crisis outreach team (MCOT) services intervention as significant programmatic improvement in processes of care.

Table 2-72 displays data for Central's PIP.

Table 2-72—PIP—*Inpatient Readmission Rates* for Central

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2019–12/31/2020)**		**Remeasurement 1 (01/01/2020–12/31/2021)**		**Remeasurement 2 (01/01/2021–12/31/2022)**		**Sustained Improvement**
The percentage of eligible psychiatric discharges in the denominator for which the members did not have a psychiatric readmission within 12 months.	N: 82 D: 119	68.9%	N: 106 D: 146	72.6%	N: 110 D: 155	71.0%	*Not Assessed*

N–Numerator D–Denominator

The baseline rate for the percentage of psychiatric discharges during CY 2019 that did not have a psychiatric readmission within next 12 months was 68.9 percent. For Remeasurement 2, Central reported a rate of 71.0 percent, which represents a decline from the Remeasurement 1 rate and a non-statistically significant improvement of 2.1 percentage points over the baseline.

Barriers/Interventions

For the PIP, Central used staff feedback and data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-73—PIP Barriers/Interventions for Central

Barriers	Interventions
For members coming out of high levels of care (specifically inpatient hospitals), there has been a varied approach on how to meet their needs.	Implement a standardized care approach wherein all Medicaid enrollees will not only have a primary therapist assigned to the case, but also an additional and specific case manager who will make frequent/weekly outreach to individuals discharged from inpatient settings for one year following discharge.
	New mobile crisis outreach team (MCOT) was developed and started. MCOT will respond to crisis situations throughout the six-county area that Central covers.

Central—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Central:

- The PIP topic that Central selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.
- The health plan achieved improvement in the performance indicator rate over the baseline for two consecutive years; however, the improvement achieved was not statistically significant over the baseline.
- The health plan also reported MCOT services intervention as significant programmatic improvement in processes of care.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of overall evaluation elements and 100 percent of critical evaluation elements across all steps completed and validated.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Central.

Recommendations

The health plan documented that it would discontinue the PIP; however, it would continue to emphasize the importance of the case management intervention and MCOT beyond the PIP. While no opportunities for improvement were identified, HSAG recommends that Central:

- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Determine a new PIP topic for next year's submission in consultation and approval from DHHS.
- Reach out to HSAG for technical assistance as it determines and designs the new PIP.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Central's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-74 presents Central's MY 2022 performance measure results.

Table 2-74—Central MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Central Rate	Statewide PMHP Average
Follow-Up Within 7 Days	66.29%	51.93%
Follow-Up Within 30 Days	78.65%	68.20%

Central—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Central:

- Central had strong validation procedures in place as part of its data integration and measure-specific review processes. Multiple staff members verified inclusion/exclusion criteria for the members included in the measure. Central staff members also ensured that accurate and complete

data were included in both their hospitalization tracking spreadsheet and their claims tracking spreadsheet.

- Central is committed to ensuring that members receive follow-up care. Central's MCOT and Case Management team followed members closely after discharge to make sure they integrated back into the community without difficulty and into aftercare services as needed.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Central:

- Central's staff members were not reviewing services reported for members in the numerator positive file to make sure that all services met encounter criteria for submission.

Recommendations

HSAG offered the following recommendations for Central:

- The State specifications for the *Follow-Up After Hospitalization for Mental Illness* measure indicate that numerator events can only include encounters that were submitted to DHHS. HSAG recommends for future reporting that Central conduct additional validations to verify that numerator compliant cases are based on services that were submitted to DHHS as encounters. Central could add a column to its hospital tracking spreadsheet as a prompt to confirm that each follow-up service meets encounter criteria.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Central—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-75 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-75—Summary of Scores for the Standards for Central

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	17	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**70**	**70**	**69**	**1**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services

- Coverage and Authorization of Services

- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard area:

- Grievance and Appeal System

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that Central revise its policy on appeals to include accurate time frames for appealing adverse benefit determinations.

VALIDATION OF NETWORK ADEQUACY

Central—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-76 displays the number and percentage of provider categories wherein Central met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-76—Compliance With Time/Distance Standards by Urbanicity—Central*

		Frontier		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Central	12	4	33.3%	3	25.0%	

*Analyses were restricted to counties and urbanicities within Central's service area.

Opportunities for Improvement

Table 2-77 displays the provider domains and categories wherein Central failed to meet the time/distance standards.

Table 2-77—Provider Categories That Failed to Meet Time/Distance Standards—Central*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic**; General Hospitals with a Psychiatric Unit; Substance Abuse Facility	
Behavioral Health—Providers	Behavioral Medical—Adult; Behavioral Medical—All**; Behavioral Medical—Pediatric**; Behavioral Therapist—Adult; Behavioral Therapist—Pediatric**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).
** No data were submitted for the provider category.

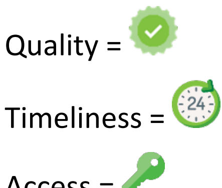
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Central did not meet the time/distance standard, HSAG recommends that Central assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Central should ensure all providers are appropriately identified in future data submissions.

Davis Behavioral Health (Davis)

Following are Davis' findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Davis continued its clinical PIP topic: *Access to Care.* The PIP Davis submitted aims to increase access to care by improving the timeliness of substance use treatment from the date of initial contact by the member for treatment to the first two clinical appointments offered to the member.

Validation Results and Interventions

Table 2-78 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-78—CY 2023 Performance Improvement Project Validation Results for Davis (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3	0	0
Outcomes Total		**3/3**	**0/3**	**0/3**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Davis progressed to reporting Remeasurement 3 results. Davis achieved statistically significant improvement in both performance indicator rates over the baseline.

Table 2-79 displays data for Davis' PIP.

Table 2-79—PIP—*Access to Care* for Davis

Performance Indicator	Baseline (01/01/2019–12/31/2019)		Remeasurement 1 (01/01/2020–12/31/2020)		Remeasurement 2 (01/01/2021–12/31/2021)		Remeasurement 3 (01/01/2022–12/31/2022)		Sustained Improvement
1. Percentage of initial appointments scheduled within 7 calendar days from first contact.	N: 126 D: 428	29.4%	N: 417 D: 531	78.5%*	N: 699 D: 764	91.5%*	N: 713 D: 804	88.7%*	*Yes*
2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	N: 195 D: 226	86.3%	N: 292 D: 323	90.4%	N: 376 D: 412	91.3%*	N: 406 D: 439	92.5%*	*Yes*

* Indicates statistically significant improvement in the rate over the baseline. N–Numerator; D–Denominator

The baseline rate for the percentage of members who had an initial appointment scheduled within seven calendar days from the first contact was 29.4 percent. For Remeasurement 3, the Performance Indicator 1 rate of 88.7 percent demonstrated a statistically significant increase ($p < 0.0001$) of 59.3 percentage points over the baseline.

The baseline rate for the percentage of members who had a second appointment scheduled within 14 calendar days from treatment admission was 86.3 percent. For Remeasurement 3, the Performance Indicator 2 rate of 92.5 percent demonstrated a statistically significant increase ($p = 0.0102$) of 6.2 percentage points over the baseline.

Davis sustained statistically significant improvement over the baseline in both performance indicator rates for two consecutive remeasurement periods.

Barriers/Interventions

For the PIP, Davis used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-80—PIP Barriers/Interventions for Davis

Barriers	Interventions
Follow-up appointment is not scheduled or rescheduled after provider cancellation or client selecting to not schedule next appointment.	Recovery Support Services (RSS) outreaches members to attempt to schedule a follow-up appointment.
Staff members were unavailable to facilitate the initial appointment within seven days or the follow-up appointment within 14 days.	The Substance Treatment Program director monitors clinical staff availability. The director follows up when a clinical staff member is unavailable within the time frames.
Members scheduled multiple (two or more) initial appointments, but members did not attend appointments.	Walk-in evaluation clinic option offered to members who schedule but do not attend the initial appointments.

Davis—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Davis:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Davis sustained statistically significant improvement over the baseline in both performance indicator rates for two consecutive remeasurement periods.

- The PIP topic that Davis selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Davis.

Recommendations

Although HSAG did not identify any opportunities for improvement for Davis, HSAG provided the following recommendations:

- Determine a new PIP topic for next year's submission with consultation and approval from DHHS.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Reach out to HSAG for technical assistance as Davis determines and designs the new PIP for next year's submission.

Validation of Performance Measures

Validation Results

The 2022 PMV Report indicated that HSAG found Davis' IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-81 presents Davis' MY 2022 performance measure results.

Table 2-81—Davis MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Davis Rate	Statewide PMHP Average
Follow-Up Within 7 Days	65.59%	51.93%
Follow-Up Within 30 Days	88.17%	68.20%

Davis—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Davis:

- Davis addressed the health care needs of its members across various scenarios. Members in need of care could meet with Davis providers in person or remotely via telehealth. Davis operated a receiving center for members in need of urgent substance use or behavioral health services, as well as a MCOT to facilitate rapid response to health care crises involving members. Davis also provided residential services to members in need and worked with schools to provide behavioral health services to children.
- Davis monitored its performance on the *Follow-Up After Hospitalization for Mental Illness* measure rates and showed improvement in measure rates from MY 2021 to MY 2022. Davis made use of its MCOT and receiving center to reduce member hospitalizations and improve timely follow-up with members discharged from a hospital.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the 2022 PMV review.

Recommendations

HSAG did not identify any recommendations related to PMV.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Davis—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-82 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-82—Summary of Scores for the Standards for Davis

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	3	1	0	0	88%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	8	3	0	0	86%
VII	Coverage and Authorization of Services	17	17	15	2	0	0	94%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
X	Practice Guidelines	3	3	2	1	0	0	83%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**70**	**70**	**62**	**8**	**0**	**0**	**94%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines

Recommendations

HSAG recommends that Davis:

- Update its policies regarding disenrollment, advance directives, and poststabilization services to include all requirements.
- Revise its coverage and authorization policies to include correct time frames for making expedited authorization decisions and requesting continuation of services.
- Update its practice guidelines to ensure there is reference to ASAM level of care placement criteria.

VALIDATION OF NETWORK ADEQUACY

Davis—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-83 displays the number and percentage of provider categories wherein Davis met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-83—Compliance With Time/Distance Standards by Urbanicity—Davis*

		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Davis	12	3	25.0%	

*Analyses were restricted to counties and urbanicities within Davis' service area.

Opportunities for Improvement

Table 2-84 displays the provider domains and categories wherein Davis failed to meet the time/distance standards.

Table 2-84—Provider Categories That Failed to Meet Time/Distance Standards—Davis*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit	
Behavioral Health—Providers	Behavioral Medical—Adult; Behavioral Medical—All**; Behavioral Medical—Pediatric; Behavioral Therapist—Adult; Behavioral Therapist—Pediatric**; Non-physician Prescribers; Substance Abuse Counselor	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

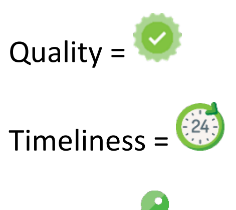
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Davis did not meet the time/distance standard, HSAG recommends that Davis assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Davis should ensure all providers are appropriately identified in future data submissions.

Four Corners Community Behavioral Health (Four Corners)

Following are Four Corners' findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Four Corners submitted its new clinical PIP topic: *Improving the Completion of Substance Use Recovery Evaluator (SURE).* The PIP Four Corners submitted aims to utilize the SURE survey as a regularly used instrument in the treatment of members in SUD treatment programs. Measuring members' recovery from drug and alcohol dependence has the potential to improve member engagement in treatment.

Validation Results and Interventions

Table 2-85 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-85—CY 2023 Performance Improvement Project Validation Results for Four Corners (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	8. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		***Not Assessed***		
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2023, Four Corners submitted the PIP design only. Four Corners had not progressed to the point of reporting data and outcomes during this validation cycle.

Barriers/Interventions

Four Corners had not progressed to the point of identifying barriers or determining and implementing interventions during this validation cycle.

Four Corners—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Four Corners:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of overall evaluation elements and 100 percent of critical evaluation elements across all steps completed and validated.
- Four Corners designed a scientifically sound project that was supported by using key research principles.
- The technical design of the PIP was sufficient to measure outcomes.
- The PIP topic that Four Corners selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Four Corners.

Recommendations

Although HSAG did not identify any opportunities for improvement for Four Corners, HSAG provided the following recommendations:

- Continually work on the PIP throughout the year.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. Additionally, member input should also be considered while determining barriers.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop a process for evaluating each PIP intervention and its impact on the PIP indicator and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical.
- Ensure that intervention-specific evaluation results guide the next steps of each intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Four Corners' IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-86 presents Four Corners' MY 2022 performance measure results.

Table 2-86—Four Corners MY 2022 *FUH* Results

Indicator	Four Corners Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**40.00%**	51.93%
Follow-Up Within 30 Days	**60.00%**	68.20%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*

Four Corners—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Four Corners:

- Four Corners increased efforts to prevent inpatient hospitalizations. Due to limited availability of hospital beds for members in crisis, Four Corners implemented transitional units that act as crisis stabilization areas in which Four Corners staff members can help stabilize at-risk members and assist with medication monitoring.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Four Corners:

- During PSV, HSAG identified five cases requiring correction due to an incorrect discharge date and/or incorrect follow-up date/service being included in the numerator positive file. After the site visit, Four Corners was able to find correct dates and make updates to the numerator positive file accordingly.
- Four Corners' rates for both measure indicators were below the statewide PMHP average.

Recommendations

HSAG recommends that Four Corners:

- Implement additional validation to its tracking spreadsheet, which could include adding additional columns along with conditional formatting (e.g., age at discharge, number of days between discharge and follow-up service, readmissions within 30 days, etc.) to identify which members should be included in the measure and to help determine numerator compliance.
- Perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Four Corners—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-87 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

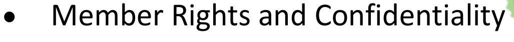
Table 2-87—Summary of Scores for the Standards for Four Corners

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	17	0	0	0	100%
X	Practice Guidelines	3	3	2	1	0	0	83%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**70**	**70**	**69**	**1**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality 
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Practice Guidelines

Recommendations

HSAG recommends that Four Corners:

- Implement a mechanism to disseminate practice guidelines to providers.

VALIDATION OF NETWORK ADEQUACY

Four Corners—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-88 displays the number and percentage of provider categories wherein Four Corners met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-88—Compliance With Time/Distance Standards by Urbanicity—Four Corners*

		Frontier		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Four Corners	12	3	25.0%	6	50.0%	

*Analyses were restricted to counties and urbanicities within Four Corners' service area.

Opportunities for Improvement

Table 2-89 displays the provider domains and categories wherein Four Corners failed to meet the time/distance standards.

Table 2-89—Provider Categories That Failed to Meet Time/Distance Standards—Four Corners*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility	
Behavioral Health—Providers	Behavioral Medical—Adult; Behavioral Medical—All; Behavioral Medical—Pediatric**; Behavioral Therapist—Adult**; Behavioral Therapist—Pediatric**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

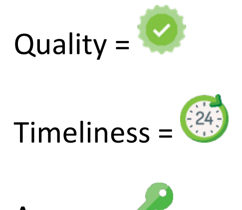
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Four Corners did not meet the time/distance standard, HSAG recommends that Four Corners assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Four Corners should ensure all providers are appropriately identified in future data submissions.

Healthy U Behavioral

Following are Healthy U Behavioral's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Healthy U Behavioral continued its clinical PIP topic: *Improving Follow-up After Hospitalization for Mental Illness*, for its Summit County PMHP members.

Validation Results and Interventions

Table 2-90 summarizes the validation findings each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-90—CY 2023 Performance Improvement Project Validation Results for Healthy U Behavioral (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	**Partially Met**	**Not Met**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	0
	Outcomes Total	**2/2**	**0/2**	**0/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

Healthy U Behavioral reported Remeasurement 2 results in the CY 2022 submission. Both performance indicators demonstrated non-statistically significant declines when compared to the baseline. However, the health plan achieved programmatically significant improvement related to the care management chart review and care management support interventions.

Table 2-91 displays data for Healthy U Behavioral's PIP.

Table 2-91—PIP—*Improving Follow-up After Hospitalization for Mental Illness* for Healthy U Behavioral

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2020–12/31/2020)**		**Remeasurement 1 (01/01/2021–12/31/2021)**		**Remeasurement 2 (01/01/2022–12/31/2022)**		**Sustained Improvement**
1. Follow-Up After Hospitalization for Mental Illness within 7 Days	N: 6	66.7%	N: 8	36.4%	N: 3	30.0%	*Not Assessed*
	D: 9		D: 22		D: 10		
2. Follow-Up After Hospitalization for Mental Illness within 30 Days	N: 7	77.8%	N: 15	68.2%	N: 6	60.0%	
	D: 9		D: 22		N: 10		

N–Numerator D–Denominator

The baseline rate for the percentage of discharges for members 6 years of age and older who were hospitalized for mental illness and who had a follow-up visit within seven days was 66.7 percent. For Remeasurement 2, the Performance Indicator 1 rate of 30.0 percent represents a decrease of 36.7 percentage points from the baseline.

The baseline rate for the percentage of discharges for members 6 years of age and older who were hospitalized for mental illness and who had a follow-up visit within 30 days was 77.8 percent. For Remeasurement 2, the Performance Indicator 2 rate of 60.0 percent represents a decrease of 17.8 percentage points from the baseline.

The eligible denominator size for the Healthy U Behavioral PIP is small. During a technical assistance call with HSAG and DHHS, Healthy U Behavioral reiterated that the selected PIP topic has a potential to improve member outcomes and is an important area of focus for the health plan. DHHS gave approval to continue with the PIP topic. Due to a very small denominator size, the change in the performance indicator rates should be interpreted with caution.

Barriers/Interventions

For the PIP, Healthy U Behavioral used a fishbone diagram and data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-92—PIP Barriers/Interventions for Healthy U Behavioral

Barriers	Interventions
Follow-up visit not scheduled by hospital discharge planner within seven days after discharge.	For members hospitalized at Huntsman Mental Health Institute (HMHI), the University of Utah Health Plan (UUHP) care management team reaches out to the HMHI discharge planner via SmartWeb or email to ensure that a follow-up appointment has been scheduled within seven days after discharge. If needed, UUHP care managers assist the discharge planner in finding available in-network providers to see members.
Members may not understand the importance of timely follow-up after hospital discharge. There may be social determinant barriers that prevent members from attending the follow-up visit.	Upon notification of hospital admission, UUHP will provide care management support to hospitalized members to ensure timely follow-up visits after discharge. Care management support involves identifying and mitigating the specific barriers for each member that may prevent the member from attending a follow-up visit.
Breakdown in communication between utilization management (UM) and care management (CM) teams can result in delays or missed opportunities to provide care management support to members and ensure timely follow-up after hospitalization.	Conduct chart reviews no less than quarterly to assess for performance on newly developed intervention-specific evaluation metrics. Use results for process improvement and for providing feedback and education to staff.

Healthy U Behavioral—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Healthy U Behavioral:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- The PIP topic that Healthy U Behavioral selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.
- Healthy U Behavioral documented a sound PIP design, accurate reporting of data, and implementation of system interventions that were related to barriers identified through appropriate QI processes.
- The health plan achieved programmatically significant improvement related to the care management chart review and care management support interventions.

Opportunities for Improvement

- During Remeasurement 2, both performance indicators demonstrated non-statistically significant declines when compared to the baseline.

Recommendations

- Healthy U Behavioral reported Remeasurement 2 data for this PIP. The health plan documented programmatic improvement with its interventions; however, the performance indicator rates continued to decline. Due to an extremely small PIP denominator population, HSAG recommends that the health plan retire this PIP and initiate a new PIP for next year's submission with consultation and approval from DHHS.
- Healthy U Behavioral should apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Healthy U Behavioral should reach out to HSAG for technical assistance as it determines and designs the new PIP.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Healthy U Behavioral's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-93 presents Healthy U Behavioral's MY 2022 performance measure results.

Table 2-93—Healthy U Behavioral MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Healthy U Behavioral Rate*	Statewide PMHP Average
Follow-Up Within 7 Days	**30.00%**	51.93%
Follow-Up Within 30 Days	**60.00%**	68.20%

*****Rates with small denominators are likely to be subject to wild swings in performance, and interpretations should be made with caution.
*Rates in **red** font indicate the rate fell below the statewide PMHP average.*

Healthy U Behavioral—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Healthy U Behavioral:

- Healthy U Behavioral used its care management team to improve the timeliness of follow-up visits for its members. The care management team met quarterly to review member charts and identify gaps in Healthy U Behavioral's processes. The team demonstrated diligent collaboration for process improvement efforts.
- Healthy U Behavioral improved its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators by leveraging technology through EHR code optimization. Healthy U Behavioral also automated processes to reduce manual data entry errors and ease administrative burden.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Healthy U Behavioral:

- Healthy U Behavioral did not have a process to ensure that all paper claims submitted to the vendor Smart Data Solutions (SDS) for translation into electronic files were accounted for in the electronic files.
- Healthy U Behavioral's rates for both measure indicators were below the statewide PMHP average.

Recommendations

HSAG offered the following recommendations for Healthy U Behavioral:

- HSAG recommends that Healthy U Behavioral enhance its vendor oversight to include tracking of all paper claims prior to scanning in order to ensure that all claims are transformed into electronic files.
- HSAG recommends that Healthy U Behavioral continue to analyze noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Healthy U Behavioral—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-94 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-94—Summary of Scores for the Standards for Healthy U Behavioral

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	4	4	0	0	3	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	17	17	0	0	2	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
X	Practice Guidelines	3	3	2	1	0	0	83%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**70**	**68**	**2**	**0**	**5**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Practice Guidelines
- Grievance and Appeal System

Recommendations

HSAG recommends that Healthy U Behavioral:

- Update its practice guidelines to ensure there is reference to ASAM level of care placement criteria.
- Review the practice guidelines on its website to ensure hyperlinks direct to the appropriate guideline.
- Update its policy on grievances and appeals to include all requirements.

VALIDATION OF NETWORK ADEQUACY

Healthy U Behavioral—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-95 displays the number and percentage of provider categories wherein Healthy U Behavioral met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Healthy U Behavioral in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-95—Compliance With Time/Distance Standards by Urbanicity—Healthy U Behavioral*

		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Healthy U Behavioral	12	12	100.0%	

*Analyses were restricted to counties and urbanicities in Healthy U Behavioral's Summit County service area.

Opportunities for Improvement

Table 2-96 displays the provider domains and categories wherein Healthy U Behavioral failed to meet the time/distance standards.

Table 2-96—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U Behavioral*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
NA	NA	

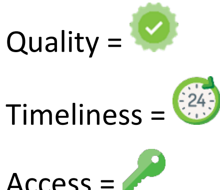
*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).
** No data were submitted for the provider category.

Recommendations

HSAG identified no network adequacy recommendations for Healthy U Behavioral.

Northeastern Counseling Center (Northeastern)

Following are Northeastern's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Northeastern continued its clinical PIP topic: *Inpatient Post Discharge Engagement and Suicide Intervention*. Northeastern aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions for members discharged from an inpatient hospital stay.

Validation Results and Interventions

Table 2-97 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-97—CY 2023 Performance Improvement Project Validation Results for Northeastern (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3	0	0
	Outcomes Total	**3/3**	**0/3**	**0/3**
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

Northeastern progressed to reporting Remeasurement 3 results for this validation cycle. Northeastern improved performance across all four performance indicators. The Remeasurement 3 rates for all four performance indicators demonstrated statistically significant improvement over the baseline, and the health plan sustained statistically significant improvement for two consecutive measurement periods.

Table 2-98 displays data for Northeastern's PIP.

Table 2-98—PIP—*Inpatient Post Discharge Engagement and Suicide Intervention* for Northeastern

Performance Indicator Results									
Performance Indicators	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Remeasurement 3 (01/01/2022–12/31/2022)**		**Sustained Improvement**
1. Percentage of inpatient discharges where members received a formal covered service per the HEDIS protocol or a documented "Caring Contact" (i.e., documented "outreach") 1 to 3 business days post discharge.	N: 18 D: 30	60.0%	N: 50 D: 59	84.7%*	N: 64 D: 79	81.0%*	N: 52 D: 64	81.3%*	*Yes*
2. Percentage of inpatient discharges where members received a personalized Safety Plan 1–7 days post discharge with or through Northeastern Counseling.	N: 6 D: 26	23.1%	N: 16 D: 50	32.0%	N: 35 D: 66	53.0%*	N: 27 D: 46	58.7%*	*Yes*

Performance Indicator Results									
Performance Indicators	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Remeasurement 3 (01/01/2022–12/31/2022)**		**Sustained Improvement**
3. Percentage of inpatient discharges where members received a Columbia Suicide Severity Risk Screening 1–7 days post discharge.	N: 7 D: 26	26.9%	N: 15 D: 50	30.0%	N: 38 D: 66	57.6%*	N: 31 D: 46	67.4%*	*Yes*
4. Percentage of inpatient discharges where members received a formal covered service or a documented "Caring Contact" (i.e., documented "outreach") 31 to 60 days post discharge.	N: 16 D: 30	53.3%	N: 47 D:59	79.7%*	N: 61 D: 79	77.2%*	N: 48 D: 61	78.7%*	*Yes*

* Represents statistically significant improvement over the baseline. N–Numerator D–Denominator

The baseline rate for the percentage of discharges wherein members receiving a formal covered service or a documented Caring Contact within one to three business days post-discharge was 60 percent. For Remeasurement 3, the rate increased to 81.3 percent, and Northeastern demonstrated a statistically significant increase (p < 0.05) of 21.3 percentage points over the baseline.

The baseline rate for the percentage of inpatient discharges wherein members received a personalized safety plan one to seven days post-discharge was 23.1 percent. For Remeasurement 3, the rate increased to 58.7 percent, and Northeastern demonstrated a statistically significant increase (p < 0.05) of 35.6 percentage points over the baseline.

The baseline rate for the percentage of inpatient discharges wherein members received a Columbia Suicide Severity Risk Screening (CSSR-S) one to seven days post discharge was 26.9 percent. For Remeasurement 3, the rate increased to 67.4 percent, and Northeastern demonstrated a statistically significant increase (p < 0.05) of 40.5 percentage points over the baseline.

The baseline rate for the percentage of inpatient discharges wherein members received a formal covered service, or a documented Caring Contact 31 to 60 days post-discharge was 53.3 percent. For Remeasurement 3, the rate increased to 78.7 percent, and Northeastern demonstrated a statistically significant increase (p < 0.05) of 25.4 percentage points over the baseline.

Northeastern sustained statistically significant improvement for two consecutive measurement periods for all four performance indicators.

Barriers/Interventions

For the PIP, Northeastern used data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-99—PIP Barriers/Interventions for Northeastern

Barriers	Interventions
Clinical staff members, support staff members, and the suicide prevention specialist lack knowledge of the expectations regarding inpatient discharge follow-up as described in this project. When inpatient providers call Northeastern for inpatient follow-up, the patient must be scheduled/offered follow-up within the three-business-day period.	In-person training of all the staff members that the three-business-day follow-up requirement applies to anyone being discharged from an inpatient unit and clinicians need to complete a safety plan and CSSR-S on the first service post-discharge from the inpatient unit. Email summary of the training is sent to the staff members three times during a year. Email new providers that are not trained face-to-face within 30 days of the provider's start date. Three in-person trainings were done in CY 2022.
Clinical staff members and the suicide prevention specialists need to understand the requirement for 31- to 60-day follow-up and Caring Contacts, including how these are tracked in Credible (Northeastern's electronic medical record [EMR] system) and on the tracking spreadsheet. Members who choose not have services provided by Northeastern must still be tracked and contacted.	Train clinicians and suicide prevention specialists regarding service and/or Caring Contact expectations (i.e., within 31 to 60 days) that include the following: • Tracking in Credible and on the tracking, spreadsheet is required for 31- to 60-day follow-up and Caring Contacts. • Members who choose to follow up with providers other than Northeastern must still have Caring Contacts within the time frames of this project, including 31 to 60 days. • Members who do not show up for an appointment or who do not cancel the appointment with support staff members are to be contacted by the clinician or suicide prevention specialist within the time frames of this project and are to use the Caring Contact follow-up service in the EMR to document those actions 31 to 60 days post-inpatient discharge. Two in-person trainings were done in CY 2022.
Lack of identification and tracking of the post-inpatient discharge population in real time to meet the additional expectations as outlined in this PIP.	The clinical director, suicide prevention specialist, and back-up specialist have developed a spreadsheet to track inpatient discharges as they occur with daily follow-up. A marker in the EMR has also been added for inpatient discharge members, which remains in place for 60 days post-inpatient discharge.

Barriers	Interventions
During day-to-day practice, clinicians see many types of members that have additional clinical criteria and required practices. Clinicians forget to administer risk screening and complete a safety plan.	The clinical services note used for hospital discharge follow-up has been altered to include “Was this Individual just discharged from an Inpatient Psychiatric Hospital?” Answering “yes” brings up a reminder that “You Must Complete the following for this visit: 1. Columbia Suicide Severity Risk Screening 2. Safety Plan”
Therapists feeling rushed to complete both the Columbia-Suicide Severity Rating Scale (C-SSRS) and Safety Plan during the FUH appointment.	Whenever possible, scheduling should include a full 60 minutes for therapist FUH services. (New intervention)
FUH tracking sheet accuracy: A small number of discharges do not make it on the tracking sheet in a timely manner.	Provide authorization calendar access to the prevention worker as another resource to ensure the lists accuracy. (New intervention)

Northeastern—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Northeastern:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Northeastern sustained statistically significant improvement over the baseline for all four performance indicators for two consecutive measurement periods.
- The PIP topic that Northeastern selected addressed CMS’ requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

- HSAG did not identify any opportunities for improvement for Northeastern.

Recommendations

Although HSAG did not identify any opportunities for improvement for Northeastern, HSAG provided the following recommendations:

- Determine a new PIP topic for next year’s submission with consultation and approval from DHHS.

- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Reach out to HSAG for technical assistance as Northeastern determines and designs the new PIP for next year's submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Northeastern's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-100 presents Northeastern's MY 2022 performance measure results.

Table 2-100—Northeastern MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Northeastern Rate	Statewide PMHP Average
Follow-Up Within 7 Days	64.06%	51.93%
Follow-Up Within 30 Days	70.31%	68.20%

Northeastern—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Northeastern:

- Northeastern implemented several efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure, including the PIP focusing on outreach to members, which helped to make sure follow-up appointments were being scheduled. Northeastern also reported that its close relationship with hospitals and hospital staff members ensured that they transferred Northeastern members to Northeastern for follow-up appointments.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the 2022 PMV review.

Recommendations

HSAG did not identify any recommendations related to PMV.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Northeastern—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-101 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-101—Summary of Scores for the Standards for Northeastern

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	17	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	26	2	0	0	96%
	Totals	**70**	**70**	**67**	**3**	**0**	**0**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System

Recommendations

HSAG recommends that Northeastern:

- Ensure that advance directive information is made available to members and the public, such as by including information on its website.
- Revise its policy on appeals to indicate that oral appeals do not need to be followed up in writing.
- Update its policy on adverse benefit determinations to include the correct time frame for requesting continuation of benefits.

VALIDATION OF NETWORK ADEQUACY

Northeastern—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-102 displays the number and percentage of provider categories wherein Northeastern met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Northeastern in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-102—Compliance With Time/Distance Standards by Urbanicity—Northeastern*

		Northeastern		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Northeastern	12	2	16.7%	

*Analyses were restricted to counties and urbanicities within Northeastern's service area.

Opportunities for Improvement

Table 2-103 displays the provider domains and categories wherein Northeastern failed to meet the time/distance standards.

Table 2-103—Provider Categories That Failed to Meet Time/Distance Standards—Northeastern*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic**; General Hospitals with a Psychiatric Unit**; Substance Abuse Facility**	
Behavioral Health—Providers	Behavioral Medical—Adult**; Behavioral Medical—All; Behavioral Medical—Pediatric**; Behavioral Therapist—Adult**; Behavioral Therapist—Pediatric**; Substance Abuse Counselor**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).
** No data were submitted for the provider category.

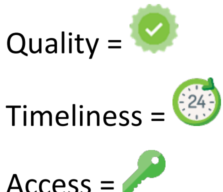
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Northeastern did not meet the time/distance standard, HSAG recommends that Northeastern assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Northeastern should ensure all providers are appropriately identified in future data submissions.

Optum/Tooele

Following are Optum/Tooele's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Optum/Tooele continued its clinical PIP topic: *Increasing Youth Engagement in Treatment Services in Tooele County*. The goal of this PIP is to increase member engagement in treatment services for youth with a mental health or SUD diagnosis.

Validation Results and Interventions

Table 2-104 summarizes the validation findings for each stage validated for CY 2023. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 2-104—CY 2023 Performance Improvement Project Validation Results for Optum/Tooele (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	0	1
	Outcomes Total	**1/2**	**0/2**	**1/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**95%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For this year's validation, Optum/Tooele reported Remeasurement 1 data. Optum/Tooele reported a decline in the percentage of members receiving at least one behavioral health service; however, there was a non-statistically significant increase in the percentage of members receiving at least one peer support service. The health plan did not report significant improvement in outcomes during Remeasurement 1.

Table 2-105 displays data for Optum/Tooele's PIP.

Table 2-105—PIP—*Increasing Youth Engagement in Treatment Services* for Optum/Tooele

Performance Indicator Results					
Performance Indicators	**Baseline (09/01/2021–02/28/2022)**		**Remeasurement 1 (09/01/2022–02/28/2023)**		**Sustained Improvement**
1. Percentage of eligible members 17 years or younger, who received at least one behavioral health service during the measurement period.	N: 356 D: 4,634	7.7%	N: 379 D: 5,072	7.5%	*Not Assessed*
2. Percentage of eligible members 17 years or younger, who received at least one family peer support service during the measurement period.	N: 3 D: 356	0.8%	N: 7 D: 387	1.8%	*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for the percentage of eligible members 17 years or younger who received at least one behavioral health service during the measurement period was 7.7 percent. For Remeasurement 1, Performance Indicator 1 rate decreased by 0.2 percentage points to 7.5 percent. The baseline rate for the percentage of eligible members 17 years or younger who received at least one family peer support service during the measurement period was almost negligible at 0.8 percent. For Remeasurement 1, the Performance Indicator 2 rate increased by 1.0 percentage point to 1.8 percent.

Barriers/Interventions

For the PIP, Optum/Tooele completed a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-106—PIP Barriers/Interventions for Optum/Tooele

Barriers	Interventions
Residents are unaware of available behavioral health services and supports for Medicaid-eligible youth in Tooele County.	1. Implementation of an information campaign targeting youth directly and those who support youth to inform them of the available services and to increase youth engagement in treatment services. Information campaign includes posting English and Spanish flyers on social media sites of the selected network providers. Flyers will also be posted in several community locations such as libraries, coffee houses, arcades, skate parks, etc. (Discontinued) 2. Optum will partner with the Tooele County School District to implement a youth booth or provider table during two of the Tooele County School District's annual, quarterly behavioral health screening events. The booth/provider table will include resources to help youth access support services and to engage in available services. Also, Optum will target school counselors and teachers at Tooele County School District's back-to-school events where resources will be provided to engage youth in available services.
No family peer support specialists (FPSSs) within the Optum Tooele County provider network.	1. Two certified family peer support specialists will be added to the provider network. (Discontinued) 2. Optum will implement and host a monthly training for all Tooele County in-network

Barriers	Interventions
	providers. The training will include FPSS recruiting, provider education about FPSS services, trainings and certifications, and resources to ensure FPSSs are rendering services as outlined in the Utah Medicaid Manual.

Optum/Tooele—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Optum/Tooele:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- The health plan designed a scientifically sound project that was supported by using key research principles.
- The PIP topic that Optum/Tooele selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Optum/Tooele.

- During Remeasurement 1, Optum/Tooele reported a decline in the Performance Indicator 1 rate; however, there was a non-statistically significant increase in the Performance Indicator 2 rate. The health plan did not report significant improvement in outcomes during Remeasurement 1.

Recommendations

HSAG provided the following recommendations for Optum/Tooele:

- Continually work on the PIP throughout the year.
- Ensure that the data reported in the PIP Submission Form are accurate and in accordance with the PIP design.
- Revisit the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.

- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Implement intervention-specific evaluation results to guide the next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results and Interventions

The 2022 PMV Report indicated that HSAG found Optum/Tooele's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-107 presents Optum/Tooele's MY 2022 performance measure results.

Table 2-107—Optum/Tooele MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Optum/Tooele Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**43.36%**	51.93%
Follow-Up Within 30 Days	**54.87%**	68.20%

Rates in ***red*** *font indicate the rate fell below the statewide PMHP average.*

Optum/Tooele—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Optum/Tooele:

- Optum/Tooele expanded its services to members who speak Spanish by encouraging peer support within the community. Additionally, Optum/Tooele created flyers in both Spanish and English to promote advocacy within the Spanish-speaking community.
- Optum/Tooele implemented new programs and contracted with more providers to provide mental health and SUD services, thereby increasing Optum/Tooele's provider network from 15 providers last year to 25–30 providers at the time of the review.

- Optum/Tooele implemented the second component of its process improvement plan to engage young members in mental health and SUD treatment services. The component includes increasing family peer support by using a community health fair strategy. Optum/Tooele ran a booth to help link families to network providers at local school health screenings.

Opportunities for Improvement

HSAG identified the following opportunity for improvement for Optum/Tooele:

- Optum/Tooele's rates for both measure indicators were below the statewide PMHP average.

Recommendations

HSAG offered the following recommendations for Optum/Tooele:

- HSAG recommends that Optum/Tooele continue to analyze noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Optum/Tooele—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-108 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-108—Summary of Scores for the Standards for Optum/Tooele

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VII	Coverage and Authorization of Services	17	17	16	1	0	0	97%
X	Practice Guidelines	4	4	4	0	0	0	100%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**71**	**71**	**69**	**2**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Emergency and Poststabilization Services
- Practice Guidelines
- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Coverage and Authorization of Services

Recommendations

HSAG recommends that Optum/Tooele:

- Revise its policy on advance directives to include all requirements and ensure that all advance directive information is made available to members.
- Revise its policy on service authorization to indicate time frames for mailing notice of adverse benefit determinations.

VALIDATION OF NETWORK ADEQUACY

Optum/Tooele—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-109 displays the number and percentage of provider categories wherein Optum/Tooele met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Optum/Tooele in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-109—Compliance With Time/Distance Standards by Urbanicity—Optum/Tooele*

		Frontier		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Optum	12	11	91.7%	

*Analyses were restricted to counties and urbanicities within Optum's Tooele County service area.

Opportunities for Improvement

Table 2-110 displays the provider domains and categories wherein Optum/Tooele failed to meet the time/distance standards.

Table 2-110—Provider Categories That Failed to Meet Time/Distance Standards—Optum/Tooele*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Providers	Behavioral Medical—All**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

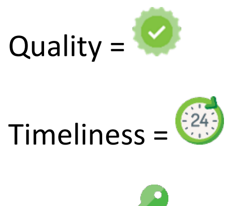
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Optum/Tooele did not meet the time/distance standard, HSAG recommends that Optum/Tooele assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Optum/Tooele should ensure that all providers are appropriately identified in future data submissions.

Salt Lake County Division of Behavioral Health Services (Salt Lake)

Following are Salt Lake's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Salt Lake initiated its clinical PIP topic: *FUH for Adults Aged 18–64.* Salt Lake aims to improve behavioral health outcomes by increasing member engagement and follow-up after discharge from inpatient hospitalization for treatment of mental illness.

Validation Results and Interventions

Table 2-111 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-111—CY 2023 Performance Improvement Project Validation Results for Salt Lake County (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	4	0	0
	Implementation Total	**7/7**	**0/7**	**0/7**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

Salt Lake reported and analyzed its baseline (CY 2022) data accurately. Salt Lake conducted appropriate QI processes to identify and prioritize barriers, and it implemented interventions that were logically linked to the barriers and have the potential to impact PIP outcomes. Salt Lake had not progressed to reporting PIP outcomes for this validation cycle.

Table 2-112 displays data for Salt Lake's PIP.

Table 2-112—PIP—*Follow-Up After Hospitalization for Adults Aged 18–64* for Salt Lake

<table>
<tr><th colspan="8">Performance Indicator Results</th></tr>
<tr><th>Performance Indicator</th><th colspan="2">Baseline (01/01/2022–12/31/2022)</th><th colspan="2">Remeasurement 1 (01/01/2023–12/31/2023)</th><th colspan="2">Remeasurement 2 (01/01/2024–12/31/2024)</th><th>Sustained Improvement</th></tr>
<tr><td rowspan="2">1. The percentage of eligible members aged 18–64 years who received at least one behavioral health service within seven days after discharge from inpatient hospitalization for treatment of mental illness.</td><td>N: 183</td><td rowspan="2">36.1%</td><td></td><td rowspan="2"></td><td></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>D: 507</td><td></td><td></td></tr>
<tr><td rowspan="2">2. The percentage of eligible members aged 18–64 years who received at least one behavioral health service within 30 days after discharge from inpatient hospitalization for treatment of mental illness.</td><td>N: 254</td><td rowspan="2">50.1%</td><td></td><td rowspan="2"></td><td></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>D: 507</td><td></td><td></td></tr>
</table>

N–Numerator D–Denominator

The baseline rate for the percentage of eligible members aged 18–64 years who received at least one behavioral health service within seven days after discharge from inpatient hospitalization for treatment of mental illness was 36.1 percent. The baseline rate for the percentage of eligible members aged 18–64 years who received at least one behavioral health service within 30 days after discharge from inpatient hospitalization for treatment of mental illness was 50.1 percent. The health plan will be assessed for achievement of improvement in PIP outcomes in the next validation cycle.

Barriers/Interventions

For the PIP, Salt Lake used data analysis, provider feedback, and a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-113—PIP Barriers/Interventions for Salt Lake

Barriers	Interventions
Members are released from inpatient care with incomplete or insufficient discharge plans.	The Optum Clinical Team will monitor discharge planning by inpatient facility. Incomplete or insufficient discharge plans will be referred to the Optum Care Coordination Team which will prioritize contact with the member within 72 hours of discharge to arrange services.
Lack of timely follow-up appointments scheduled with a network provider at discharge.	Facilitate quarterly meetings with in-network inpatient facilities and review year-to-date *FUH* data. Identify and respond to real-time barriers linking members to care.
Inpatient facilities have insufficient knowledge of available Optum Salt Lake County network providers who offer both therapy and medication management services.	Create and distribute a resource guide for the purpose of assisting inpatient facilities with connecting members to timely and appropriate follow-up care.

Salt Lake—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Salt Lake:

- The PIP topic that Salt Lake selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.
- Salt Lake designed a scientifically sound project that was supported by using key research principles.

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Sale Lake.

Recommendations

Although HSAG did not identify any opportunities for improvement for Salt Lake, HSAG provided the following recommendations:

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation data must be included in the PIP submission.
- Implement intervention-specific evaluation results to guide the next steps for each individual intervention.
- Implement interventions in a timely manner to impact PIP outcomes during the remeasurement period.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Salt Lake's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-114 presents Salt Lake's MY 2022 performance measure results.

Table 2-114—Salt Lake MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Salt Lake Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**43.79%**	51.93%
Follow-Up Within 30 Days	**58.65%**	68.20%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*

Salt Lake—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Salt Lake:

- Salt Lake demonstrated a proactive approach to meeting the health care needs of its adult members. Salt Lake conducted data analysis and identified underlying causes for adult members not meeting the 30-day follow-up visit after discharge. As a result, Salt Lake implemented a new process improvement plan for adult members that included regular meetings with contracted inpatient facilities, the distribution of information to inpatient facilities to ensure better understanding of network resources for discharge planning, and additional support from care coordinators and care advocates for inpatient adult members.

Opportunities for Improvement

HSAG identified the following opportunity for improvement for Salt Lake:

- Salt Lake's rates for both measure indicators were below the statewide PMHP average.

Recommendations

HSAG offered the following recommendations for Salt Lake:

- HSAG recommends that Salt Lake continue to analyze noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Salt Lake—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-115 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the

compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-115—Summary of Scores for the Standards for Salt Lake

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	16	1	0	0	97%
X	Practice Guidelines	4	4	4	0	0	0	100%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**71**	**71**	**69**	**2**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Emergency and Poststabilization Services
- Practice Guidelines
- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Coverage and Authorization of Services

Recommendations

HSAG recommends that Salt Lake:

- Revise its policy on advance directives to include all requirements and ensure that all advance directive information is made available to members.
- Revise its policy on service authorization to indicate time frames for mailing notice of adverse benefit determinations.

Validation of Network Adequacy

Salt Lake—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-116 displays the number and percentage of provider categories wherein Salt Lake met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Salt Lake in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-116—Compliance With Time/Distance Standards by Urbanicity—Salt Lake*

		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Salt Lake	12	9	75.0%	

*Analyses were restricted to counties and urbanicities within Salt Lake's service area.

Opportunities for Improvement

Table 2-117 displays the provider domains and categories wherein Salt Lake failed to meet the time/distance standards.

Table 2-117—Provider Categories That Failed to Meet Time/Distance Standards—Salt Lake*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**; General Hospitals with a Psychiatric Unit	

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Providers	Behavioral Medical—All**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

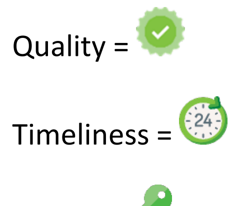
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Salt Lake did not meet the time/distance standard, HSAG recommends that Salt Lake assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Salt Lake should ensure that all providers are appropriately identified in future data submissions.

Southwest Behavioral Health Center (Southwest)

Following are Southwest's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Southwest continued its clinical PIP topic: *Increased Number of PMHP Clients Receiving Peer Support Services*. The goal of this PIP is to improve processes and outcomes of members' mental health care by increasing the percentage of eligible members receiving peer support services.

Validation Results and Interventions

Table 2-118 summarizes the validation findings for each stage validated for CY 2023. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 2-118—CY 2023 Performance Improvement Project Validation Results for Southwest (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (is sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicator(s)	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	2	1	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**8/9**	**1/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	2
	Outcomes Total	**2/2**	**0/2**	**0/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**95%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

State fiscal year (SFY) 2023 is the Remeasurement 1 year for this PIP. Southwest achieved statistically significant improvement in the performance indicator rate during Remeasurement 1 as compared to the baseline rate.

Table 2-119 displays data for Southwest's PIP.

Table 2-119—PIP—*Increased Number of PMHP Clients Receiving Peer Support Services* for Southwest

Performance Indicator Results					
Performance Indicators	**Baseline (07/01/2021–06/30/2022)**		**Remeasurement 1 (07/01/23–06/30/23)**		**Sustained Improvement**
The percentage of eligible members who received at least one peer support service during the measurement period.	N: 73	3.6%	N: 201	7.7%*	*Not Assessed*
	D: 2,015		D: 2,619		

* Indicates statistically significant improvement over the baseline. N–Numerator; D–Denominator

The baseline rate for the percentage of eligible members who received at least one peer support service was 3.6 percent. For Remeasurement 1, the rate increased to 7.7 percent, and Southwest demonstrated a statistically significant increase ($p < 0.05$) of 4.1 percentage points over the baseline.

Barriers/Interventions

For the PIP, Southwest used data analysis and brainstorming to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-120—PIP Barriers/Interventions for Southwest

Barriers	Interventions
No peer support supervisor or policy. This is a barrier because the lack of a policy and trained staff and a supervisor to provide peer support will result in no peer support services provided.	Hired a peer support supervisor and created a peer support policy. Identified staff with similar experience and included them in certified peer support training. This will facilitate an increase of peer support services.
Since all peer support staff members are new to the position, the lack of training is a barrier. They need to receive guidance and training according to best practice and the peer support policy.	Train all staff members with lived experience as a certified peer support staff and send them to multiple in-person and virtual conferences and trainings. The training is a clear intervention that is needed as the staff members are now able to provide peer support services.
The health plan have multiple teams in the agency that have little to no knowledge of peer support services and how to refer clients to receive these services. It is important to train all teams outside of the peer support team about peer support services.	Train all teams and therapists at all locations in addition to the peer support team about peer support services and how to refer clients to receive these services. This intervention will provide all the therapists with the benefits of the services, along with how to refer clients and take advantage of peer support.

Southwest—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Southwest:

- The PIP topic that Southwest selected addressed CMS' requirements related to quality outcomes—specifically, the quality of and access to care and services.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated. Southwest designed a scientifically sound project that was supported by using key research principles.
- Southwest achieved statistically significant improvement in the performance indicator rate during Remeasurement 1 as compared to the baseline rate.

Opportunities for Improvement

There is an opportunity to improve reporting on whether or not there were any factors that could threaten the validity and comparability of the reported performance indicator data.

Recommendations

HSAG offered the following recommendations for Southwest:

- Document in the data narrative whether or not there were any threats to the validity and comparability of the remeasurement data to the baseline.
- Continue with its improvement efforts to sustain the improvement achieved in the performance indicator results.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement. Southwest should consider using QI science-based tools, such as process mapping for causal/barrier analysis.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Consider that intervention-specific evaluation results must guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Southwest's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-121 presents Southwest's MY 2022 performance measure results.

Table 2-121—Southwest MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Southwest Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**45.65%**	51.93%
Follow-Up Within 30 Days	**60.43%**	68.20%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*

Southwest—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Southwest:

- With the migration of EHR systems, Southwest performed several checks to ensure that member data were transferred correctly from Credible to Axiom. Southwest ran reports out of Credible to ensure data matched what was in Axiom. Southwest also performed random sampling of member records and compared demographic information to members' original demographic records in Credible.
- Southwest implemented several interventions to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure, including improved care coordination, increased utilization of hospital staff members to coordinate follow-up appointments, and having case managers follow members closely post-discharge to ensure timely follow-up visits.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Southwest:

- During PSV, HSAG found that one hospital claim was not entered into Axiom. While this member did have proof of hospital authorization and payment, this could be an issue for encounter submission to DHHS. After the site visit, Southwest further researched the issue and reported that the claim was in the upload file to Axiom but was missed during the upload process.
- Southwest's rates for both measure indicators were below the statewide PMHP average.

Recommendations

HSAG offered the following recommendations for Southwest:

- HSAG recommends that Southwest consider an automated process instead of a manual process to enter claims into Axiom. If Southwest continues to have its EHR vendor enter claims manually, HSAG recommends that Southwest carry out its proposed plan of monitoring the claims entry process by its EHR vendor more closely to ensure that all claims are entered and included in encounter submission.
- HSAG recommends that Southwest continue to analyze noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Southwest—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-122 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-122—Summary of Scores for the Standards for Southwest

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	5	2	0	0	86%
IV	Emergency and Poststabilization Services	11	11	9	2	0	0	91%
VII	Coverage and Authorization of Services	17	17	17	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**70**	**70**	**66**	**4**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Emergency and Poststabilization Services

Recommendations

HSAG recommends that Southwest:

- Revise its policies regarding member rights, advance directives, and emergency services to include all requirements.
- Ensure that required information on advance directives is included in a member-facing document or on its website.

VALIDATION OF NETWORK ADEQUACY

Southwest—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-123 displays the number and percentage of provider categories wherein Southwest met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Southwest in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-123—Compliance With Time/Distance Standards by Urbanicity—Southwest*

		Frontier		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Southwest	12	7	58.3%	7	58.3%	

*Analyses were restricted to counties and urbanicities within Southwest's service area.

Opportunities for Improvement

Table 2-124 displays the provider domains and categories wherein Southwest failed to meet the time/distance standards.

Table 2-124—Provider Categories That Failed to Meet Time/Distance Standards—Southwest*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit**; Substance Abuse Facility	
Behavioral Health—Providers	Behavioral Medical—All	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).
** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Southwest did not meet the time/distance standard, HSAG recommends that Southwest assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Southwest should ensure all providers are appropriately identified in future data submissions.

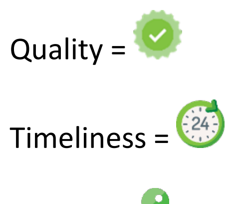
Wasatch Behavioral Health (Wasatch)

Following are Wasatch's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Wasatch initiated its clinical PIP topic: *Increasing SURE Utilization in SUD*. Wasatch aims to improve the monthly administration of the SURE questionnaire to members receiving treatment for a primary SUD. According to the PIP documentation, the administration of SURE may help to detect and ultimately improve substance use recovery outcomes.

Validation Results and Interventions

Table 2-125 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-125—CY 2023 Performance Improvement Project Validation Results for Wasatch (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Method (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	2	0	0
Design Total		**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	5	0	0

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Implementation Total	**8/8**	**0/8**	**0/8**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

Wasatch reported and analyzed its baseline (CY 2022) data accurately. Wasatch conducted appropriate QI processes to identify and prioritize barriers, and it implemented interventions that were logically linked to the barriers with a potential to impact PIP outcomes. Wasatch had not progressed to reporting PIP outcomes for this validation cycle.

Table 2-126 displays data for Wasatch's PIP.

Table 2-126—PIP—*Increasing SURE Utilization in Substance Use Disorder* for Wasatch

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Sustained Improvement**
The percentage of members diagnosed with a primary substance use disorder who receive treatment at one of the eligible substance use treatment programs and who complete the SURE questionnaire each month.	N: 19 D: 7,132	0.3%			

N–Numerator; D–Denominator

The baseline rate for the percentage of members diagnosed with a primary SUD who received treatment at one of the eligible substance use treatment programs and who completed the SURE questionnaire each month was 0.3 percent.

The health plan will be assessed for achievement of improvement in PIP outcomes in the next validation cycle.

Barriers/Interventions

For the PIP, Wasatch used staff feedback and data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-127—PIP Barriers/Interventions for Wasatch

Barriers	Interventions
Lack of awareness and accountability.	SUD division director and program managers will receive reports each month outlining the total number of administrations of SURE in SUD services. Progress toward the goal of improving administration of SURE will be discussed at least monthly at a meeting of Wasatch's executive team and program managers. Results from the previous month for SUD programs will be compared and discussed. Program managers for SUD services will provide information about their administration of SURE or lack thereof each month in their monthly reports to the executive director.
Lack of provider training on use of SURE.	In-person training will be given to SUD clinicians and case managers in administering and interpreting SURE. Video training will also be given to care team assistants in SUD services.

Wasatch—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Wasatch:

- The PIP topic that Wasatch selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Wasatch's performance suggests a sound PIP design, accurate reporting of data, and implementation of interventions that were related to barriers identified through QI processes and have the potential to drive improvement toward the desired outcomes.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Wasatch.

Recommendations

Although HSAG did not identify any opportunities for improvement, HSAG recommends that Wasatch:

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation data must be included in the PIP submission.
- Implement intervention-specific evaluation results to guide the next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Wasatch's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-128 presents Wasatch's MY 2022 performance measure results.

Table 2-128—Wasatch MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Wasatch Rate	Statewide PMHP Average
Follow-Up Within 7 Days	71.95%	51.93%
Follow-Up Within 30 Days	80.49%	68.20%

Wasatch—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Wasatch:

- Wasatch addressed the health care needs of its members through organizational stability, efforts to improve the delivery of services, and the various member-centric interventions in place. Most members of Wasatch's leadership team have been part of the organization for more than 15 years, allowing for consistency in its operations. Wasatch employees and providers have received training on motivational interviewing best practices from leaders in the field and using artificial intelligence tools. Lastly, Wasatch ensured that members had access to needed services through Therapy Connect and used special intervention teams to facilitate rapid response to health care crises and reduce hospitalizations.
- Wasatch maintained effective data tracking and reporting processes for the *Follow-Up After Hospitalization for Mental Illness* measure in MY 2022. Built-in edits in Junction and an annual audit of contracted providers helped to ensure the accuracy and completeness of the data used to calculate performance measure rates.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the 2022 PMV review.

Recommendations

HSAG did not identify any recommendations related to PMV.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Wasatch—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-129 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-129—Summary of Scores for the Standards for Wasatch

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
IV	Emergency and Poststabilization Services	11	11	10	1	0	0	95%
VII	Coverage and Authorization of Services	17	17	16	1	0	0	97%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	26	2	0	0	96%
	Totals	**70**	**70**	**65**	**5**	**0**	**0**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Wasatch:

- Update its policies regarding advance directives, poststabilization services, and appeals to include all requirements.
- Revise its policy regarding adverse benefit determinations and appeals to include the correct time frames for making expedited authorization decisions and requesting continued services.

VALIDATION OF NETWORK ADEQUACY

Wasatch—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-130 displays the number and percentage of provider categories wherein Wasatch met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Wasatch in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-130—Compliance With Time/Distance Standards by Urbanicity—Wasatch*

		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Wasatch	12	1	8.3%	

*Analyses were restricted to counties and urbanicities within Wasatch's service area.

Opportunities for Improvement

Table 2-131 displays the provider domains and categories wherein Wasatch failed to meet the time/distance standards.

Table 2-131—Provider Categories That Failed to Meet Time/Distance Standards—Wasatch*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**; Behavioral Therapy Agency/Clinic**; General Hospitals with a Psychiatric Unit**; Substance Abuse Facility**	
Behavioral Health—Providers	Behavioral Medical—Adult; Behavioral Medical—All**; Behavioral Medical—Pediatric**; Behavioral Therapist—Adult; Behavioral Therapist—Pediatric**; Non-physician Prescribers; Substance Abuse Counselor	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

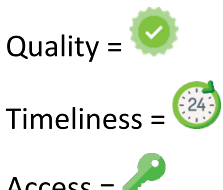
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Wasatch did not meet the time/distance standard, HSAG recommends that Wasatch assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Wasatch should ensure all providers are appropriately identified in future data submissions.

Weber Human Services (Weber)

Following are Weber's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Weber initiated its clinical PIP topic: *Treating Anxiety and Depression with Evidence-Based Treatment (EBT).* Weber aims improve processes and outcomes of members' behavioral health care by increasing the use of EBT called Unified Protocol in members diagnosed with anxiety or depression.

Validation Results and Interventions

Table 2-132 summarizes the validation findings for each stage validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-132—CY 2023 Performance Improvement Project Validation Results for Weber (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	4	0	0
	Implementation Total	**7/7**	**0/7**	**0/7**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

Weber reported and analyzed its baseline (CY 2022) data accurately. Weber had not progressed to reporting PIP outcomes for this validation cycle.

Table 2-133 displays data for Weber's PIP.

Table 2-133—PIP—*Treating Anxiety and Depression with EBT* for Weber

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Sustained Improvement**
The percent of members with an anxiety or depression diagnosis who are participating in the Unified Protocol.	N: 0	0.0%			
	D: 324				

N–Numerator; D–Denominator

The baseline rate for the percentage of members with an anxiety or depression diagnosis who were participating in the Unified Protocol was 0.0 percent. The health plan will be assessed for achievement of improvement in PIP outcomes in the next validation cycle.

Barriers/Interventions

For the PIP, Weber used data analysis and review of EBT practices to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-134—PIP Barriers/Interventions for Weber

Barriers	Interventions
Shortage of staff trained and certified in the Unified Protocol.	Two clinical quality supervisors with be certified as supervisors/trainers in the Unified Protocol.

Barriers	Interventions
	Twelve clinicians will be trained/certified in the Unified Protocol.

Weber—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Weber:

- The PIP topic that Weber selected addressed CMS' requirements related to quality outcomes—specifically, the quality, access, and timeliness of care and services.
- Weber designed a scientifically sound project that was supported by using key research principles.
- Weber conducted appropriate QI processes to identify and prioritize barriers, and it implemented interventions that were logically linked to the barriers with a potential to impact PIP outcomes.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Weber.

Recommendations

Although HSAG did not identify any opportunities for improvement, HSAG recommends that Weber:

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement. Weber should consider using QI science-based tools, such as process mapping, causal/barrier analysis, or FMEA, to identify barriers to improvement.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation data must be included in the PIP submission.

- Implement intervention-specific evaluation results to guide the next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Weber's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-135 presents Weber's MY 2022 performance measure results.

Table 2-135—Weber MY 2022 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Weber Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**49.51%**	51.93%
Follow-Up Within 30 Days	68.93%	68.20%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*

Weber—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths for Weber:

- Weber addressed the health care needs of its members across various scenarios. Members in need of care could meet with Weber providers in person or remotely via telehealth. Weber operated a receiving center in partnership with McKay-Dee Hospital to serve members in need of urgent substance use or behavioral health services, as well as an MCOT to facilitate rapid response to health care crises involving members. Weber also provided residential services to members in need and is working to address challenges with nursing home placement for members with severe mental illness and physical disabilities.
- Weber's approach to partner with McKay-Dee Hospital simplified the care management process and ensured timely services for members. The Weber staff members embedded at the hospital facilitated the prior authorization of hospital stays, collaborated with hospital staff members during discharge planning, and scheduled follow-up services with members post-discharge.

Opportunities for Improvement

HSAG identified the following opportunity for improvement for Weber:

- Weber's rate for the *7-Day Follow-Up* measure indicator was below the statewide PMHP average.

Recommendations

HSAG offered the following recommendations for Weber:

- HSAG recommends that Weber continue to analyze noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Weber—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-136 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-136—Summary of Scores for the Standards for Weber

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	4	4	4	0	0	0	100%
II	Member Rights and Confidentiality	7	7	5	2	0	0	86%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	17	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	25	3	0	0	95%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
	Totals	**70**	**70**	**65**	**5**	**0**	**0**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Grievance and Appeal System

Recommendations

HSAG recommends that Weber:

- Revise its policies on member rights as well as grievances and appeals to include all requirements.

VALIDATION OF NETWORK ADEQUACY

Weber—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-137 displays the number and percentage of provider categories wherein Weber met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-137—Compliance With Time/Distance Standards by Urbanicity—Weber*

		Rural		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Weber	12	9	75.0%	9	75.0%	

*Analyses were restricted to counties and urbanicities within Weber's service area.

Opportunities for Improvement

Table 2-138 displays the provider domains and categories wherein Weber failed to meet the time/distance standards.

Table 2-138—Provider Categories That Failed to Meet Time/Distance Standards—Weber*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**	
Behavioral Health—Providers	Behavioral Medical—Adult**; Behavioral Therapist—Pediatric**	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Weber did not meet the time/distance standard, HSAG recommends that Weber assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Weber should ensure all providers are appropriately identified in future data submissions.

Medicaid PAHPs Providing Dental Services

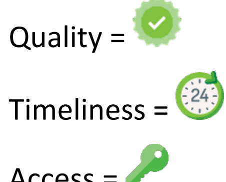
Premier Access

Following are Premier Access' findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



Validation of Performance Improvement Projects

For CY 2023, Premier Access continued its clinical PIP topic: *School Based Care for Medicaid Members.* The goal of this PIP is to increase dental care delivery in a school-based setting to improve dental care utilization.

Validation Results and Interventions

Table 2-139 summarizes the validation findings for each stage validated for CY 2023. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 2-139—CY 2023 Performance Improvement Project Validation Results for Premier Access (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	***Partially Met***	***Not Met***
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicator(s)	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	***Partially Met***	***Not Met***
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	0	1
	Outcomes Total	**1/2**	**0/2**	**1/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**95%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For this year's validation, Premier Access reported Remeasurement 1 results. Premier Access had a decline in the performance indicator rate as compared to the baseline. The interventions did not result in significant clinical or programmatic improvement.

Table 2-140 displays data for Premier*'s* PIP.

Table 2-140—PIP—*School Based Care for Medicaid Members* for Premier Access

Performance Indicator Results					
Performance Indicators	**Baseline (06/01/2021–05/31/2022)**		**Remeasurement 1 (06/01/2021–05/31/2022)**		**Sustained Improvement**
Percentage of Premier Access Medicaid members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 184 D: 7,935	2.3%	N: 205 D: 10,497	2.0%	*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for the percentage of eligible Medicaid members 5–10 years of age who received dental care in a school was 2.3 percent. For Remeasurement 1, Premier Access reported a rate of 2.0 percent, which represents a decline of 0.3 percentage points from the baseline.

Barriers/Interventions

For the PIP, Premier Access used feedback from the dental provider groups to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-141—PIP Barriers/Interventions for Premier Access

Barriers	Interventions
Members do not have signed consent forms on the day that the provider is in the school.	Send text messages containing educational information and a link to an electronic consent form.
Members do not receive consent text messages.	Mailed materials containing educational information and a quick response (QR) code linking to an electronic consent form. (Discontinued)

Premier Access—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Premier Access:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- The PIP topic that Premier Access selected addressed CMS' requirements related to quality outcomes—specifically, the quality and access to care and services.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for Premier Access:

- Premier Access had a decline in the performance indicator rate as compared to the baseline. The interventions did not result in significant clinical or programmatic improvement.

Recommendations

HSAG provided the following recommendations for Premier Access:

- Continually work on the PIP throughout the year.
- Consider revisiting the current QI process and use QI science-based tools, such as process mapping, causal/barrier analysis, or FMEA, to identify barriers to improvement. Determining if additional

barriers exist and initiating new interventions gives the dental plan a greater opportunity to have an impact on the performance indicator.

- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.
- Ensure that it has accurate member contact information. Success of member outreach through mailers and text interventions is dependent on the accuracy of member contact information.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Premier Access' HEDIS compliance auditor found Premier Access' IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Premier Access contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier Access' FAR revealed that Premier Access' HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-142 shows Premier Access' HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-142—Premier Access HEDIS MY 2022 Results

HEDIS Measure	Premier Access MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	43.95%	36.33%
4–6 Years	62.77%	54.79%
7–10 Years	66.17%	58.42%
11–14 Years	60.80%	53.08%
15–18 Years	51.12%	44.92%
19–20 Years	36.23%	29.17%
Total	57.89%	47.27%

Premier Access—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Premier Access exceeded the MY 2022 NCQA Quality Compass average for all of the performance indicators:

- *Annual Dental Visit—2-3 Years*
- *Annual Dental Visit—4-6 Years*
- *Annual Dental Visit—7-10 Years*
- *Annual Dental Visit—11-14 Years*
- *Annual Dental Visit—15-18 Years*
- *Annual Dental Visit—19-20 Years*
- *Annual Dental Visit—Total*

Opportunities for Improvement

Premier Access did not fall below the MY 2022 NCQA Quality Compass average for any of the performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and as such does not have any recommendations.

Assessment of Compliance With Medicaid Managed Care Regulations

Premier Access—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-143 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-143—Summary of Scores for the Standards for Premier Access

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	8	8	8	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	15	1	1	0	91%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	21	7	0	0	88%
	Totals	**70**	**70**	**60**	**9**	**1**	**0**	**92%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Emergency and Poststabilization Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Premier Access:

- Provide provisions for community education regarding advance directives.
- Implement a policy or procedure to describe its mechanisms to ensure consistent application of review criteria for authorization decisions.

- Revise its letter templates to meet all of the requirements of the notice of adverse benefit determination.
- Revise its policies and other health plan documents on grievances and appeals to include all requirements, including applicable time frames for resolving grievances and requesting continued services during an appeal and State fair hearing.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

Premier Access—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-144 displays the number and percentage of provider categories by provider domain wherein Premier Access met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Premier Access in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-144—Compliance With Time/Distance Standards by Provider Domain—Premier Access

		Premier Access		
Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
General Dental	2	2	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-145 displays the provider domains and categories wherein Premier Access failed to meet the time/distance standards.

Table 2-145—Provider Categories That Failed to Meet Time/Distance Standards—Premier Access*

Provider Domain	Provider Category
NA	NA

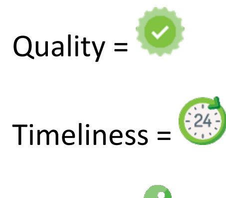
*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

HSAG identified no network adequacy recommendations for Premier Access.

MCNA

Following are MCNA's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, MCNA continued its clinical PIP topic: *Annual Dental Visit.* The goal of this PIP is to improve processes and outcomes of members' oral health by improving detection of dental care needs.

Validation Results and Interventions

Table 2-146 summarizes the validation findings for the PIP validated for CY 2023. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-146—CY 2023 Performance Improvement Project Validation Results for MCNA (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3	0	0
	Outcomes Total	**3/3**	**0/3**	**0/3**
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

The dental plan progressed to reporting Remeasurement 3 data for this validation cycle. As compared to the baseline, there was a decline in rates for both performance indicators during Remeasurement 3; however, the dental plan documented data-driven, significant clinical improvement using the care gap alerts and text message interventions. The number of members impacted by the interventions appears to be small as compared to the total eligible population.

Table 2-147 displays the data for MCNA's PIP.

Table 2-147—PIP—*Annual Dental Visit* for MCNA

Performance Indicator Results									
Performance Indicators	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Remeasurement 3 (01/01/2022–12/31/2022)**		**Sustained Improvement**
1. The percentage of members ages 1–20 years who had at least one dental visit during the measurement year.	N: 30,020 D: 57,218	52.5%	N: 27,323 D: 55,013	49.7%	N: 32,036 D: 65,039	49.3%	N: 34,417 D: 71,759	48.0%	*Not Assessed*
2. The percentage of members ages 21 years and older who had at least one dental visit during the measurement year.	N: 5,756 D: 20,980	27.4%	N: 4,882 D: 20,831	23.4%	N: 1,062 D: 5,130	20.7%	N: 899 D: 9,459	9.5%	*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for members 1 to 20 years of age who had at least one dental visit during the measurement year was 52.5 percent. For Remeasurement 3, the Performance Indicator 1 rate was 48.0 percent, which represents a decrease of 4.5 percentage points as compared to the baseline rate. The baseline rate for members ages 21 years and older who accessed a dentist at least once during the measurement year was 27.4 percent. For Remeasurement 3, the Performance Indicator 2 rate was 9.5 percent, which represents a decrease of 17.9 percentage points as compared to the baseline rate.

Barriers/Interventions

For the PIP, MCNA used a fishbone diagram and data analysis to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-148—PIP Barriers/Interventions for MCNA

Barriers	Interventions
The members' lack of knowledge of coverage benefits and of the importance and frequency of routine dental checkups.	1. Care gap alerts: MCNA member service representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls, which indicates the member is overdue for a preventive dental visit. The MSR offers to locate a provider if the member does not already have one and performs a three-way call, if necessary, with the provider office to schedule an appointment. 2. Automated outbound call campaigns: Conduct outbound calls to members who have not had a dental checkup within the last six months to encourage them to schedule an appointment.
Providers have a limited or non-robust appointment reminder system.	Text messages: Send text messages once a month to members who have no claims history on file. Members will continue to receive a text message until an encounter is received.

MCNA—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following the following strengths for MCNA:

- The PIP topic that MCNA selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.

- The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- MCNA indicated that it achieved significant clinical improvement in the *Annual Dental Visit* measure using the care gap alerts and text message interventions.

Opportunities for Improvement

HSAG identified the following opportunity for improvement for MCNA:

- The dental plan reported a decline in performance indicator rates over the baseline.

Recommendations

HSAG provided the following recommendations for MCNA:

- Initiate a new PIP topic for next year's submission with consultation and approval from DHHS.
- Continue to expand successful interventions to realize improvement in the overall performance indicator rate.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Reach out to HSAG for technical assistance as MCNA determines and designs the new PIP.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that MCNA's HEDIS compliance auditor found MCNA's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. MCNA contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of MCNA's FAR revealed that MCNA's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-149 shows MCNA's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-149—MCNA HEDIS MY 2022 Results

HEDIS Measure	MCNA MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	39.95%	36.33%
4–6 Years	58.04%	54.79%
7–10 Years	62.23%	58.42%
11–14 Years	56.56%	53.08%
15–18 Years	46.65%	44.92%
19–20 Years	**23.56%**	29.17%
Total	52.96%	47.27%

MCNA—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

MCNA exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*
- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18-Years*
- *Annual Dental Visit—Total*

Opportunities for Improvement

MCNA fell below the MY 2022 NCQA Quality Compass average for the following performance indicator:

- *Annual Dental Visit—19–20 Years*

Recommendations

MCNA's performance on the *Annual Dental Visit—19-20 Years* measure indicator declined from MY 2021 to MY 2022, suggesting that fewer adolescent members received at least one dental visit in CY 2022. HSAG recommends that MCNA engage with dental care providers to identify potential access issues or understand behavior patterns of noncompliant members. Additionally, HSAG recommends

that MCNA implement targeted programs to encourage adolescent members to receive recommended dental services.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

MCNA—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-150 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-150—Summary of Scores for the Standards for MCNA

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	7	0	0	0	100%
IV	Emergency and Poststabilization Services	8	8	8	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	16	1	0	0	97%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	28	0	0	0	100%
	Totals	**70**	**70**	**69**	**1**	**0**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Practice Guidelines

- Grievance and Appeal System

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard area:

- Coverage and Authorization of Services

Recommendations

HSAG recommends that MCNA:

- Simplify the language of its notice of adverse benefit determination template letter to a sixth-grade reading level, as required.

VALIDATION OF NETWORK ADEQUACY

MCNA—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-151 displays the number and percentage of provider categories by provider domain wherein MCNA met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and MCNA in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-151—Compliance With Time/Distance Standards by Provider Domain—MCNA

		MCNA		
Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
General Dental	2	1	50.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-152 displays the provider domains and categories wherein MCNA failed to meet the time/distance standards.

Table 2-152—Provider Categories That Failed to Meet Time/Distance Standards—MCNA*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
General Dental	Pediatric Dentists	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which MCNA did not meet the time/distance standard, HSAG recommends that MCNA assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, MCNA should ensure all providers are appropriately identified in future data submissions.

Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—CHIP

CHIP MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services

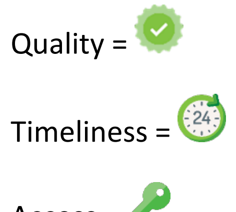
Molina Healthcare of Utah CHIP (Molina CHIP)

Following are Molina CHIP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =



VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Molina CHIP continued its clinical PIP topic: *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*. The goal of this PIP is to increase the body mass index (BMI) screening rate among its CHIP members.

Validation Results and Interventions

Table 2-153 summarizes the validation findings for each stage validated for CY 2023. Overall, 96 percent of all applicable evaluation elements received a score of *Met*.

Table 2-153—CY 2023 Performance Improvement Project's Validation Results for Molina CHIP (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	7	0	0

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	4	0	0
Design Total		**16/16**	**0/16**	**0/16**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
Implementation Total		**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	1
Outcomes Total		**2/3**	**0/3**	**1/3**
Percentage Score of Applicable Evaluation Elements *Met*		**96%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Molina CHIP progressed to reporting Remeasurement 4 results. Molina CHIP indicated achievement of significant programmatic improvement in the five high-volume pediatric groups participating in the interventions. However, the health plan was not able to sustain the statistically significant improvement in the performance indicator rate that was achieved during Remeasurement 1.

Table 2-154 displays data for Molina CHIP's PIP.

Table 2-154—PIP—*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening* for Molina CHIP

Performance Indicator Results											
Performance Indicator	**Baseline (01/01/2018–12/31/2018)**		**R1 (01/01/2019–12/31/2019)**		**R2 (01/01/2020–12/31/2020)**		**R3 (01/01/2021–12/31/2021)**		**R4 (01/01/2022–12/31/2022)**		**Sustained Improvement**
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who	N: 265	64.5%	N: 335	81.5%*	N: 275	66.9%	N: 246	59.9%	N: 255	62.0%	*No*

Performance Indicator Results											
Performance Indicator	Baseline (01/01/2018–12/31/2018)		R1 (01/01/2019–12/31/2019)		R2 (01/01/2020–12/31/2020)		R3 (01/01/2021–12/31/2021)		R4 (01/01/2022–12/31/2022)		Sustained Improvement
had evidence of BMI percentile documentation during the measurement year.	D: 411		D: 411		D: 411		D: 411		D: 411		

* Indicates statistically significant improvement over the baseline. N–Numerator; D–Denominator, R-Remeasurement

For the baseline measurement period, Molina CHIP reported that 64.5 percent of children 3 to 17 years of age had evidence of BMI percentile documentation during the measurement year. For Remeasurement 1, the health plan demonstrated a statistically significant ($p < 0.0001$) improvement of 17.0 percentage points over the baseline; however, for Remeasurement 4, the rate was 2.5 percentage points below the baseline at 62.0 percent. The health plan was not able to sustain statistically significant improvement in the performance indicator rate that was achieved during Remeasurement 1.

Barriers/Interventions

For the PIP, Molina CHIP used a fishbone diagram and staff feedback to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-155—PIP Barriers/Interventions for Molina CHIP

Barriers	Interventions
Members are not obtaining a well-child exam. Possible reasons for noncompliance include: • No vaccinations necessary in older children. • Not required for school or other activities. • Parent availability. • Only seek medical care when ill. • No established PCP.	Conducted targeted outreach to six high-volume pediatric groups to disseminate monthly reports of children in need of well-child visits. Incentives were offered for gap closure. In mid-2022, the number of high-volume providers participating in the intervention increased to 17.
Providers are not capturing or reporting BMI accurately. Providers' lack of understanding of the *WCC* HEDIS measure and requirements.	Disseminate a missing services list to value-based contracting (VBC) groups and conduct monthly discussions with providers for support.
Billing codes from providers do not include the correct codes for numerator compliance with the *WCC* measure.	Research billing code issue reasons. Collaborate with various health plan staff members to develop mitigation strategies. Educate providers regarding coding issues and resolutions.

Molina CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Molina CHIP:

- The PIP topic that Molina CHIP selected addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services.
- Molina CHIP demonstrated statistically significant improvement in the performance indicator rate over the baseline during Remeasurement 1.
- Molina CHIP indicated achievement of significant programmatic improvement in the five high-volume pediatric groups participating in the interventions.

Opportunities for Improvement

- Molina CHIP had a decline in the Remeasurement 4 performance indicator rate as compared to the baseline.

Recommendations

- Molina CHIP reported Remeasurement 4 in this year's submission. Typically, a PIP includes a baseline and two remeasurement periods. HSAG recommends that the health plan retire this PIP and initiate a new PIP topic for next year's submission with consultation and approval from DHHS.
- Molina CHIP should continue to expand successful interventions to realize improvement in the overall performance indicator rate.
- Molina CHIP should apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.
- Molina CHIP should reach out to HSAG for technical assistance as it determines and designs the new PIP.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Molina CHIP's HEDIS compliance auditor found Molina CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Molina CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Molina CHIP's FAR revealed that Molina CHIP's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-156 shows Molina CHIP's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table 2-156—Molina CHIP HEDIS MY 2022 Results

HEDIS Measure	Molina CHIP MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	94.12%	92.60%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	NA	63.16%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	87.80%	78.32%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**62.04%**	76.75%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	NA	56.76%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**56.14%**	56.50%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.

Molina CHIP—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Molina CHIP exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for URI—3 months–17 years*
- *Immunizations for Adolescents—Combination 1*

Opportunities for Improvement

Molina CHIP fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

Molina CHIP fell below the MY 2022 NCQA Quality Compass average for two of the six performance indicators (33.33 percent), indicating some areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are attending scheduled appointments, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.

  - Health plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the outcomes align with performance goals.
- Implementing programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Molina CHIP measures that fell below the national average rely on women coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

Molina CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-157 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-157—Summary of Scores for the Standards for Molina CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	6	1	0	0	93%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	11	0	0	0	100%
VII	Coverage and Authorization of Services	19	19	17	2	0	0	95%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**70**	**5**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Emergency and Poststabilization Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Molina CHIP:

- Update its policies regarding disenrollment and member rights to include all requirements.
- Update its policies and provider manual to include the applicable time frame for making pharmacy decisions.
- Update its policies to include applicable time frames for making expedited authorization decisions and requesting State fair hearings.

VALIDATION OF NETWORK ADEQUACY

Molina CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-158 displays the number and percentage of provider categories by provider domain wherein Molina CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Molina CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-158—Compliance With Time/Distance Standards by Provider Domain—Molina CHIP

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Pediatric	17	3	17.6%	
Additional Physical Health—Providers	5	4	80.0%	
Additional Physical Health—Facilities	6	0	0.0%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	2	66.7%	
Behavioral Health—Facilities	4	0	0.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-159 displays the provider domains and categories wherein Molina CHIP failed to meet the time/distance standards.

Table 2-159—Provider Categories That Failed to Meet Time/Distance Standards—Molina CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology; Laboratory; Outpatient Dialysis; Outpatient Infusion/Chemotherapy**; Skilled Nursing Facility; Surgical Services (Outpatient or ASC)	
Additional Physical Health—Providers	Audiologist	
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility	

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Providers	Substance Abuse Counselor	
Hospitals	Hospital—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric**; Endocrinology, Pediatric; Gastroenterology, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric**; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

**No data were submitted for the provider category.

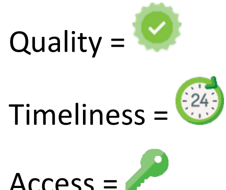
Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Molina CHIP did not meet the time/distance standard, HSAG recommends that Molina CHIP assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina CHIP should ensure all providers are appropriately identified in future data submissions.

SelectHealth CHIP

Following are SelectHealth CHIP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, SelectHealth CHIP continued its clinical PIP topic: *Well-Child Visits for CHIP Members*. The goal of this PIP is to improve the percentage of CHIP members who had at least one comprehensive well-care visit during the measurement year.

Validation Results and Interventions

Table 2-160 summarizes the PIP validation findings for CY 2023. Overall, 93 percent of all applicable evaluation elements received a score of *Met*.

Table 2-160—CY 2023 Performance Improvement Project Validation Results for SelectHealth CHIP (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Method (if sampling was made)	*Not Applicable*		
	5. Review the Selected Performance Indicator(s)	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	2	0	1
	8. Assess the Improvement Strategies	3	0	0
	Implementation Total	**5/6**	**0/6**	**1/6**

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**93%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

SelectHealth CHIP reported and analyzed its baseline (CY 2022) data in this year's submission. The health plan documented one barrier and intervention that were identified after completion of a cause-and-effect diagram by the QI team. There were opportunities for improvement in reporting of factors affecting the validity of the data and providing adequate details about the identified intervention. The health plan had not yet initiated intervention testing at the time of the PIP submission. CY 2022 is the baseline year for this PIP. SelectHealth CHIP had not progressed to the point of reporting PIP outcomes.

Table 2-161 displays data for SelectHealth CHIP's PIP.

Table 2-161—PIP—*Well-Child Visits for CHIP Members* for SelectHealth CHIP

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2022—12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Sustained Improvement**
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrics/gynecology (OB/GYN) practitioner during the measurement year.	N: 1,403 D: 2,337	60.0%			

N–Numerator; D–Denominator

The baseline rate for the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner was 60.0 percent. The health plan will be assessed for achievement of improvement in the next annual submission when Remeasurement 1 data are reported.

Barriers/Interventions

For the PIP, SelectHealth CHIP completed a cause-and-effect diagram to identify and prioritize the following barrier and identified the following intervention to address the barrier. The health plan had not initiated the intervention at the time of the PIP submission.

Table 2-162—PIP Barriers/Interventions for SelectHealth CHIP

Barriers	Interventions
Gap for well-child visits and no PCP was assigned.	For the identified population without a PCP, provide an incentive to schedule a well-child visit (WCV).

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for SelectHealth CHIP:

- SelectHealth CHIP designed a scientifically sound project that was supported by using key research principles.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 93 percent of overall evaluation elements across all steps completed and validated.
- The PIP topic that SelectHealth CHIP selected addressed CMS' requirements related to quality outcomes—specifically, the quality of, timeliness of, and access to care and services.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement in the reporting factors affecting the validity of the data.

Recommendations

Although HSAG did not identify any opportunities for improvement for SelectHealth CHIP, HSAG provided the following recommendations:

- Continually work on the PIP through the year.
- Begin intervention testing in a timely manner to impact the Remeasurement 1 rates.
- Revisit the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.

- In the barriers/interventions table, include details about the about the nature of the incentive, how the incentive information will be shared with the members, and how the barrier of members not having an assigned PCP will be addressed.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table. The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data. Year-to-date intervention evaluation data must be included in the PIP submission.
- Implement intervention-specific evaluation results that guide the next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that SelectHealth CHIP's HEDIS compliance auditor found SelectHealth CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. SelectHealth CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of SelectHealth CHIP's FAR revealed that SelectHealth CHIP's HEDIS compliance auditor documented the following key findings and recommendations:

- The auditor commended SelectHealth CHIP again for reporting nearly all ECDS measures for some submissions and suggested that SelectHealth CHIP continue to explore possible source systems of record it may access and use for future continuation and expansion of ECDS reporting.
- Several of SelectHealth CHIP's initiatives, incentives, and forward-thinking updates to processes have resulted in notable increases in rates. For example, for the *WCC* measure, SelectHealth CHIP's increase in education handouts attached to the visit in the EHR enabled verification that anticipatory guidance for nutrition was given to the patient via the education handout.
- The supplemental data impact report included events for measures that were not included in the events list used for PSV selection for nonstandard data sources. These events were immaterial to reporting for the measures that were affected. HSAG recommends that Selectealth CHIP ensure that all measures are included in the events list submitted for PSV for all nonstandard data sources used for future HEDIS reporting.
- During review of Roadmap Section 5: Supplemental Data, multiple discrepancies were noted across numerous data sources. SelectHealth CHIP was able to successfully address these discrepancies in every Section 5 where they occurred. HSAG recommends that Selectealth CHIP develop a process

to reconcile all questions in Roadmap Section 5 against the designed supplemental data reporting strategy.

Performance Measure Outcomes

Table 2-163 shows SelectHealth CHIP's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table 2-163—SelectHealth CHIP HEDIS MY 2022 Results

HEDIS Measure	SelectHealth CHIP MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	92.68%	92.60%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	73.53%	63.16%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	91.04%	78.32%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	84.72%	76.75%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	79.07%	56.76%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	62.97%	56.50%

SelectHealth CHIP—Assessment With Respect to Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth CHIP exceeded the MY 2022 NCQA Quality Compass average for all the performance indicators:

- *Appropriate Treatment for URI—3 months–17 years*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Opportunities for Improvement

SelectHealth CHIP did not fall below the MY 2022 NCQA Quality Compass average for any of the performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and as such does not have any recommendations.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-164 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-164—Summary of Scores for the Standards for SelectHealth CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	11	11	8	3	0	0	86%
VII	Coverage and Authorization of Services	19	19	19	0	0	0	100%
X	Practice Guidelines	3	3	3	0	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	0	98%
	Totals	**75**	**75**	**70**	**5**	**0**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Coverage and Authorization of Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Grievance and Appeal System

Recommendations

HSAG recommends that SelectHealth CHIP:

- Update its policy regarding member rights to include all requirements.
- Revise its policy regarding emergency and poststabilization services to clarify SelectHealth CHIP's financial responsibility for these services.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

VALIDATION OF NETWORK ADEQUACY

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-165 displays the number and percentage of provider categories by provider domain wherein SelectHealth CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and SelectHealth CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-165—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CHIP

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Pediatric	17	0	0.0%	
Additional Physical Health—Providers	5	3	60.0%	
Additional Physical Health—Facilities	6	1	16.7%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	1	33.3%	
Behavioral Health—Facilities	4	0	0.0%	

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-166 displays the provider domains and categories wherein SelectHealth CHIP failed to meet the time/distance standards.

Table 2-166—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology**; Laboratory; Outpatient Dialysis; Outpatient Infusion/Chemotherapy; Surgical Services (Outpatient or ASC)	
Additional Physical Health—Providers	Audiologist; Speech Therapist	
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit**; Substance Abuse Facility	
Behavioral Health—Providers	Behavioral Medical—Pediatric; Substance Abuse Counselor	
Hospitals	Hospital—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric**; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

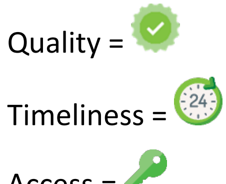
HSAG offers the following recommendations:

- For the provider categories for which SelectHealth CHIP did not meet the time/distance standard, HSAG recommends that SelectHealth CHIP assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, SelectHealth CHIP should ensure all providers are appropriately identified in future data submissions.

CHIP PAHP Providing Dental Services

Premier Access—CHIP

Following are Premier Access CHIP's findings, strengths, opportunities for improvement, and recommendations by EQR-related activity with assessment of the relationship to the quality of, timeliness of, and access to care and services.



Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2023, Premier Access CHIP continued its PIP topic: *School Based Care for CHIP Members.* The goal of this PIP is to increase dental care delivery in a school-based setting to improve dental care utilization.

Validation Results and Interventions

Table 2-167 summarizes the validation findings for each stage validated for CY 2023. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 2-167—CY 2023 Performance Improvement Project Validation Results for Premier Access CHIP (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	*Not Applicable*		
	5. Review the Selected Performance Indicator(s)	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	***Partially Met***	***Not Met***
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	0	1
	Outcomes Total	**1/2**	**0/2**	**1/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**95%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For this year's validation, Premier Access CHIP reported Remeasurement 1 results. Premier Access CHIP had a statistically significant decline in the performance indicator rate as compared to the baseline. The interventions did not result in significant clinical or programmatic improvement.

Table 2-168 displays data for Premier Access CHIP's PIP.

Table 2-168—PIP—*School Based Care for CHIP Members* for Premier Access CHIP

Performance Indicator Results					
Performance Indicators	**Baseline (06/01/2021–05/31/2022)**		**Remeasurement 1 (06/01/2022–05/31/2023)**		**Sustained Improvement**
Percentage of Premier Access CHIP members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 13 D: 681	1.9%	N: 1 D: 525	0.2%	*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for the percentage of eligible CHIP members 5–10 years of age who received dental care in a school was 1.9 percent. For Remeasurement 1, Premier Access CHIP reported a rate of 0.2 percent, which represents a statistically significant decline of 1.7 percentage points from the baseline.

Barriers/Interventions

For the PIP, Premier Access CHIP used feedback from dental provider groups to identify the following barriers and implemented the following interventions to address those barriers.

Table 2-169—PIP Barriers/Interventions for Premier Access CHIP

Barriers	Interventions
Members do not have signed consent forms on the day that the provider is in the school.	Send text messages containing educational information and a link to an electronic consent form.
Members do not receive consent text messages.	Mailed materials containing educational information and a quick response (QR) code linking to an electronic consent form.

Premier Access CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths for Premier Access CHIP:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- The PIP topic that Premier Access CHIP selected addressed CMS' requirements related to quality outcomes—specifically, the quality and access to care and services.

Opportunities for Improvement

HSAG identified a statistically significant decline in the performance indicator rate as compared to the baseline.

Recommendations

HSAG provided the following recommendations for Premier Access CHIP:

- With the significant decline in performance, consider revisiting the current QI process and use QI science-based tools, such as process mapping, causal/barrier analysis, or a FMEA, to identify barriers to improvement. Determining if additional barriers exist and initiating new interventions gives the dental plan a greater opportunity to have an impact on the performance indicator.
- Continually work on the PIP throughout the year.
- Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table The evaluation process for each intervention must include what data (quantitative or qualitative) will be collected by the health plan to determine whether an intervention is effective. For evaluation results, the health plan must include data in accordance with the identified evaluation process. This intervention evaluation data should be separate from the performance indicator data and should be collected frequently (weekly, biweekly, monthly, or quarterly), unlike the annual performance indicator data.

- Ensure that it has accurate member contact information. Success of member outreach through mailers and text interventions is dependent on the accuracy of member contact information.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2022 showed that Premier Access CHIP's HEDIS compliance auditor found Premier Access CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2022. Premier Access CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier Access CHIP's FAR revealed that Premier Access CHIP's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-170 shows Premier Access CHIP's HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates for the *Annual Dental Visit* measure. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP measure rates to these averages should be interpreted with caution.

Table 2-170—Premier Access CHIP HEDIS MY 2022 Results

HEDIS Measure	Premier CHIP MY 2022 Rate	MY 2022 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	55.23%	36.33%
4–6 Years	76.36%	54.79%
7–10 Years	84.64%	58.42%
11–14 Years	80.20%	53.08%
15–18 Years	70.64%	44.92%
19–20 Years	30.00%	29.17%
Total	77.05%	47.27%

Premier Access CHIP—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Premier Access CHIP exceeded the MY 2022 NCQA Quality Compass average for all of the performance indicators:

- *Annual Dental Visit—2-3 Years*

- *Annual Dental Visit—4-6 Years*
- *Annual Dental Visit—7-10 Years*
- *Annual Dental Visit—11-14 Years*
- *Annual Dental Visit—15-18 Years*
- *Annual Dental Visit—19-20 Years*
- *Annual Dental Visit—Total*

Opportunities for Improvement

Premier Access CHIP did not fall below the MY 2022 NCQA Quality Compass average for any of the performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and as such does not have any recommendations.

Assessment of Compliance With CHIP Managed Care Regulations

Premier Access CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-171 presents the number of requirements within each of the six standards reviewed in CY 2023; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table 2-171—Summary of Scores for the Standards for Premier Access CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	0	93%
IV	Emergency and Poststabilization Services	8	8	8	0	0	0	100%
VII	Coverage and Authorization of Services	17	17	15	1	1	0	91%
X	Practice Guidelines	3	3	3	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
XIII	Grievance and Appeal System	28	28	21	7	0	0	88%
	Totals	**70**	**70**	**60**	**9**	**1**	**0**	**92%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths

HSAG identified strengths within the following standard areas:

- Enrollment and Disenrollment
- Emergency and Poststabilization Services
- Practice Guidelines

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Confidentiality
- Coverage and Authorization of Services
- Grievance and Appeal System

Recommendations

HSAG recommends that Premier Access CHIP:

- Provide methods for community education regarding advance directives.
- Implement a policy or procedure to describe its mechanisms for ensuring consistent application of review criteria for authorization decisions.
- Revise its letter templates to meet all of the requirements of the notice of adverse benefit determination.
- Revise its policies and other health plan documents on grievances and appeals to include all requirements, including applicable time frames for resolving grievances and requesting continued services during an appeal and State fair hearing.
- Develop a process to ensure that all grievances are captured together for reporting and trending purposes.

VALIDATION OF NETWORK ADEQUACY

Premier Access CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-172 displays the number and percentage of provider categories by provider domain wherein Premier Access CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Premier Access CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-172—Compliance With Time/Distance Standards by Provider Domain—Premier Access CHIP

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
General Dental	2	2	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-173 displays the provider domains and categories wherein Premier CHIP failed to meet the time/distance standards.

Table 2-173—Provider Categories That Failed to Meet Time/Distance Standards—Premier Access CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
NA	NA	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

HSAG identified no network adequacy recommendations for Premier CHIP.

Appendix A. Objectives and Methodology for External Quality Review by EQR Activity

Validation of Performance Improvement Projects

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a health plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence in the health plans' improvement strategies and that reported improvement in study indicator outcomes is supported by significant change.

Description of Data Obtained

DHHS required each health plan to conduct one PIP during CY 2023. Each health plan chose its own PIP topic. HSAG obtained the data needed to conduct the PIP validations from each health plan's CY 2023 PIP Submission Form. The PIP submission forms submitted provided detailed information about each health plan's PIP as it related to the protocol activities and associated steps HSAG reviewed and evaluated for the CY 2023 validation cycle.

Each section of the PIP submission form includes steps to be undertaken when conducting PIPs. The form presents instructions for documenting information related to each of the protocol steps. The health plans could also attach relevant supporting documentation with the PIP Submission Form. Each health plan completed the form for PIP activities conducted during the MY and submitted it to HSAG for validation.

Methodology and Technical Methods of Data Collection

In its PIP evaluation and validation, HSAG used CMS' EQR Protocol 1 cited earlier in this report to evaluate the following components of the QI process:

1. Evaluation of the technical structure of the PIP. This component ensures that the health plans design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's validation determines whether the PIP design (e.g., PIP question, population, PIP indicator[s], sampling techniques, and data collection methodology/processes) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring improvement.
2. Evaluation of the implementation of the PIP. Once a PIP is designed, its effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the health plans improve outcomes, and the quality of, access to, and timeliness of care provided to its members by implementing effective QI processes.

How Data Were Aggregated and Analyzed

HSAG obtained the data needed to conduct the PIP validation from the health plan's PIP Summary Form submitted in CY 2023. This form provided detailed information about the health plan's completed PIP activities.

To monitor, assess, and validate PIPs, HSAG uses an outcome-focused scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS' EQR Protocol 1. With DHHS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Step 1—Review the Selected PIP Topic

Step 2—Review the PIP Aim Statement

Step 3—Review the Identified PIP Population

Step 4—Review the Sampling Method

Step 5—Review the Selected PIP Variables and Performance Measures

Step 6—Review the Data Collection Procedures

Step 7—Review Data Analysis and Interpretation of PIP Results

Step 8—Assess the Improvement Strategies

Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred

How Conclusions Were Drawn

Each required protocol step is evaluated using one or more evaluations elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given protocol activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The HSAG PIP Review Team would give the health plan a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP activities were designed to evaluate the validity and quality of a health plan's processes for conducting valid PIPs. Therefore, HSAG determined that all PIPs had the potential impact the quality domain of care. Additionally, a health plan's particular PIP also may have also been associated with the timeliness or access domains, depending on the specific PIP topic. HSAG therefore analyzed each health plan's performance in conducting PIPs across the three domains of care based on those associations and the potential impact on member outcomes related to the domains of care.

Validation of Performance Measures

Objectives

The primary objectives of PMV were to:

- Evaluate the accuracy of the performance measure rates calculated by the health plans.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for each measure.

Description of Data Obtained

Medicaid ACOs, UMIC and CHIP MCOs, and Dental PAHPs

The ACOs, UMIC and CHIP MCOs, and dental PAHPs were required to calculate applicable HEDIS measures following the *HEDIS MY 2022 Technical Specifications*, undergo an NCQA HEDIS Compliance Audit[A-1] performed by an NCQA-certified auditor, and report the results of their HEDIS audit to DHHS. These health plans were also required to provide the HEDIS data, FARs, and a copy of the auditor's certification to DHHS. HSAG obtained the HEDIS FARs from DHHS and evaluated the FARs to assess the health plans' compliance with the NCQA HEDIS Compliance Audit standards.

PMHPs and HOME

The 11 PMHPs and HOME were required to calculate and report one measure, *Follow-Up After Hospitalization for Mental Illness*, which was a modified version of NCQA's HEDIS MY 2022 *Follow-Up After Hospitalization for Mental Illness* measure. The measure was based on claims/encounter data and data from the organization's care management tracking systems. DHHS required the PMHPs and HOME to maintain a data system that allowed for tracking, monitoring, calculating, and reporting this performance measure.

HSAG conducted PMV activities for the 11 PMHPs and HOME to assess the accuracy of performance measure rates reported and to determine the extent to which the calculated performance rates followed the measure specifications and reporting requirements. HSAG conducted virtual audits and reviewed these health plans' submitted documentation and performance measure rates.

Methodology and Technical Methods of Data Collection

Validation of Performance Measures

At the end of the NCQA HEDIS Compliance Audit season, the ACOs, UMIC plans, MCOs, and dental PAHPS submitted their FARs and final auditor-locked Interactive Data Submission System (IDSS) rate submissions to DHHS. HSAG obtained the HEDIS data and FARs from DHHS.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in CMS' EQR Protocol 2 cited earlier in this report. The CMS protocol activities for validation of performance measures includes the following methodology for data collection:

1. Conducted pre-virtual review activities including collecting and reviewing relevant documentation and rate review.

[A-1] HEDIS Compliance Audit ™ is a trademark of the NCQA.

- HSAG obtained a list of the indicators selected for validation as well as the indicator definitions from DHHS for the validation team to review.
- HSAG prepared a documentation request for the PMHPs and HOME, which included the Information Systems Capabilities Assessment Tool (ISCAT). HSAG customized the ISCAT to collect data consistent with Utah's service delivery model and forwarded the ISCAT to each organization with a timeline for completion and instructions for submission. HSAG responded to organizations' ISCAT-related questions during the pre-virtual phase.

2. Conducted virtual site visits using a webinar format with each organization.
   - HSAG collected information using several methods, including interviews with key staff, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports.
3. Conducted post-virtual-site visit activities including compiling and analyzing findings, and reporting results to DHHS.

How Data Were Aggregated and Analyzed

HSAG reviewed and evaluated the HEDIS 2021 FARs for the ACOs, UMIC plans, MCOs, and dental PAHPS to assess health plan compliance with the NCQA HEDIS Compliance Audit standards. The IS standards are:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry.
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry.
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry.
- IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight.
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry.
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity.

HSAG then analyzed each health plan's performance based on measure rates by reviewing the certified HEDIS rates in comparison to MY 2022 NCQA Quality Compass rates for Medicaid Health Maintenance Organizations (HMOs) to identify strengths and opportunities for improvement.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in CMS' EQR Protocol 2 cited earlier in this report. The CMS protocol activities for validation of performance measures include aggregation and analysis of documentation submitted by the organization including the ISCAT and supporting documentation, interviews with key staff during the virtual review, systems demonstrations

during the virtual review, review of data output files, PSV of records used for denominator and numerator identification, observation of data processing, and review of data reports.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care provided by the Utah's Medicaid and CHIP health plans, HSAG first ensured that each of the HEDIS performance measures reported was associated with one or more of the three domains of care (quality, timeliness, and access). Each measure may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance in comparison to MY 2022 NCQA Quality Compass rates for Medicaid HMOs to draw conclusions about the health plan's effectiveness in ensuring the quality and timeliness of, and access to care for its members.

Based on all validation activities with the PMHPs and HOME, HSAG determined results for each performance measure. As set forth in CMS' EQR Protocol 2, HSAG gave a validation finding of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported* (see Table A-1) to each performance measure. HSAG based each validation finding on how significant the errors were in each measure's evaluation elements, not by the number of elements determined to be noncompliant. For example, it was possible that a single error could result in a designation of *Do Not Report* if the impact of the error biased the rate by more than 5 percentage points. Conversely, even if multiple errors were identified, if the errors had little or no impact on the rate, the indicator was given a designation of *Reportable*.

After completing the validation process, HSAG prepared a report of the PMV findings and recommendations for each PMHP and HOME. HSAG forwarded these reports to DHHS and the appropriate health plan. Finally, HSAG analyzed each health plan's performance based on measure rates and reviewed the rates in comparison to the statewide average. Section 2 contains information about the health plan-specific performance measure rates and validation status.

Table A-1—Designation Categories for Performance Indicators

Reportable (R)	Measure was compliant with the State's specifications.
Do Not Report (DNR)	The PMHP rate was materially biased and should not be reported.
Not Applicable (NA)	The PMHP was not required to report the measure.
Not Reported (NR)	The measure was not reported because the PMHP did not offer the required benefit.

Compliance Monitoring

Objectives

The objective of the compliance review activities is to determine the extent to which the health plan complies with the standards set forth at 42 CFR Part 438 and with State contract requirements. In addition, the compliance review process provides meaningful information to DHHS and the health plans regarding:

- The quality and timeliness of, and access to, health care furnished by the health plan.
- Corrective actions required and interventions needed to improve quality.
- Activities needed to enhance and sustain performance and processes.

Description of Data Obtained

During CY 2023, HSAG conducted an assessment of the Utah health plans' compliance with Medicaid managed care regulations and State contract requirements, evaluating six managed care standards under 42 CFR §438 et seq. The remaining seven managed care standards will be assessed in CY 2024, as displayed in the Methodology and Technical Methods of Data Collection section. HSAG required that health plans complete a CAP to address requirements that were found to be out of compliance. HSAG then conducted a review of the implementation of each health plan's CAP.

Documents reviewed consisted of the following:

- The compliance monitoring tool with a portion completed by the health plan
- A document request form outlining the compliance review process where health plans added high-level organizational information and delegation information
- Policies and procedures
- Staff training materials
- Key committee meeting minutes
- Provider and member informational materials
- Paper and electronic UM and appeal determination records
- Correspondence related to NABDs and appeals
- Documentation of grievances, including the electronic record, correspondence, and grievance logs
- Records pertaining to grievance and appeal activities

In addition, HSAG obtained data for assessing compliance with regulations through telephonic interviews with key health plan staff members during virtual site reviews.

Methodology and Technical Methods of Data Collection

To accomplish the stated objectives for the virtual site reviews, for assessing each health plan's compliance with Medicaid and CHIP managed care regulations HSAG collaborated with DHHS on the development of compliance monitoring tools and methods, document review and assessment processes, schedules, agendas, and scoring methodology. HSAG completed document review and virtual interviews to assess all standards. Upon completion of each review, for each health plan, HSAG assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable* to each individual requirement reviewed and indicated where required actions existed, if appropriate. Table A-2 presents the organization of the Medicaid managed care regulations into 13 standards to be reviewed during CY 2023 and CY 2024:

Table A-2—Compliance Standards and Review Years

Standard Number and Title	Regulations Included	CY 2023	CY 2024
Standard I—Enrollment and Disenrollment	438.3(d) 438.56	X	
Standard II—Member Rights and Confidentiality	438.100 438.224	X	
Standard III—Member Information	438.10		X
Standard IV—Emergency and Poststabilization Services	438.114	X	
Standard V—Adequate Capacity and Availability of Services	438.206 438.207		X
Standard VI—Coordination and Continuity of Care	438.208		X
Standard VII—Coverage and Authorization of Services	438.210	X	
Standard VIII—Provider Selection and Program Integrity	438.214		X
Standard IX—Subcontractual Relationships and Delegation	438.230		X
Standard X—Practice Guidelines	438.236	X	
Standard XI—Health Information Systems	438.242		X
Standard XII—Quality Assessment and Performance Improvement Program	438.330		X
Standard XIII—Grievance and Appeal System	438.228 438.400 438.402 438.404 438.406 438.408	X	

Standard Number and Title	Regulations Included	CY 2023	CY 2024
	438.410 438.414 438.416 438.420 438.424		

HSAG conducted compliance review activities consistent with CMS' EQR Protocol 3 cited earlier in this report. The CMS protocol for assessing health plan compliance with regulations includes five protocol activities. To conduct compliance review activities, HSAG:

1. Collaborated with DHHS on the development of the compliance monitoring tool.
   - Collaborated with DHHS to determine review and scoring methods and thresholds.
   - Collaborated with the health plans and DHHS to determine schedules, agendas, and to explain the compliance monitoring processes and address questions.
2. Collected and reviewed data and documents and performed a preliminary review.
3. Conducted a virtual review using a telephonic or webinar strategy.
4. Compiled and analyzed and the data and information collected.
5. Prepared a report that delineated findings and required corrective actions (if applicable).
   - Submitted the health plan-specific draft reports to DHHS with a second draft to each health plan for review.
   - Submitted the final health plan-specific reports to the health plans and DHHS.

How Data Were Aggregated and Analyzed

HSAG assessed health plan compliance with the Medicaid managed care final rule, finalized November 9, 2020, through a proprietary compliance tool that itemized each of the regulations at 42 CFR Part 438, as noted in the Methodology and Technical Methods of Data Collection section of this report. Once the assessments were finalized, HSAG assigned scores (*Met*, *Partially Met*, *Not Met*, or *Not Applicable)* for each requirement and then assigned a point value, with *Met* equaling one point, *Partially Met* equaling one-half point, and *Not Met* equaling zero points. HSAG used this scoring methodology to determine scores for each requirement within the standards and then calculated a percent *Met* score for each standard. Finally, HSAG determined a weighted score for the entire assessment. With this information, HSAG was able to conduct analyses across standards; among health plan types (ACO, UMIC, CHIP, dental PAHP, and PMHP); and in the aggregate (statewide).

How Conclusions Were Drawn

HSAG assessed each requirement within the standards set forth at 42 CFR Part 438 and assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To make conclusions regarding the domains of care (quality, timeliness, and access) provided by each health plan, HSAG determined the requirements within each standard that were associated with each domain. Each element may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance across the three domains of care based on those associations and potential impact on member outcomes related to the domains of care.

Validation of Network Adequacy

Objectives

Under the contract for EQR, DHHS requested that HSAG conduct NAV analyses including a network capacity analysis and a geographic network distribution analysis for the CHIP health plans during CY 2023.

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in the CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. CMS published this protocol in February 2023, requiring alignment with the activity protocol to be published in the April 2025 CMS Technical Report. Since this activity was already underway prior to the publication of the new protocol, it does not completely align with the new protocol, but does provide an important assessment of the state of network adequacy for the Utah Medicaid health plans. The activity conducted in CY 2024 will align with all requirements of the new CMS Validation of Network Adequacy protocol.

The purpose of the network capacity and geographic distribution analyses was to determine the geographic distribution of the providers relative to member populations and to assess the capacity of a given provider network.

Description of Data Obtained

The CY 2023 NAV analyses included all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., health care facilities) contracted to provide care as of June 1, 2023, through one of Utah's Medicaid or CHIP managed care health plans.

Medicaid and CHIP Member Data Request

To complete the NAV analysis, HSAG obtained Medicaid and CHIP member eligibility, enrollment, and demographic information from DHHS. Key data elements requested included unique member identifier, gender, age, health plan in which the member is enrolled, and residential address as of June 1, 2023. Upon receiving the member data files from DHHS, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. HSAG collaborated with DHHS to resolve questions identified during the data review process.

Health Plan Data Request

HSAG submitted a detailed data requirements document to the health plans to request information about providers actively enrolled as June 1, 2023. HSAG supplied the health plans with the provider crosswalk that detailed the methods for classifying each provider category using provider type, specialty, taxonomy, and credentials. The health plans used the provider crosswalk to classify their providers to the appropriate provider categories. Key data elements requested included, but were not limited to, unique provider identifier, enrollment status with the health plans, provider category, provider type, provider specialty, and PCP indicator.

Methodology and Technical Methods of Data Collection

Under the contract for EQR, DHHS requested that HSAG conduct NAV analyses including a network capacity analysis and a geographic network distribution analysis for the Medicaid and CHIP health plans during CY 2023. As part of the analyses, HSAG updated the provider crosswalk developed in CY 2019 and revised in CY 2022, which the health plans used to classify providers into appropriate provider categories. HSAG then calculated the time/distance and provider ratio results for each health plan and validated each health plan's compliance with access standards. Additionally, for provider types that did not meet the time/distance requirements, a saturation analysis was completed to determine the degree to which each health plan's provider network reflects available providers. Figure A-1 describes HSAG's three main phases for the CY 2023 network adequacy tasks.

Figure A-1—Summary of CY 2023 Network Adequacy Tasks

CY 2023 Network Adequacy Tasks		
Data Collection	**Synthesis & Analysis**	**Reporting**
• Data request to DHHS and the health plans • Receive data from DHHS and the health plans	• Generate NAV analysis • Conduct saturation analysis • Conduct NAV analysis trending • Develop Tableau-based reporting dashboard • Request and receive responses from the health plans regarding provider categories not meeting the time/distance standards	• Report on NAV analysis and saturation analysis • Deploy Tableau dashboard

How Data were Aggregated and Analyzed

Network Capacity Analysis

HSAG calculated the provider ratio for the provider categories defined in the provider crosswalks for the health plans. Specifically, the provider ratio measures the number of providers by provider category (e.g., PCPs, cardiologists) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations.

Geographic Network Distribution Analysis

The second dimension of this study evaluated the geographic distribution of providers relative to the health plans' members. While the network capacity analysis identifies whether the network infrastructure is sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluates whether the provider locations in a health plan's provider network are proportional to the health plans' Medicaid and/or CHIP population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider specialties identified in the provider crosswalks:

- **Percentage of members within predefined access standards:**[A-2] A higher percentage of members meeting access standards indicates better geographic distribution of a health plan's providers in relation to its Medicaid or CHIP members.
- **Average travel distance (in miles) and travel time**[A-3] **(in minutes) to the nearest one to three providers:** A smaller distance or shorter travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care.

HSAG used GeoAccess software to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to three providers for all provider categories identified in the provider crosswalks. All study results were stratified by health plan.

Provider Saturation Analysis

Based on the time/distance validation results, HSAG identified the provider categories for which each health plan failed to meet the established standard at the county level. For each time/distance standard in which a health plan did not meet the time/distance requirements, HSAG determined the extent to which deficiencies in the health plan provider network resulted from the failure to contract with available providers versus a lack of available providers for the provider type and/or geographic area. HSAG collaborated with DHHS to determine any limitations that should be applied when assessing potentially available providers. For example, HSAG worked with DHHS to determine if providers in adjacent counties should be included when determining potential network deficiencies.

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each EQR-related activity conducted in CY 2023. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality or timeliness of, or access to care and services provided by each health plan as well as related to potential statewide improvement. To accomplish this analysis, HSAG used the following three step process:

[A-2] The percentage of members within predefined standards was calculated for provider categories with predefined access standards.

[A-3] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid or CHIP members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times were estimated based on the following drive speeds: urban areas were estimated at a drive speed of 30 miles per hour, suburban areas were estimated at a drive speed of 45 miles per hour, and rural areas were estimated at a drive speed of 55 miles per hour.

Step 1: HSAG analyzed the quantitative results obtained from each EQR-related activity, for each health plan, to identify strengths and weaknesses (opportunities for improvement) in each domain of care (quality and timeliness of, and access to care and services).

Step 2: From the information collected, HSAG identified common themes and salient patterns that emerged for each domain of care and drew conclusions about the quality and timeliness of, and access to care and services furnished by the health plans.

Step 3: From the analysis identifying common themes and patterns related to the domains of quality, timeliness, and access, HSAG evaluated the patterns and determined whether statewide recommendations may be appropriate.

How Conclusions Were Drawn

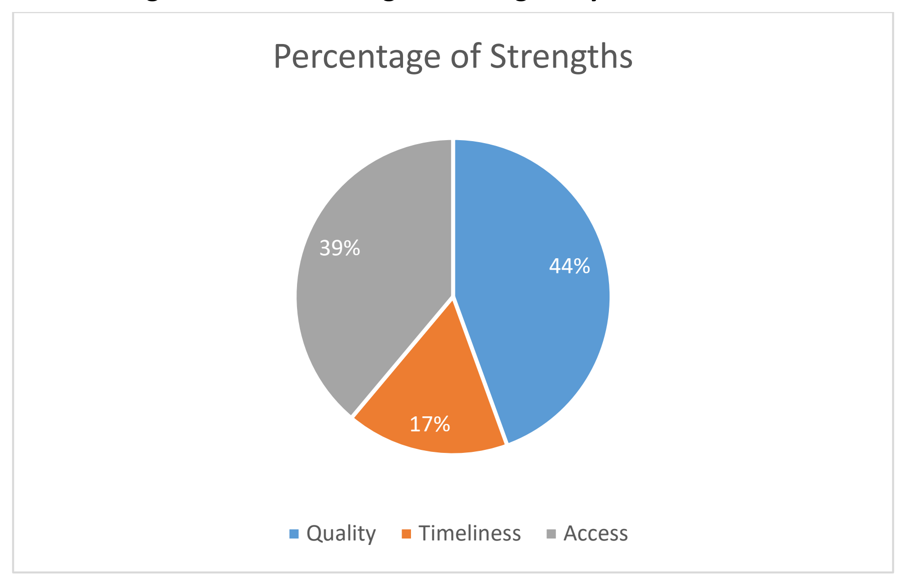
HSAG determined that results of network adequacy activities could provide information about health plan performance related to the quality and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Medicaid and CHIP member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the health plans' ability to track and monitor their respective provider networks.

Appendix B. Statewide Comparative Results

Statewide Strengths, Opportunities for Improvement, and Recommendations Across External Quality Review Activities

Figure B-1 and Figure B-2 provide an overall assessment of the percentages of strengths and weakness (opportunities for improvement) that HSAG assessed to likely impact each of the care domains—quality, timeliness, and access. These percentages were derived from the results of all mandatory and optional EQR-related activities conducted during CY 2023.

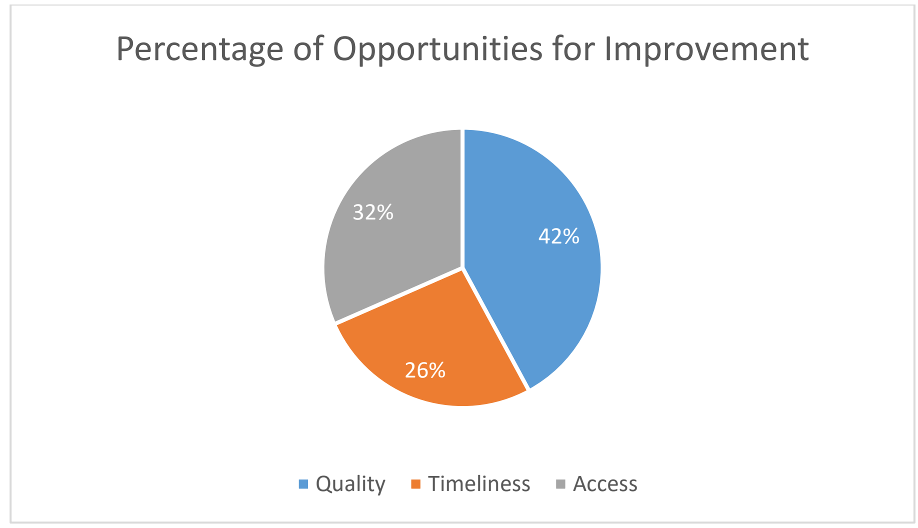
Figure B-1—Percentage of Strengths by Care Domain*



*Each strength may impact one or more domains of care (quality, timeliness, or access).

Figure B-2 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality and timeliness of, and access to care and services.

Figure B-2—Percentage of Opportunities for Improvement by Care Domain*



*Each recommendation may impact one or more domains of care (quality, timeliness, or access).

Statewide Strengths Related to All Activities

Across all health plans and all activities, HSAG found that the Utah health plans generally scored high in all mandatory EQR activities except performance measures and identified the following statewide strengths:

- PIP scores indicted that the validation status was *Met* for 23 of the 25 health plans, indicating that 92 percent of Utah health plans were in full compliance with critical PIP validation elements.
- Based on performance measure validation results:
  - HEDIS compliance auditors determined that the IS and processes of three of the health plans were fully compliant, and that one health plan's IS and processes were partially compliant with the applicable IS standards and reporting requirements for HEDIS MY 2022.
  - HSAG determined that the IS and processes of all 11 PMHPs and HOME were compliant with IS standards and that the performance indicators calculated by the PMHPs had a status of "Reportable" based on the reporting requirements for MY 2022 PMV.
- Based on performance measure outcomes:
  - At least three out of four ACOs exceeded the MY 2022 NCQA Quality Compass average for five (33.33 percent) of the 15 performance indicators.
  - At least three out of four MCOs exceeded the MY 2022 NCQA Quality Compass average for four (22.22 percent) of the 18 performance indicators.
  - Four PMHPs and HOME exceeded the statewide PMHP average for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, and two PMHPs exceeded the statewide

PMHP average for one of the two *Follow-Up After Hospitalization for Mental Illness* measure indicators.
  - Both CHIP MCOs exceeded the MY 2022 NCQA Quality Compass average for three (50 percent) of the six performance indicators.
  - The Medicaid dental PAHPs and CHIP dental plan exhibited strong results, as only one measure fell below the MY 2022 NCQA Quality Compass average for one Medicaid dental PAHP.
- Based on compliance with Medicaid managed care requirement findings, all Utah health plans scored at or above 92 percent as a cumulative weighted score. Of the 25 health plans, 22 scored 97 percent or greater.
- CY 2023 NAV results indicate that the Utah health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider categories.

Statewide Opportunities Related to All Activities

Across all health plans and all activities, HSAG identified the following statewide opportunities for improvement:

- Based on performance measure outcomes:
  - At least three of the four ACOs fell below the MY 2022 NCQA Quality Compass average for five (33.33 percent) of the 15 performance indicators.
  - At least three of the four MCOs fell below the MY 2022 NCQA Quality Compass average for nine (50 percent) of the 18 performance indicators.
  - Five PMHPs fell below the statewide PMHP average for both measure indicators.
- Based on compliance with Medicaid managed care requirement findings, HSAG identified required actions related to:
  - Maintaining up-to-date electronic information pertaining to practice guidelines and advance directive community education.
  - Accurate definitions and timelines for utilization management and appeals policies.

Statewide Recommendations Related to All Activities

For all activities, HSAG offers the following statewide recommendations:

- HSAG recommends that Utah Medicaid and CHIP health plans' leadership assess performance measure rates where the score fell below the MY 2022 NCQA Quality Compass average or the Statewide average (for PMHPs) and develop health plan-specific initiatives to address low rates, where appropriate.

- HSAG also recommends that Utah's Medicaid and CHIP health plans continue to work to align health plan policies and procedures with requirements set forth by federal regulations and the State managed care contracts.

Validation of Performance Improvement Projects

Statewide Comparative Results

For CY 2023, each health plan submitted one PIP for validation for a total of 25 PIPs. For a breakdown of statewide strengths, opportunities for improvement, and recommendations for PIPs, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Validation of Performance Improvement Projects.

ACO, MCO, and UMIC Plans

MEDICAID ACOS

All four ACOs received an overall *Met* validation status for their PIP. Three of the four ACOs achieved 100 percent and SelectHealth achieved 86 percent of all the applicable evaluation elements on HSAG's PIP validation tool.

UTAH MEDICAID INTEGRATED CARE (UMIC) PLANS

Three of the four UMIC plans received an overall *Met* validation status for their PIP. SelectHealth CC UMIC received an overall *Partially Met* validation status, with an 85 percent *Met* score on all the applicable evaluation elements.

Table B-1 lists the PIP topics and validation scores for each ACO, MCO, and UMIC health plan.

Table B-1—CY 2023 PIP Topics Selected by Medicaid ACO, MCO, and UMIC Plans Summary of Each Medicaid Health Plan's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Health Choice	*Well-Child Visits in the First 30 Months of Life*	100%	100%	*Met*
Health Choice UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*Met*
Healthy U	*Improving Access to Well Visits in the First 15 and 30 Months of Life*	100%	100%	*Met*
Healthy U Integrated	*Improving Adults' Access to Preventive/Ambulatory Care Services*	95%	100%	*Met*

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Molina	*Well-Child Visits in the First 30 Months of Life*	100%	100%	*Met*
Molina UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*Met*
SelectHealth CC	*Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members*	86%	100%	*Met*
SelectHealth CC UMIC	*7-day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members*	85%	90%	*Partially Met*

PMHPs and HOME

Ten of the 11 PMHPs received an overall *Met* validation status for their PIP. Bear River received an overall *Partially Met* validation status.

HOME

Table B-2 lists the PIP topics and validation scores for HOME.

Table B-2—CY 2023 PIP Topic Selected by HOME
Summary of HOME's PIP Validation Scores and Status

PIP	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic	100%	100%	*Met*

PMHPs

Table B-3 lists the PIP topics and validation scores for each PMHP.

Table B-3—CY 2023 PIP Topics Selected by PMHPs
Summary of Each PMHP's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Bear River	*YOQ/OQ*	80%	90%	*Partially Met*
Central	*Inpatient Readmission Rates*	100%	100%	*Met*
Davis	*Access to Care*	100%	100%	*Met*
Four Corners	*Collection and Meaningful Use of the SURE*	100%	100%	*Met*

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Healthy U Behavioral	*Improving Follow-up After Hospitalization for Mental Illness*	100%	100%	*Met*
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	100%	100%	*Met*
Optum/Tooele	*Increasing Youth Engagement in Treatment Services in Tooele County*	95%	100%	*Met*
Salt Lake	*Follow-Up After Hospitalization for Adults Aged 18–64*	100%	100%	*Met*
Southwest	*Increased Number of PMHP Clients Receiving Peer Support Services*	95%	100%	*Met*
Wasatch	*Increasing SURE Utilization in SUD*	100%	100%	*Met*
Weber	*Treating Anxiety and Depression with EBT*	100%	100%	*Met*

CHIP MCOs

Both CHIP MCOs received an overall *Met* validation status for their PIP.

Table B-4 lists the PIP topics and validation scores for each CHIP.

Table B-4—CY 2023 PIP Topics Selected by CHIP Health Plans
Summary of Each CHIP Health Plan's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Molina CHIP	*Weight Assessment and Counseling for Nutrition and Physician Activity—BMI Screening*	96%	100%	*Met*
SelectHealth CHIP	*Well-Child Visits for CHIP Members*	93%	100%	*Met*

MEDICAID AND CHIP DENTAL PAHPS

For CY 2023, HSAG validated one PIP for each of the two Medicaid dental PAHPs and the CHIP dental PAHP. All three dental PAHPs received an overall *Met* validation status for their PIP.

Table B-5 lists the PIP topics and validation scores for each dental PAHP.

Table B-5—CY 2023 PIP Topics Selected by Dental PAHPs
Summary of Each Dental PAHP's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
MCNA	*Annual Dental Visit*	100%	100%	*Met*
Premier Access	*School Based Care for Medicaid Members*	95%	100%	*Met*
Premier Access CHIP	*School Based Care for CHIP Members*	95%	100%	*Met*

Validation of Performance Measures

Statewide Comparative Results

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for performance measures, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Validation of Performance Measures.

ACOs

VALIDATION FINDINGS

The Medicaid ACOs' HEDIS compliance auditors determined that the IS and processes of three of the health plans were fully compliant, and that one health plan's IS and processes were partially compliant with the applicable IS standards and reporting requirements for HEDIS MY 2022.

PERFORMANCE MEASURE RESULTS

All four ACOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for URI—3 months–17 years*

Three of the four ACOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Controlling High Blood Pressure*

- *Use of Imaging Studies for Low Back Pain*

The following performance indicators demonstrated the most need for improvement, as all four ACOs fell below the MY 2022 NCQA Quality Compass average:

- *Breast Cancer Screening*
- *Immunizations for Adolescents—Combination 2*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

In addition, three of the four ACOs fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Cervical Cancer Screening*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

Based on performance measure outcomes:

- At least three out of four ACOs exceeded the MY 2022 NCQA Quality Compass average for five (33.33 percent) of the 15 performance indicators.
- At least three of the four ACOs fell below the MY 2022 NCQA Quality Compass average for five (33.33 percent) of the 15 performance indicators.

Table B-6 shows the ACOs' HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table B-6—ACOs' HEDIS MY 2022 Results

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth CC	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services					
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	**71.87%**	74.15%	73.95%	79.76%	72.74%
Antidepressant Medication Management					
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant	67.82%	63.82%	70.10%	72.82%	60.91%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth CC	MY 2022 NCQA Quality Compass Average
medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)					
Appropriate Treatment for URI					
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	94.81%	95.72%	94.77%	96.07%	92.60%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**35.74%**	**38.42%**	**34.39%**	**46.98%**	52.43%
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**50.12%**	**52.07%**	**44.04%**	63.29%	55.92%
Childhood Immunization Status					
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	**60.83%**	66.18%	**41.36%**	70.07%	63.16%
Hemoglobin A1c (HbA1c) Testing					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)*	—	—	—	—	—
Eye Exam for Patients With Diabetes					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**50.61%**	52.31%	**46.72%**	58.95%	51.47%
Controlling High Blood Pressure					
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	75.28%	67.84%	**40.88%**	72.24%	60.86%
Immunizations for Adolescents					
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**26.28%**	**34.55%**	**23.11%**	**34.94%**	35.55%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth CC	MY 2022 NCQA Quality Compass Average
Prenatal and Postpartum Care					
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	**72.42%**	85.67%	**76.40%**	92.75%	82.95%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**72.68%**	77.78%	**72.02%**	82.13%	76.96%
Use of Imaging Studies for Low Back Pain					
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	73.83%	**68.81%**	74.19%	75.73%	73.35%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**72.75%**	80.89%	**54.99%**	86.79%	76.75%
Well-Child Visits in the First 30 Months of Life					
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**46.45%**	**43.95%**	**46.60%**	58.73%	56.76%
Child and Adolescent Well-Care Visits					
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**46.36%**	**47.70%**	**47.45%**	**53.44%**	56.50%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.

**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[B-1]

[B-1] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

UMIC Plans

VALIDATION FINDINGS

The UMIC plans' HEDIS compliance auditors determined that the IS and processes of three health plans were fully compliant, and that one health plan's IS and processes were partially compliant with the applicable IS standards and reporting requirements for HEDIS MY 2022.

PERFORMANCE MEASURE RESULTS

All four MCOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total*

Three of the four MCOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Controlling High Blood Pressure*

The following performance indicators demonstrated the most need for improvement, as all four MCOs fell below the MY 2022 NCQA Quality Compass average:

- *Breast Cancer Screening*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

In addition, three of the four MCOs fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Cervical Cancer Screening*
- *Eye Exam (Retinal) Performed*
- *Use of Imaging Studies for Low Back Pain*

Based on performance measure outcomes:

- At least three out of four MCOs exceeded the MY 2022 NCQA Quality Compass average for four (22.22 percent) of the 18 performance indicators.
- At least three of the four MCOs fell below the MY 2022 NCQA Quality Compass average for nine (50 percent) of the 18 performance indicators.

Table B-7 shows the UMIC plans' HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates.

Table B-7—UMIC Plans' HEDIS MY 2022 Results

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	MY 2022 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services					
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**56.60%**	**63.98%**	**64.66%**	73.20%	72.74%
Antidepressant Medication Management					
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	80.00%	63.08%	62.69%	**59.36%**	60.91%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**35.36%**	**36.25%**	**32.18%**	**49.94%**	52.43%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	NA	NA	NA	75.95%
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**31.39%**	**45.74%**	**37.71%**	58.31%	55.92%

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	MY 2022 NCQA Quality Compass Average
Hemoglobin A1c (HbA1c) Testing					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)*	—	—	—	—	—
Eye Exam for Patients With Diabetes					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**42.09%**	**47.45%**	**40.39%**	55.61%	51.47%
Controlling High Blood Pressure					
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	62.03%	68.81%	**45.01%**	72.50%	60.86%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	**71.57%**	NA	83.33%	**74.42%**	79.00%
Diabetes Monitoring for People With Diabetes and Schizophrenia					
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	NA	NA	NA	67.94%
Follow-Up After Emergency Department Visit for Mental Illness					
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up—Total)	**26.45%**	**23.26%**	**24.38%**	**36.43%**	41.53%
The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up—Total)	**36.36%**	**36.05%**	**33.75%**	**47.21%**	55.19%
Follow-Up After Emergency Department Visit for Substance Use					
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up—Total)	28.38%	25.25%	25.27%	25.78%	25.00%

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	MY 2022 NCQA Quality Compass Average
The percentage of ED visits among members age 13 years and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up—Total)	**35.31%**	**34.50%**	40.13%	39.59%	36.43%
Follow-Up After Hospitalization for Mental Illness					
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up—Total)	**20.34%**	**24.19%**	**24.27%**	**33.45%**	36.61%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up—Total)	**38.98%**	**44.19%**	**43.57%**	**54.50%**	57.05%
Initiation and Engagement of SUD Treatment					
Initiation of SUD Treatment: Adults who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of SUD Treatment—Total)	48.87%	49.71%	46.33%	48.31%	45.01%
Engagement of SUD Treatment: Adults who initiated treatment and had two or more additional SUD services or MAT within 34 days of the initiation visit. (Engagement of SUD Treatment—Total)	15.86%	**13.48%**	**14.29%**	16.26%	14.91%
Use of Imaging Studies for Low Back Pain					
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	75.21%	**69.27%**	**69.23%**	**72.66%**	73.35%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.

**NCQA retired the HEDIS HbA1c Testing measure for MY 2022.*[B-2]

[B-2] National Committee for Quality Assurance. HEDIS 2022: See What's New, What's Changed and What's Retired. Available at: https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/. Accessed on: Jan 18, 2024.

PMHPs and HOME

VALIDATION FINDING

HSAG determined that the IS and processes of all 11 PMHPs and HOME were compliant with IS standards and that the performance indicators calculated by the PMHPs had a status of "Reportable" based on the reporting requirements for MY 2022 PMV.

PERFORMANCE MEASURE RESULTS

For MY 2022, the PMHPs and HOME calculated and reported the State-modified *Follow-Up After Hospitalization for Mental Illness* measure. This measure helps PMHPs and HOME monitor and ensure that members receive timely follow-up outpatient services after hospital discharge. Timely follow-up can help reduce the risk of rehospitalizations. Since the PMHPs and HOME used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. The PMHPs' results were compared to a calculated statewide PMHP average. HOME was not included in or compared to the statewide PMHP average.

Based on performance measure outcomes, four PMHPs exceeded the statewide PMHP average for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, while five PMHPs fell below the statewide PMHP average for both measure indicators. Two PMHPs exceeded the statewide PMHP average for one of the two *Follow-Up After Hospitalization for Mental Illness* measure indicators.

HOME

Table B-8 presents the findings reported by HOME for the *Follow-Up After Hospitalization for Mental Illness* measure.

Table B-8—HOME MY 2021 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	48.39%
Follow-Up Within 30 Days	90.32%

PMHPs

Table B-9 presents the findings reported by the PMHPs for the *Follow-Up After Hospitalization for Mental Illness* measure.

Table B-9—PMHPs MY 2021 *Follow-Up After Hospitalization for Mental Illness* Results

PMHP	Follow-Up Within 7 Days	Follow-Up Within 30 Days
Statewide PMHP Average	**51.93%**	**68.20%**
Bear River	**51.04%**	69.71%
Central	66.29%	78.65%
Davis	65.59%	88.17%
Four Corners	**40.00%**	**60.00%**
Healthy U Behavioral	**30.00%**	**60.00%**
Northeastern	64.06%	70.31%
Optum/Tooele	**43.36%**	**54.87%**
Salt Lake	**43.79%**	**58.65%**
Southwest	**45.65%**	**60.43%**
Wasatch	71.95%	80.49%
Weber	**49.51%**	68.93%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*

CHIP MCO

VALIDATION FINDINGS

The CHIP MCOs' HEDIS compliance auditors determined that the IS and processes of both health plans were compliant with the applicable IS standards and reporting requirements for HEDIS MY 2022.

PERFORMANCE MEASURE RESULTS

Both CHIP MCOs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for URI—3 months–17 years*
- *Immunizations for Adolescents—Combination 1*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

One CHIP MCO fell below the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Based on performance measure outcomes:

- Both CHIP MCOs exceeded the MY 2022 NCQA Quality Compass average for three (50 percent) of the six performance indicators.
- One of the CHIP MCOs fell below the MY 2022 NCQA Quality Compass average for two (33.33 percent) of the six performance indicators.

Table B-10 shows CHIP MCOs' HEDIS MY 2022 results as compared to the MY 2022 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table B-10—CHIP MCO HEDIS MY 2022 Results

HEDIS Measure	Molina CHIP	SelectHealth CHIP	MY 2022 NCQA Quality Compass Average
Appropriate Treatment for URI			
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	94.12%	92.68%	92.60%
Childhood Immunization Status			
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	NA	73.53%	63.16%
Immunizations for Adolescents			
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	87.80%	91.04%	78.32%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**62.04%**	84.72%	76.75%
Well-Child Visits in the First 30 Months of Life			
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	65.22%	79.07%	56.76%

HEDIS Measure	Molina CHIP	SelectHealth CHIP	MY 2022 NCQA Quality Compass Average
Child and Adolescent Well-Care Visits			
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**56.14%**	62.97%	56.50%

Rates in ***red*** *font indicate the rate fell below the Quality Compass average.*

Medicaid and CHIP Dental PAHPs

VALIDATION FINDINGS

Two dental PAHPs (Premier Access and MCNA) contracted with DHHS to serve the Medicaid population, while DHHS contracted with Premier Access to also serve the CHIP population. The PAHPs' HEDIS compliance auditors determined that both PAHPs' IS and processes were compliant with the applicable IS standards and reporting requirements for MY 2022.

PERFORMANCE MEASURE RESULTS

Both Medicaid dental PAHPs exceeded the MY 2022 NCQA Quality Compass average for the following performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*
- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—Total*

One Medicaid dental PAHP fell below the MY 2022 NCQA Quality Compass average for the following performance indicator:

- *Annual Dental Visit—19–20 Years*

Table B-11 shows the HEDIS MY 2022 results for the dental PAHPs serving the Medicaid population as compared to the MY 2022 NCQA Quality Compass average rates.

Table B-11—Medicaid Dental PAHPs HEDIS MY 2022 Results

HEDIS Measure	MCNA	Premier Access	MY 2022 NCQA Quality Compass Average
Annual Dental Visit			
2–3 Years	39.95%	43.95%	36.33%
4–6 Years	58.04%	62.77%	54.79%
7–10 Years	62.23%	66.17%	58.42%
11–14 Years	56.56%	60.80%	53.08%
15–18 Years	46.65%	51.12%	44.92%
19–20 Years	**23.56%**	36.23%	29.17%
Total	52.96%	57.89%	47.27%

Premier Access' performance for the CHIP population exceeded the MY 2022 NCQA Quality Compass average for all of the *Annual Dental Visit* performance indicators.

Table B-12 shows the HEDIS MY 2022 results for the dental PAHP serving the CHIP populations compared to the MY 2022 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP PAHP measure rates to these averages should be interpreted with caution.

Table B-12—CHIP Dental PAHP HEDIS MY 2022 Results

HEDIS Measure	Premier Access CHIP	MY 2022 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	55.23%	36.33%
4–6 Years	76.36%	54.79%
7–10 Years	84.64%	58.42%
11–14 Years	80.20%	53.08%
15–18 Years	70.64%	44.92%
19–20 Years	30.00%	29.17%
Total	77.05%	47.27%

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Comparative Results

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for compliance activities, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Compliance Monitoring.

ACOs

For the CY 2023 compliance reviews, HSAG conducted an assessment of the four Medicaid ACOs' compliance with Medicaid managed care regulations and State contract requirements, evaluating the following standards under 42 CFR §438 et seq:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Table B-13 presents the standard scores and overall compliance scores for each Medicaid ACO. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table B-13—Statewide ACO Compliance Scores

Standard	Health Choice	Healthy U	Molina	SelectHealth CC	Statewide Average
Standard I—Enrollment and Disenrollment	100%	100%	93%	100%	98%
Standard II—Member Rights and Confidentiality	100%	100%	93%	93%	97%
Standard IV—Emergency and Poststabilization Services	100%	100%	100%	86%	97%
Standard VII—Coverage and Authorization of Services	95%	100%	95%	100%	98%
Standard X—Practice Guidelines	100%	100%	100%	100%	100%
Standard XIII—Grievance and Appeal System	96%	98%	98%	98%	98%
Total Weighted Score*	**97%**	**99%**	**97%**	**97%**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified trends when comparing the findings for these four organizations. In CY 2023, the statewide average score was highest for Standard X—Practice Guidelines at 100 percent. Additionally, statewide average scores for the remaining standards reviewed were 97 percent or above, indicating strong compliance with federal regulations and State contract requirements.

Regarding enrollment and disenrollment, HSAG found that three ACOs (Health Choice, Healthy U, and SelectHealth CC) achieved full compliance, as the health plans were able to describe the process for enrollment and disenrollment and had applicable policies and procedures in place. One ACO (Molina) had required actions related to updating its policy to include the requirement that the ACO will give the member 30 days' written notice of the proposed disenrollment and notify the member of his or her opportunity to use the ACO's grievance process.

Regarding member rights and confidentiality, HSAG found that two ACOs (Health Choice and Healthy U) achieved full compliance. Both health plans had policies on member rights and advance directives that clearly outlined all federal regulations and State contract requirements that pertain to member rights. Two ACOs (Molina and SelectHealth CC) had required actions related to ensuring that policies include all provisions related to member rights.

For Standard IV—Emergency and Poststabilization Services, HSAG found that three ACOs (Health Choice, Healthy U, and Molina) achieved full compliance. Each of these three MCOs maintained definitions of "emergency medical condition," "emergency services," and "poststabilization care services" as required and were able to describe policies and procedures for handling crisis and emergency service needs, as well as coverage of poststabilization services. One ACO (SelectHealth CC) had required actions related to clarifying the ACO's financial responsibility for emergency and poststabilization services within policies and internal processes.

Regarding coverage and authorization of services, HSAG found that two ACOs (Healthy U and SelectHealth CC) achieved full compliance. The two ACOs had comprehensive policies and procedures to explain the processes for coverage and authorization of services, including descriptions of which staff members make decisions and what time frames are followed. Two ACOs (Health Choice and Molina) had required actions to revise policies to include applicable time frames for making coverage determinations. Further, one ACO (Health Choice) had a required action related to ensuring that notice of adverse benefit determination letter templates meet the language and format requirements of 42 CFR §438.10(c).

For Standard X—Practice Guidelines, HSAG found that all four ACOs achieved full compliance. Each of the four MCOs had policies that aligned with federal requirements to ensure that practice guidelines are based on valid and reliable clinical evidence and consider the needs of members.

For Standard XIII—Grievance and Appeal System, HSAG found that each of the four ACOs had required actions related to this standard. Three ACOs (Health Choice, Healthy U, and Molina) had required actions related to ensuring that all requirements, including grievance and appeal processing time frames, were included and accurate in grievance and appeal policies. Further, HSAG found that two

ACOs (Health Choice and SelectHealth CC) were not capturing all grievances in their reporting, and thus had required actions related to updating processes.

UMIC Plans and HOME

For the CY 2023 compliance reviews, HSAG conducted an assessment of four UMIC plans' and HOME's compliance with Medicaid managed care regulations and State contract requirements, evaluating the following standards under 42 CFR §438 et seq:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Table B-14 presents the standard scores and overall compliance scores for each Medicaid UMIC plan and HOME (MCOs). Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table B-14—Standard Compliance Scores by MCO

Standard	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	HOME	Statewide Average
Standard I—Enrollment and Disenrollment	100%	100%	93%	100%	100%	99%
Standard II—Member Rights and Confidentiality	100%	100%	93%	93%	100%	97%
Standard IV—Emergency and Poststabilization Services	100%	100%	100%	86%	100%	97%
Standard VII—Coverage and Authorization of Services	95%	100%	95%	100%	100%	98%
Standard X—Practice Guidelines	100%	83%	100%	100%	83%	93%
Standard XIII—Grievance and Appeal System	96%	98%	98%	98%	100%	98%
Total Weighted Score*	**97%**	**98%**	**97%**	**97%**	**99%**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified trends when comparing the findings for these five organizations. In CY 2023, the statewide average score was highest for Standard I—Enrollment and Disenrollment at 99 percent, followed by Standard VII—Coverage and Authorization of Services and Standard XIII—Grievance and

Appeal System at 98 percent. Additionally, statewide average scores for five out of six standards reviewed were 95 percent or above, indicating strong compliance with federal regulations and State contract requirements.

Regarding enrollment and disenrollment, HSAG found that four MCOs (Health Choice UMIC, Healthy U Integrated, SelectHealth CC UMIC, and HOME) achieved full compliance, as the health plans were able to describe the process for enrollment and disenrollment and had applicable policies and procedures in place. One MCO (Molina UMIC) had required actions related to updating its policy to include the requirement that the MCO will give the member 30 days' written notice of the proposed disenrollment and notify the member of his or her opportunity to use the MCO's grievance process.

Regarding member rights and confidentiality, HSAG found that three MCOs (Health Choice UMIC, Healthy U Integrated, and HOME) achieved full compliance. These three health plans had policies on member rights and advance directives that clearly outlined all federal requirements and State contract requirements that pertain to member rights. Two MCOs (Molina UMIC and SelectHealth CC UMIC) had required actions related to ensuring that policies include all provisions related to member rights.

For Standard IV—Emergency and Poststabilization Services, HSAG found that four MCOs (Health Choice UMIC, Healthy U Integrated, Molina UMIC, and HOME) achieved full compliance. Each of these MCOs maintained definitions of "emergency medical condition," "emergency services," and "poststabilization care services" as required and were able to describe policies and procedures for handling crisis and emergency service needs, as well as coverage of poststabilization services. One MCO (SelectHealth CC UMIC) had required actions related to clarifying the MCO's financial responsibility for emergency and poststabilization services within policies and internal processes.

Regarding coverage and authorization of services, HSAG found that three MCOs (Healthy U Integrated, SelectHealth CC, and HOME) achieved full compliance. The three MCOs had comprehensive policies and procedures to explain the processes for coverage and authorization of services, including descriptions of which staff members make decisions and what time frames are followed. Two MCOs (Health Choice UMIC and Molina UMIC) had required actions to revise policies to include applicable time frames for making coverage determinations. Further, one MCO (Health Choice) had a required action related to ensuring notice of adverse benefit determination letter templates meet the language and format requirements of 42 CFR §438.10(c).

For Standard X—Practice Guidelines, HSAG found that three MCOs (Health Choice UMIC, Molina UMIC, and SelectHealth CC UMIC) achieved full compliance. The three MCOs had policies that aligned with federal requirements to ensure that practice guidelines are based on valid and reliable clinical evidence, consider the needs of members, and use the ASAM level of care placement criteria for SUD services. Two MCOs (Healthy U Integrated and HOME) had required actions to ensure the use of ASAM level of care placement criteria within practice guidelines and that all practice guidelines are appropriately made available to members and providers.

For Standard XIII—Grievance and Appeal System, HSAG found that only one MCO (HOME) achieved full compliance with this standard. The remaining four MCOs (Health Choice UMIC, Healthy U Integrated, Molina UMIC, and SelectHealth CC UMIC) had required actions. Three MCOs (Health Choice UMIC, Healthy U Integrated, and Molina UMIC) had required actions related to ensuring that all requirements, including grievance and appeal processing time frames, are included and accurate in grievance and appeals policies. Further, HSAG found that two MCOs (Health Choice UMIC and SelectHealth CC UMIC) were not capturing all grievances in their reporting, and thus had required actions related to updating processes.

PMHPs

For the CY 2023 compliance reviews, HSAG conducted an assessment of the PMHP's compliance with Medicaid managed care regulations and State contract requirements, evaluating the following standards under 42 CFR §438 et seq:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Table B-15 presents the standard scores and overall compliance scores for each Medicaid PMHP. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table B-15—Standard Compliance Scores by PMHP

Standard	Bear River	Central	Davis	Four Corners	Healthy U Behavioral	North-eastern	Optum Tooele	Salt Lake	South-west	Wasatch	Weber	State-wide Avg
Standard I—Enrollment and Disenrollment	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	99%
Standard II—Member Rights and Confidentiality	86%	100%	93%	100%	100%	93%	93%	93%	86%	93%	86%	93%
Standard IV—Emergency and Poststabilization Services	95%	100%	86%	100%	100%	100%	100%	100%	91%	95%	100%	97%
Standard VII—Coverage and Authorization of Services	97%	100%	94%	100%	100%	100%	97%	97%	100%	97%	100%	98%
Standard X—Practice Guidelines	100%	100%	83%	83%	83%	100%	100%	100%	100%	100%	100%	95%

Standard	Bear River	Central	Davis	Four Corners	Healthy U Behavioral	North-eastern	Optum Tooele	Salt Lake	South-west	Wasatch	Weber	State-wide Avg
Standard XIII—Grievance and Appeal System	100%	98%	100%	100%	98%	96%	100%	100%	100%	96%	95%	98%
Total Weighted Score*	**97%**	**99%**	**94%**	**99%**	**99%**	**98%**	**99%**	**99%**	**97%**	**96%**	**96%**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Although the 11 PMHPs were spread across the State and continued to have different needs and challenges within their member populations and regional service areas, HSAG was able to identify trends by comparing findings across these 11 organizations. In CY 2023, the statewide average score was highest for Standard I—Enrollment and Disenrollment at 99 percent, followed by Standard VII—Coverage and Authorization of Services and Standard XIII—Grievance and Appeal System at 98 percent. Additionally, statewide average scores for five out of six standards reviewed were 95 percent or above, indicating strong compliance with federal regulations and State contract requirements.

Regarding enrollment and disenrollment, HSAG found that 10 PMHPs achieved full compliance, as the health plans were able to describe the process for enrollment and disenrollment and had applicable policies and procedures in place.

Regarding member rights and confidentiality, HSAG found that three PMHPs (Central, Four Corners, and Healthy U Behavioral) achieved full compliance. These three health plans had policies on member rights and advance directives that clearly outlined all federal requirements and State contract requirements that pertain to member rights. The remaining eight PMHPs (Bear River, Davis, Northeastern, Optum/Tooele, Salt Lake, Southwest, Wasatch, and Weber) had required actions. Three PMHPs (Bear River, Southwest, and Weber) had required actions regarding revising member rights policies to include all member rights provisions. Six PMHPs (Davis, Northeastern, Optum/Tooele, Salt Lake, Southwest, and Wasatch) had required actions related to updating policies on advance directives, including ensuring that advance directive information is made available to health plan members and members of the community.

For Standard IV—Emergency and Poststabilization Services, HSAG found that seven PMHPs (Central, Four Corners, Healthy U Behavioral, Northeastern, Optum/Tooele, Salt Lake, and Weber) achieved full compliance. Each of these PMHPs had comprehensive policies and were able to describe policies and procedures for handling crisis and emergency service needs, as well as coverage of poststabilization services. Four PMHPs (Bear River, Davis, Southwest, and Wasatch) had required actions related to ensuring that poststabilization policies include all requirements.

Regarding coverage and authorization of services, HSAG found that six PMHPs (Central, Four Corners, Healthy U Behavioral, Northeastern, Southwest, and Weber) had comprehensive policies and procedures to explain the processes for coverage and authorization of services, including descriptions

of how treatment plan determinations are made, oversight procedures to ensure consistency of decisions, and the time frames that are followed. Five PMHPs (Bear River, Davis, Optum/Tooele, Salt Lake, and Wasatch) had required actions to revise policies to include applicable time frames for coverage and authorization of services, including time frames for sending notices to members.

For Standard X—Practice Guidelines, HSAG found that eight PMHPs (Bear River, Central, Northeastern, Optum/Tooele, Salt Lake, Southwest, Wasatch, and Weber) achieved full compliance. The eight PMHPs had policies that aligned with federal requirements to ensure that practice guidelines are based on valid and reliable clinical evidence, consider the needs of members, and use the ASAM level of care placement criteria for SUD services. Further, the PMHPs ensured that the guidelines were made available to providers and members, as required. Three PMHPs (Davis, Four Corners, and Healthy U Behavioral) had required actions to ensure the use of ASAM level of care placement criteria within practice guidelines and that all practice guidelines are made available to members and providers upon request.

For Standard XIII—Grievance and Appeal System, HSAG found that six PMHPs (Bear River, Davis, Four Corners, Optum/Tooele, Salt Lake, and Southwest) achieved full compliance with this standard. The six PMHPs had policies in place that described processes for accepting, acknowledging, and responding to member grievances and requests for appeals, and for documenting grievance and appeal system activities. The remaining five PMHPs (Central, Healthy U Behavioral, Northeastern, Wasatch, and Weber) had required actions related to ensuring that all requirements, including grievance and appeal processing time frames, were included and accurate in grievance and appeal policies.

CHIP MCOs

For the CY 2023 compliance reviews, HSAG conducted an assessment of the CHIP MCOs' compliance with CHIP managed care regulations and State contract requirements, evaluating the following standards under 42 CFR §438 et seq:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Table B-16 provides the standard scores and overall compliance scores for each CHIP MCO. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table B-16—Standard Compliance Scores by CHIP MCO

Standard	Molina CHIP	SelectHealth CHIP	Statewide Average
Standard I—Enrollment and Disenrollment	93%	100%	97%
Standard II—Member Rights and Confidentiality	93%	93%	93%
Standard IV—Emergency and Poststabilization Services	100%	86%	93%
Standard VII—Coverage and Authorization of Services	95%	100%	98%
Standard X—Practice Guidelines	100%	100%	100%
Standard XIII—Grievance and Appeal System	98%	98%	98%
Total Weighted Score*	**97%**	**97%**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified commonalities when comparing the findings in these two organizations. In CY 2023, the CHIP MCO statewide average score was highest for Standard X—Practice Guidelines at 100 percent. Additionally, the CHIP average scores for four out of six standards reviewed were above 95 percent, indicating strong compliance with federal regulations and State contract requirements.

Regarding enrollment and disenrollment, HSAG found that although only one CHIP MCO (SelectHealth CHIP) achieved full compliance, both CHIP MCOs were able to describe the process for enrollment and disenrollment. One CHIP MCO (Molina CHIP) had a required action related to updating its policy to include the requirement that the CHIP MCO will give the member 30 days' written notice of the proposed disenrollment and notify the member of his or her opportunity to use the CHIP MCO's grievance process.

Regarding member rights and confidentiality, HSAG found that both CHIP MCOs had policies on member rights and advance directives that clearly outlined most federal requirements and State contract requirements that pertain to member rights. However, both CHIP MCOs had required actions related to ensuring that policies include all provisions related to member rights.

For Standard IV—Emergency and Poststabilization Services, HSAG found that although only one CHIP MCO (Molina CHIP) achieved full compliance, both CHIP MCOs maintained definitions of "emergency medical condition," "emergency services," and "poststabilization care services" as required and were able to describe policies and procedures for handling crisis and emergency service needs. However, one CHIP MCO (SelectHealth CHIP) had a required action related to clarifying the CHIP MCO's financial responsibility for emergency and poststabilization services within policies and internal processes.

Regarding coverage and authorization of services, HSAG found that although only one CHIP MCO (SelectHealth CHIP) achieved full compliance, the two CHIP MCOs had policies and procedures to explain the processes for coverage and authorization of services, including descriptions of which staff

members make decisions. However, one CHIP MCO (Molina CHIP) had a required action to revise policies to include applicable time frames for making coverage determinations.

For Standard X—Practice Guidelines, HSAG found that both CHIP MCOs achieved full compliance. Each of the CHIP MCOs had policies that aligned with federal requirements to ensure that practice guidelines are based on valid and reliable clinical evidence and consider the needs of members.

For Standard XIII—Grievance and Appeal System, HSAG found that both CHIP MCOs had required actions related to this standard. One CHIP MCO (Molina CHIP) had a required action related to ensuring that all requirements, including grievance and appeal processing time frames, are included and accurate in grievance and appeals policies. HSAG found that the other CHIP MCO (SelectHealth CHIP) was not capturing all grievances in its reporting, and thus had a required action related to updating processes.

Medicaid and CHIP Dental PAHPs

For the CY 2023 compliance reviews, HSAG conducted an assessment of the Medicaid and CHIP dental PAHPs' compliance with Medicaid managed care regulations and State contract requirements, evaluating the following standards under 42 CFR §438 et seq:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Table B-17 provides the standard scores and overall compliance scores for the Medicaid and CHIP PAHPs. Standards that are not included in this table were reviewed in CY 2021 and will be reviewed in CY 2024.

Table B-17—Standard Compliance Scores by Dental PAHP

Standard	Premier Medicaid	Premier CHIP	MCNA	Statewide Average
Standard I—Enrollment and Disenrollment	100%	100%	100%	100%
Standard II—Member Rights and Confidentiality	93%	93%	100%	95%
Standard IV—Emergency and Poststabilization Services	100%	100%	100%	100%
Standard VII—Coverage and Authorization of Services	91%	91%	97%	93%
Standard X—Practice Guidelines	100%	100%	100%	100%
Standard XIII—Grievance and Appeal System	88%	88%	100%	92%

Standard	Premier Medicaid	Premier CHIP	MCNA	Statewide Average
Total Weighted Score*	**92%**	**92%**	**99%**	**94%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified commonalities when comparing the findings for these two programs (Premier Access' and MCNA's Medicaid lines of business, and Premier Access CHIP line of business). In CY 2023, statewide average scores were highest for Standard I—Enrollment and Disenrollment, Standard IV—Emergency and Poststabilization Services, and Standard X—Practice Guidelines at 100 percent, followed by Standard II—Member Rights and Confidentiality at 95 percent. These scores indicate strong compliance with federal regulations and State contract requirements.

Regarding enrollment and disenrollment, HSAG found that both Medicaid PAHPs and the CHIP PAHP were able to describe the process used to enroll new members using State-provided information, as well as how discrepancies were identified and rectified through communications with the State. While the Medicaid PAHPs and the CHIP PAHP reported that there were no instances of a member requesting to disenroll due to access or quality of care issues, staff members were able to describe disenrollment process and were aware of State contacts, if needed.

Regarding member rights and confidentiality, HSAG found that while only one Medicaid PAHP (MCNA) achieved full compliance, both Medicaid PAHPs and the CHIP PAHP had policies that clearly outlined all federal requirements and State contract requirements that pertain to member rights. However, Premier Medicaid and Premier CHIP had required actions related to ensuring that policies include provisions for community education regarding advance directives.

For Standard IV—Emergency and Poststabilization Services, HSAG found that the Medicaid PAHPs and CHIP PAHP achieved full compliance. Each of these dental health plans had written policies and procedures that addressed emergency and poststabilization care services, as required. The Medicaid PAHPs and CHIP PAHP were able to describe processes for handling crisis and emergency service needs, such as covering out-of-network emergency services through a one-time service agreement with the treating dental provider.

Regarding coverage and authorization of services, HSAG found that the Medicaid PAHPs and CHIP PAHP maintained comprehensive policies and procedures describing the process for coverage and authorization of services and had processes in place to ensure that services were sufficient in amount, duration, and scope, and that no services were arbitrarily denied or reduced. However, the Medicaid PAHPs and CHIP PAHP had required actions related to ensuring that letter templates meet all of the requirements of the notice of adverse benefit determination.

For Standard X—Practice Guidelines, HSAG found that the Medicaid PAHPs and CHIP PAHP achieved full compliance. The dental health plans adopted sufficient guidelines to help providers make decisions

about appropriate care specific to dental treatments and conditions and were able to describe how these guidelines were reviewed and approved by various clinical committees on a regular basis to ensure that guidelines remain appropriate to the member population.

For Standard XIII—Grievance and Appeal System, HSAG found that only the Medicaid PAHP (MCNA) achieved full compliance with this standard. Each dental health plan had policies in place that described processes for accepting, acknowledging, and responding to member grievances and requests for appeals, and for documenting grievance and appeal system activities. Premier Medicaid and Premier CHIP had several required actions related to ensuring that grievance and appeal processes are in compliance with time frames, that all grievance and appeal documents put forth applicable requirements, and that all grievances resolved by the dental health plans are included in required reporting.

Validation of Network Adequacy

Statewide Comparative Results

Table B-18 displays the number of provider categories meeting the time/distance standards by health plan statewide and by urbanicity. Health plans had to meet the standard for each urbanicity (i.e., urban, rural, and frontier) to meet the statewide time/distance standard for a provider category. UMIC plans operate only in urban areas. Since most PMHPs are inherently regional, statewide results are not presented for those regional health plans.

Overall, the Utah CY 2023 NAV results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider categories. Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards.

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for NAV, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Validation of Network Adequacy.

Table B-18—Compliance With Time/Distance Standards by Health Plan, Statewide, and Urbanicity

		Statewide*		Frontier		Rural		Urban	
Health Plan	Number of Provider Categories	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard
ACOs									
Health Choice	56	64.3%	36	94.6%	53	82.1%	46	67.9%	38
Healthy U	56	83.9%	47	98.2%	55	83.9%	47	94.6%	53
Molina	56	75.0%	42	75.0%	42	82.1%	46	80.4%	45
SelectHealth	56	69.6%	39	69.6%	39	69.6%	39	80.4%	45
UMIC Plans and HOME MCO									
HOME	55	98.2%	54	98.2%	54	98.2%	54	98.2%	54
Health Choice	41	90.2%	37	NA	NA	NA	NA	90.2%	37
Healthy U	41	97.6%	40	NA	NA	NA	NA	97.6%	40
Molina	41	87.8%	36	NA	NA	NA	NA	87.8%	36
SelectHealth	41	87.8%	36	NA	NA	NA	NA	87.8%	36
CHIP MCOs									
Molina CHIP	42	35.7%	15	35.7%	15	69.0%	29	61.9%	26
SelectHealth CHIP	42	26.2%	11	26.2%	11	47.6%	20	42.9%	18
PMHPs									
Bear River	10	40.0%	4	40.0%	4	40.0%	4	NA	NA
Central	12	25.0%	3	33.3%	4	25.0%	3	NA	NA
Davis	12	25.0%	3	NA	NA	NA	NA	25.0%	3
Four Corners	12	25.0%	3	25.0%	3	50.0%	6	NA	NA
Healthy U Behavioral	12	100.0%	12	NA	NA	100.0%	12	NA	NA
Northeastern	12	16.7%	2	16.7%	2	NA	NA	NA	NA
Optum/Tooele	12	91.7%	11	91.7%	11	NA	NA	NA	NA
Salt Lake	12	75.0%	9	NA	NA	NA	NA	75.0%	9

		Statewide*		Frontier		Rural		Urban	
Health Plan	Number of Provider Categories	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard
Southwest	12	58.3%	7	58.3%	7	58.3%	7	NA	NA
Wasatch	12	8.3%	1	NA	NA	NA	NA	8.3%	1
Weber	12	75.0%	9	NA	NA	75.0%	9	75.0%	9
PAHPs									
MCNA	2	50.0%	1	50.0%	1	100.0%	2	100.0%	2
Premier	2	100.0%	2	100.0%	2	100.0%	2	100.0%	2
CHIP PAHP									
Premier CHIP	2	100.0%	2	100.0%	2	100.0%	2	100.0%	2

NA refers to areas outside the serviced counties for each health plan or indicates that statewide results are not presented for PMHPs because they are regional.

Appendix C. Assessment of Health Plan Follow-Up on Prior Year's Recommendations

Medicaid ACOs Providing Physical Health Services

Health Choice Utah

Validation of Performance Improvement Projects

Health Choice's *Well-Child Visits in the First 30 Months of Life* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, Health Choice Utah's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for 10 of 16 indicators. HSAG recommended that Health Choice focus its improvement efforts on the following:

- Conduct a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Focus on programs that address barriers most experienced by women in the Utah Medicaid population, since most of the Health Choice measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

Health Choice Utah's response did not address HSAG's CY 2022 recommendations regarding HEDIS performance indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Health Choice had successfully implemented interventions to address outstanding required actions related to the Member Rights and Information, and Subcontractual Relationships and Delegation standards. HSAG identified 13 ongoing required corrective actions related to the Coverage and Authorization; Access and Availability; Grievance and Appeal System; Provider Selection and Program Integrity; and QAPIP, Practice Guidelines, and Health Information standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance

review, Health Choice submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Health Choice's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Health Choice's provider network, HSAG recommended that Health Choice conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Health Choice, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Health Choice reported that network adequacy deficiencies were almost universally in rural or frontier counties, and that Health Choice has contracted with nearly all available offices and systems in those areas.

In CY 2023, HSAG reevaluated Health Choice's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy U

Validation of Performance Improvement Projects

Healthy U's *Well-Child Visits in the First 30 Months of Life* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, Healthy U's rates on HEDIS performance indicators fellow below the MY 2021 NCQA Quality Compass average for nine of 16 indicators. HSAG recommended that Healthy U focus improvement efforts on the following:

- Conduct a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Healthy U measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

Healthy U reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- Healthy U developed an educational letter to support member adherence with taking antidepressant medications. The letter is sent to members identified as being in the eligible population for the measure. Additionally, Healthy U reported that it is developing a text/interactive voice response (IVR) refill reminder campaign as part of Healthy U's medication therapy management (MTM) efforts that will support adherence to antidepressant medications and is scheduled to launch in Q1 of 2024.
- Healthy U developed an IVR education and reminder campaign for breast cancer screening in partnership with two mammography screening centers. The IVR call provided members an opportunity to warm transfer directly to a mammography screening center for scheduling an appointment. Healthy U implemented value-based payment (VBP) arrangements with several provider groups. Breast cancer screening is included in the VBP quality measure set where providers are given a financial incentive to close care gaps. Healthy U also used member reminder letters and provider gap lists.
- Healthy U developed an IVR education and reminder campaign for cervical cancer screening. Members were offered the opportunity to warm transfer to health plan customer service for assistance with finding a PCP or women's health provider in order to schedule an appointment. Healthy U also used member reminder letters and provider gap lists.
- Healthy U included diabetic eye exams in the quality measure set for its VBP arrangements. Additionally, Healthy U implemented a diabetic disease management program to support diabetic members in managing their diabetes and receiving appropriate preventive health care services. Healthy U's Pharmacy Team implemented an MTM program to support member adherence with diabetic and cardiovascular medications. During MTM calls, pharmacists monitored members for

related care gaps (such as diabetic eye exams) to assist with closing those care gaps. Healthy U also used a member letter campaign that included a form to record the receipt of the diabetic eye exam, which could then be sent back to the member's PCP.

- Healthy U plans to implement a Text4Baby educational text campaign in mid-2024 to provide helpful messages to women starting in early pregnancy, the postpartum period, and through the first month of the child's life. The Short Message Service (SMS) message will include education and reminders about the importance of timely prenatal and postpartum care. Additionally, Healthy U made outreach calls to all high-risk pregnant members for referral into the U Baby Care Management program. Women identified for the program were followed throughout the pregnancy and postpartum period. Once a woman delivered, a care manager reached out to complete a postpartum questionnaire that assesses birth control, completion of a postpartum visit, and screens for postpartum depression. Healthy U sent educational materials and resources about prenatal/postnatal visits, tobacco cessation, mental health, and nutrition through a secure email platform to all pregnant members, regardless of risk status.
- Healthy U's QI Advisory Council adopted clinical practice guidelines in September 2023 to support the appropriate use of imaging in the treatment of low back pain. The guidelines were distributed to providers through the provider newsletter and posted on Health U's website. Additionally, Healthy U reported that it is exploring the possibility of including this measure in future VBP arrangements.
- Healthy U promoted the Well Visit Record Card for children under 3 years of age and developed a newborn resource packet for all newborns that includes the Well Visit Record Card as well as information on developmental milestones, what to expect at well visits, immunizations, car seats, and more. Healthy U made reminder phone calls and sent letters to members of all age groups (0–21 years) to encourage well visits and made VBP arrangements with providers to increase receipt of well visits. Healthy U plans to implement a Text4Baby/Text4Kids educational SMS campaign in mid-2024 to provide helpful messages to women regarding pregnancy, the postpartum period, well baby/child visits, immunizations, etc. Lastly, Healthy U is taking steps to improve data capture to include well-visit claims that were missing from the first month of life and improve provider specialty mapping accuracy.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Healthy U had successfully implemented interventions to address all outstanding required corrective actions related to the Access and Availability and Subcontractual Relationships and Delegation standards. HSAG identified 12 ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Healthy U submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U's provider network, HSAG recommended that Healthy U conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Healthy U, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Healthy U will reevaluate future data submissions, as some deficiencies may be due to categorizations within the data. Healthy U also stated that it contracts with all adult and pediatric hospitals throughout Utah and all pediatric specialists with privileges to those children's hospitals, and believes this deficiency is due to a lack of available pediatric hospitals and specialists throughout the State. Healthy U reported that it will continue to evaluate member complaints related to access to care or network adequacy and will monitor requests to access out-of-network providers on a quarterly basis.

In CY 2023, HSAG reevaluated Healthy U's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Molina Healthcare of Utah

Validation of Performance Improvement Projects

Molina's *Well-Child Visits in the First 30 Months of Life* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, Molina's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for 10 of 16 indicators. HSAG recommended that Molina focus improvement efforts on the following:

- Conduct a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Health Choice measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

Molina reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- Molina incentivized providers to close HEDIS gaps with quarterly bonus payments (97 groups in 2021; 34 opt-in groups in 2022; 39 opt-in groups in 2023, 12 are new).
- Molina provided in-home postpartum follow-up examinations.
- Molina used omnichannel communication to educate and inform members regarding services, benefits, programs, etc.
- Molina used a vendor to reach out to members and offer reward fulfillment for closing HEDIS gaps.
- Molina sent pregnant members a gift box for providing early pregnancy notification.
- Molina collaborated with other ACOs in Utah to develop a well-child and immunization tracker postcard to promote to members through the well-child performance improvement project. Molina promoted the tracker postcard through a relay message and added the postcard to its website and member portal.
- Molina sent a box with prepared meals to members completing an early prenatal visit and sent a box with fresh produce to members for completing postpartum care.
- Molina hosted a luncheon for office staff members for closing HEDIS gaps through scheduling.
- Molina reported that it is investigating the potential to include HbA1c testing and eye exams as part of comprehensive diabetes care visits.
- Molina incentivized providers to close HEDIS gaps with an annual payout based on contract performance. HEDIS gap closure dictates the percentage of shared savings that providers receive.
- Molina providers closed diabetes and blood pressure gaps through in-home assessments. Providers also conducted a social determinants of health questionnaire with members.
- Molina made outbound calls to assist members with scheduling needed visits and/or finding a PCP. Molina targeted women for these calls.

- Molina called members with only a few well-child visits left to improve performance on the *Well-Child Visits in the First 30 Months of Life* measure indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Molina had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards. HSAG identified four ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Molina submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina's provider network, HSAG recommended that Molina conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Molina, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Molina reported that it performs a gap analysis for network adequacy no less than quarterly. Any identified gaps are then worked on to remediate them in a timely manner. Molina also uses Quest Analytics for provider network adequacy management and ongoing monitoring. Molina receives quarterly reports from CVS that provide pharmacy network adequacy compliance with standards contained in its contracts, as well as a weekly report that identifies any changes in the pharmacy network, including pharmacies added or terminated.

In CY 2023, HSAG reevaluated Molina's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

SelectHealth Community Care

Validation of Performance Improvement Projects

Select Health CC's *Well-Child Visits in the First 30 Months of Life* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, SelectHealth CC's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for two of 16 indicators. HSAG recommended that SelectHealth CC focus targeted improvement efforts on the following:

- Conduct a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since all of the SelectHealth CC measures that fell below the national average rely on women receiving preventive care or coordinating preventive care for their children.

SelectHealth CC reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- SelectHealth CC conducted a segmentation analysis to look at the most vulnerable population and determined that members with a well-child visit open gap did not have a PCP. To target this population, SelectHealth CC developed a "Protect Your Child: Toddler to Teen" brochure and mailed the brochure to parents/guardians.
- SelectHealth CC conducted a survey of members to gain information regarding barriers to obtaining a mammogram. The survey results identified access to care as one of the barriers. SelectHealth CC is working with providers on extended hours and appointment availability to improve access for members.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that SelectHealth CC had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services and Provider Selection and Program Integrity standards. HSAG identified four ongoing required corrective actions related to the Access and Availability, Member Rights and Information, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, SelectHealth CC submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate SelectHealth CC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding SelectHealth CC's provider network, HSAG recommended that SelectHealth CC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with SelectHealth, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, SelectHealth CC reported several changes it will make to its provider reports submitted to HSAG to align with HSAG's provider crosswalk.

In CY 2023, HSAG reevaluated SelectHealth CC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services

Health Choice UMIC

Validation of Performance Improvement Projects

Health Choice UMIC's *Follow-Up After Hospitalization for Mental Illness* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, Health Choice UMIC's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for eight of 19 indicators. HSAG recommended that Health Choice UMIC focus its improvement efforts on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
  - Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Health Choice UMIC care management program.

Health Choice UMIC's response did not address HSAG's CY 2022 recommendations regarding HEDIS performance indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Health Choice UMIC had successfully implemented interventions to address all outstanding required actions related to the Member Rights and Information, and Subcontractual Relationships and Delegation standards. HSAG identified 13 ongoing required corrective actions related to the Coverage and Authorization; Access and Availability; Grievance and Appeal System; Provider Selection and Program Integrity; and QAPIP, Practice Guidelines, and Health Information standards

that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Health Choice UMIC submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Health Choice UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Health Choice UMIC's provider network, HSAG recommended that Health Choice UMIC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Health Choice UMIC, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Health Choice UMIC reported that network adequacy deficiencies are almost universally in rural or frontier counties, and that Health Choice UMIC has contracted with nearly all available offices and systems in those areas.

In CY 2023, HSAG reevaluated Health Choice UMIC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy Outcomes Medical Excellence (HOME)

Validation of Performance Improvement Projects

HOME's *Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for HOME during the PMV review.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that HOME had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards. HSAG identified six ongoing required corrective actions related to the Member Rights and Information and Grievance and Appeal System standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, HOME submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate HOME's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding HOME's provider network, HSAG recommended that HOME conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with HOME, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, HOME noted that it is monitoring member access to providers according to the network time/distance standards. In CY 2023, HSAG reevaluated HOME's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy U Integrated

Validation of Performance Improvement Projects

Healthy U Integrated's *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified an opportunity for improvement related to achievement of significant improvement in PIP outcomes. In the CY 2023 submission, the health plan did not achieve any improvement.

Validation of Performance Measures

In CY 2022, Healthy U Integrated's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for 11 of 19 indicators. HSAG recommended that Healthy U Integrated focus improvement efforts on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Healthy U Integrated care management program.

Healthy U Integrated reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- Healthy U Integrated completed member phone calls and sent reminder letters to assist adult members with finding a PCP. Additionally, Healthy U Integrated launched an IVR/text/email campaign in order to reach additional members and provide assistance in finding a primary care provider.
- Healthy U Integrated developed an educational letter to support member adherence with taking antidepressant medications. The letter is sent to members identified as being in the eligible population for the measure. Additionally, Healthy U Integrated is developing a text/IVR refill reminder campaign as part of its MTM efforts that will support adherence antidepressant medications and is scheduled to launch Q1 2024.
- Healthy U Integrated developed an IVR education and reminder campaign for breast cancer screening in partnership with two mammography screening centers. The IVR call provided

members an opportunity to warm transfer directly to a mammography screening center for scheduling an appointment. Healthy U Integrated implemented VBP arrangements with several provider groups. Breast cancer screening is included in the VBP quality measure set where providers are given a financial incentive to close care gaps. Healthy U Integrated also used member reminder letters and provider gap lists.

- Healthy U Integrated developed an IVR education and reminder campaign for cervical cancer screening. Members were offered the opportunity to warm transfer to health plan customer service for assistance with finding a primary care provider or women's health provider in order to schedule an appointment. Healthy U Integrated also used member reminder letters and provider gap lists.
- Healthy U Integrated included diabetic eye exams in the quality measure set for its VBP arrangements. Additionally, Healthy U Integrated implemented a Diabetic Disease Management program to support diabetic members in managing their diabetes and receiving appropriate preventive health care services. Healthy U Integrated's Pharmacy Team implemented an MTM program to support member adherence with diabetic and cardiovascular medications. During MTM calls, pharmacists monitored members for related care gaps (such as diabetic eye exams) to assist with closing those care gaps. Healthy U Integrated also used a member letter campaign that included a form to record the receipt of the diabetic eye exam, which could then be sent back to the member's PCP.
- Healthy U Integrated developed processes as part of the care management program to ensure timely follow-up for members after hospitalization for mental illness. Care managers completed post-discharge assessments of members to identify care needs and determined if the member had scheduled and/or attended a seven- and 30-day follow-up. In addition, care managers were able to refer members to the HMHI Transitions Clinic within seven days of discharge until the member was able to get an appointment with a longer-term provider.
- Healthy U Integrated's QI Advisory Council adopted clinical practice guidelines in September 2023 to support the appropriate use of imaging in the treatment of low back pain. The guidelines were distributed to providers through the provider newsletter and posted on Health U Integrated's website. Additionally, Healthy U Integrated is exploring the possibility of including this measure in future VBP arrangements.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Healthy U Integrated had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, and Subcontractual Relationships and Delegation standards. HSAG identified 13 ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Healthy U Integrated submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U Integrated's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U Integrated's provider network, HSAG recommended that Healthy U Integrated conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Healthy U Integrated, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Healthy U Integrated did not report any specific activities to address recommendations from the 2022 Annual EQR Technical Report for NAV.

In CY 2023, HSAG reevaluated Healthy U Integrated's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Molina UMIC

Validation of Performance Improvement Projects

Molina UMIC's *Follow-Up After Hospitalization for Mental Illness* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified an opportunity for improvement related to achievement of significant improvement in PIP outcomes. In the CY 2023 submission, the health plan did not achieve any improvement.

Validation of Performance Measures

In CY 2022, Molina UMIC's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for 14 of 19 indicators. HSAG recommended that Molina UMIC focus improvement efforts on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Molina UMIC care management program.

Molina UMIC reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- Molina UMIC incentivized providers to close HEDIS gaps with quarterly bonus payments (97 groups in 2021; 34 opt-in groups in 2022; 39 opt-in groups in 2023, 12 are new).
- Molina UMIC used omnichannel communication to educate and inform members regarding services, benefits, programs, etc.
- Molina UMIC used a vendor to reach out to members and offer reward fulfillment for closing HEDIS gaps.
- Molina UMIC submitted admission, discharge, and transfer data to Care Connections and Centauri to support follow-up calls to members.
- Molina UMIC made outbound calls to members discharged with a behavioral health or drug/substance abuse diagnosis to complete a follow-up. Follow-up visits were performed by a licensed clinical social worker either in person or via telehealth.
- Molina UMIC incentivized providers to close HEDIS gaps with an annual payout based on contract performance. HEDIS gap closure dictates the percentage of shared savings that providers receive.
- Molina UMIC providers closed diabetes and blood pressure gaps through in-home assessments. Providers also conducted a social determinants of health questionnaire with members.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Molina UMIC had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards. HSAG identified four ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, and Provider Selection and Program Integrity standards that were not adequately addressed and required a

continued CAP. Following the CY 2022 compliance review, Molina UMIC submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina UMIC's provider network, HSAG recommended that Molina UMIC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Molina UMIC, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Molina reported that it performs a gap analysis for network adequacy no less than quarterly. Any identified gaps are then worked on to remediate them in a timely manner. Molina also uses Quest Analytics for provider network adequacy management and ongoing monitoring. Molina receives quarterly reports from CVS that include pharmacy network adequacy data, as well as a weekly report that identifies any changes in the pharmacy network, including pharmacies added or terminated.

In CY 2023, HSAG reevaluated Molina UMIC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

SelectHealth CC UMIC

Validation of Performance Improvement Projects

SelectHealth CC UMIC's *Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* PIP received a *Met* score for 85 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified opportunities for improvement related to capturing appropriate data to evaluate interventions for effectiveness and achievement of significant improvement in PIP

outcomes. In the CY 2023 submission, the health plan did not address the deficiencies identified in last year's PIP submission.

Validation of Performance Measures

In CY 2022, SelectHealth CC UMIC's rates on HEDIS performance indicators fell below the MY 2021 NCQA Quality Compass average for seven of 19 indicators. HSAG recommended that SelectHealth CC UMIC focus targeted improvement efforts on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.
- Establishing partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
  - Providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the SelectHealth CC UMIC care management program.

SelectHealth CC UMIC reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- SelectHealth CC UMIC initiated a letter campaign to members on antidepressant medications.
- SelectHealth CC UMIC added the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators to the Quality Provider Program (QPP) incentive program.
- SelectHealth CC UMIC has an ongoing PIP related to the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators. Additionally, SelectHealth CC UMIC included these indicators in the QPP incentive program. SelectHealth CC UMIC is conducting further data analysis to determine the impact of prior behavioral health engagement and voluntary versus involuntary admissions.
- SelectHealth CC UMIC's rate on the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* measure indicator has surpassed the MY 2022 national rate without much attention being placed on this specific measure.
- SelectHealth CC UMIC noted that variation in the rate for the *Use of Imaging Studies for Low Back Pain* measure indicator is due to a low denominator with a small eligible population.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that SelectHealth CC UMIC had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, and Provider Selection and Program Integrity standards. HSAG identified six ongoing required corrective actions related to the Member Rights and Information, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, SelectHealth CC UMIC submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate SelectHealth CC UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding SelectHealth CC UMIC's provider network, HSAG recommended that SelectHealth CC UMIC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with SelectHealth CC UMIC, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, SelectHealth CC UMIC reported several changes it will make to its provider reports submitted to HSAG to align with HSAG's provider crosswalk.

In CY 2023, HSAG reevaluated SelectHealth CC UMIC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Medicaid PIHP PMHPs Providing Mental Health and/or Substance Use Disorder Services

Bear River Mental Health Services

Validation of Performance Improvement Projects

Bear River's *YOQ/OQ* PIP received a *Met* score for 92percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified opportunities for improvement related to documentation of the data collection process and performance indicator data. In the CY 2023 submission, the health plan addressed the deficiencies identified in last year's PIP submission.

Validation of Performance Measures

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for Bear River during the PMV review.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Bear River had successfully implemented interventions to address outstanding required actions related to the Access and Availability and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified 11 ongoing required corrective actions related to the Coverage and Authorization of Services, Coordination and Continuity of Care, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Bear River submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Bear River's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Bear River's provider network, HSAG recommended that Bear River conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Bear River, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Bear River did not report any specific activities to address recommendations from the 2022 Annual EQR Technical Report for NAV.

In CY 2023, HSAG reevaluated Bear River's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Central Utah Counseling Center

Validation of Performance Improvement Projects

Central's *Inpatient Readmission Rates* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for Central during the PMV review.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Central had successfully implemented interventions to address all outstanding required actions related to the Coordination and Continuity of Care and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified five ongoing required corrective actions related to the Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Central submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Central's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Central's provider network, HSAG recommended that Central conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Central, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Central did not report any specific activities to address recommendations from the 2022 Annual EQR Technical Report for NAV.

In CY 2023, HSAG reevaluated Central's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Davis Behavioral Health

Validation of Performance Improvement Projects

Davis' *Access to Care* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure indicator, HSAG recommended that Davis focus targeted improvement efforts on the following:

- Continue to contact members identified for follow-up services after discharge from a hospital. Davis should contact members multiple times to schedule follow-up services.
- Regularly verify that documentation provided by the hospital is saved within Credible to ensure that Davis stores proper documentation.

- Perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Davis reported that it made use of its MCOT and receiving center to reduce member hospitalizations and improve timely follow-up with members discharged from a hospital. As a result, Davis' performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators improved from MY 2021 to MY 2022.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Davis had successfully implemented interventions to address all outstanding required actions related to the Access and Availability; Grievance and Appeal System; and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified two ongoing required corrective actions related to the Member Rights and Information and the Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Davis submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Davis' provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Davis' provider network, HSAG recommended that Davis conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Davis, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Davis did not report any specific activities to address recommendations from the 2022 Annual EQR Technical Report for NAV.

In CY 2023, HSAG reevaluated Davis' provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Four Corners Community Behavioral Health

Validation of Performance Improvement Projects

For CY 2023, Four Corners submitted a new PIP, *Improving the Completion of Substance Use Recovery Evaluator (SURE)*. Therefore, this section is not applicable to this PIP.

Validation of Performance Measures

In CY 2022, HSAG recommended that Four Corners have at least two different team members perform additional validation of its numerator-positive cases and eligible population in the denominator to reduce potential errors. Additionally, HSAG recommended that Four Corners validate hospital discharge dates against claims that are documented in the EHR, and also validate dates of follow-up services. To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Four Corners perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Four Corners reported that it implemented transitional units to stabilize at-risk members and assist with medication monitoring.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Four Corners had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services; Access and Availability; and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified six ongoing required corrective actions related to the Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Four Corners submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

Four Corners reported that it hired a full-time corporate compliance officer who is focusing on reviewing and updating policies, procedures, defined terms, and documents to ensure consistency and

adherence to federal and State regulations and requirements. This staff member is working closely with the clinical director and other staff members to ensure adherence, and that easy-to-understand language is being used. This staff member is also refining the processes related to denials, appeals, and grievances, and working with Four Corners' HR staff on credentialing and recredentialing processes.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Four Corners' provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Four Corners' provider network, HSAG recommended that Four Corners conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Four Corners, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

In response to HSAG's NAV recommendations, Four Corners reported that it frequently has internal discussions on how to improve provider ratios in its various areas. Four Corners reported that it has implemented a variety of initiatives to address these concerns, such as having staff members from fully staffed clinics offer services in clinics that are experiencing staffing shortages, both in person and through telehealth services.

In CY 2023, HSAG reevaluated Four Corners' provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy U Behavioral

Validation of Performance Improvement Projects

Healthy U Behavioral's *Improving Follow-up After Hospitalization for Mental Illness* PIP received a *Met* score for 84 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified opportunities for improvement related to capturing appropriate data to evaluate

interventions for effectiveness and achievement of significant improvement in PIP outcomes. In the CY 2023 submission, the health plan addressed the recommendation related to capturing appropriate intervention evaluation data; however, improvement in PIP outcomes was not achieved.

Validation of Performance Measures

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Healthy U Behavioral perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Healthy U Behavioral reported that it leveraged EHR code optimization and automated processes to reduce data entry errors, ease administrative burden, and improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess all outstanding required actions from CY 2021. HSAG found that Healthy U Behavioral had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, and Subcontractual Relationships and Delegation standards. HSAG identified 11 ongoing required corrective actions related to the Coverage and Authorization of Services, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Healthy U Behavioral submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U Behavioral's provider network and identified network inadequacies compared to DHHS'

minimum time and distance network standards. Regarding Healthy U Behavioral's provider network, HSAG recommended that Healthy U Behavioral conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Healthy U Behavioral, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Healthy U Behavioral reported that it will continue to monitor any potential barriers to care and network adequacy.

In CY 2023, HSAG reevaluated Healthy U Behavioral's provider network and did not identify any ongoing network inadequacies, as detailed in Section 2 of this report.

Northeastern Counseling Center

Validation of Performance Improvement Projects

Northeastern's *Inpatient Post Discharge Engagement and Suicide Intervention* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for Northeastern during the PMV review.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review, to assess outstanding required actions from CY 2021. HSAG found that Northeastern had successfully implemented interventions to address all outstanding required actions related to the Member Rights and Information; Grievance and Appeal System; and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified one ongoing required corrective action related to the Provider Selection and Program Integrity standard that was not compliant. Northeastern submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services

- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Northeastern's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Northeastern's provider network, HSAG recommended that Northeastern conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Northeastern, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Northeastern did not report any specific activities to address recommendations from the 2022 Annual EQR Technical Report for NAV.

In CY 2023, HSAG reevaluated Northeastern's provider network and identified the ongoing network inadequacies detailed above Section 2 of this report.

Optum/Tooele

Validation of Performance Improvement Projects

Optum/Tooele's *Increasing Youth Engagement in Treatment Services in Tooele County* PIP received a *Met* score for 93 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified an opportunity for improvement in the narrative interpretation of data. In the CY 2023 submission, the health plan addressed the deficiency identified in last year's PIP submission.

Validation of Performance Measures

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Optum/Tooele perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Optum/Tooele reported the following efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators:

- Created flyers in Spanish to engage Spanish-speaking members and advocate for timely follow-up visits.

- Increased its network of mental health and SUD treatment providers from 15 to approximately 30 providers as of the review.
- Implemented the second component of its process improvement plan to engage young members in mental health and SUD treatment services. Optum/Tooele used a community health fair strategy to increase family and peer support for mental health and SUD treatment services.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Optum/Tooele had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Grievance and Appeal System, and Provider Selection and Program Integrity standards. HSAG identified two ongoing required corrective actions related to the Member Rights and Information and the Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Optum/Tooele submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Optum/Tooele's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Optum/Tooele's provider network, HSAG recommended that Optum/Tooele conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Optum/Tooele, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

In response to HSAG's NAV recommendations, Optum/Tooele reported that it does not pay for medical services outside of licensed psychiatrists. HSAG recommends that Optum/Tooele continue to collaborate with HSAG to ensure appropriate reporting of providers for the NAV activity.

In CY 2023, HSAG reevaluated Optum/Tooele's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Salt Lake County Division of Behavioral Health Services

Validation of Performance Improvement Projects

For CY 2023, Salt Lake submitted a new PIP, *Follow-Up After Hospitalization for Adults Aged 18–64*. Therefore, this section is not applicable to this PIP.

Validation of Performance Measures

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Salt Lake perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Salt Lake reported the implementation of a new process improvement plan that includes regular meetings with contracted inpatient facilities, the distribution of information to inpatient facilities to ensure better understanding of network resources for discharge planning, and the provision of additional support from care coordinators and care advocates for inpatient adult members.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to address outstanding required actions from CY 2021. HSAG found that Salt Lake had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, and the Provider Selection and Program Integrity standards. HSAG identified three ongoing required corrective actions related to the Member Rights and Information and the Grievance and Appeal System standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Salt Lake submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services

- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Salt Lake's provider network and identified network inadequacies compared to DHHS' minimum time and distance standards. Regarding Salt Lake's provider network, HSAG recommended that Salt Lake conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Salt Lake, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

In response to HSAG's NAV recommendations, Salt Lake reported that it does not pay for medical services outside of licensed psychiatrists and noted that it has providers that are available but were not reported according to HSAG's provider crosswalk. Salt Lake will collaborate with HSAG to ensure that its future provider submissions align with HSAG's provider crosswalk.

In CY 2023, HSAG reevaluated Sale Lake's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Southwest Behavioral Health Center

Validation of Performance Improvement Projects

Southwest's *Increased Number of PMHP Clients Receiving Peer Support Services* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Southwest perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Southwest reported several efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, including improved care coordination, increased utilization of hospital staff members to coordinate follow-up appointments, and having case managers follow members closely post-discharge to ensure timely follow-up visits.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Southwest had successfully implemented interventions to assess outstanding required actions related to all standard areas and thus did not have to submit a CAP.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Southwest's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Southwest's provider network, HSAG recommended that Southwest conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Southwest, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

In response to HSAG's NAV recommendations, Southwest reported that it does not have a behavioral health hospital, but it does contract with Intermountain Health and other hospitals in the area. Southwest also continues to look for mental health and SUD agencies to contract with to improve member treatment for those members who live in rural areas.

In CY 2023, HSAG reevaluated Southwest's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Wasatch Behavioral Health

Validation of Performance Improvement Projects

For CY 2023, Wasatch initiated a new PIP, *Increasing SURE Utilization in Substance Use Disorder.* Therefore, this section is not applicable to this PIP.

Validation of Performance Measures

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for Wasatch during the PMV review.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Wasatch had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services standard. HSAG identified 10 ongoing required corrective actions related to the Access and Availability, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Wasatch submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Wasatch's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Wasatch's provider network, HSAG recommended that Wasatch conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Wasatch, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV findings, Wasatch has informed HSAG that network adequacy was not reported correctly, and Wasatch has learned how to report this information correctly for future submissions.

In CY 2023, HSAG reevaluated Wasatch's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Weber Human Services

Validation of Performance Improvement Projects

For CY 2023, Weber initiated a new PIP, *Treating Anxiety and Depression with Evidence-Based Treatment (EBT).* Therefore, this section is not applicable to this PIP.

Validation of Performance Measures

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Weber perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Weber reported that it partnered with a local hospital (McKay-Dee Hospital) to simplify the care management process and ensure timely services for members. Weber staff members were embedded at the hospital to facilitate the prior authorization of hospital stays, to collaborate with hospital staff members during discharge planning, and to schedule follow-up services with members post-discharge. Additionally, Weber operated a receiving center in partnership with McKay-Dee Hospital to serve members in need of urgent substance use or behavioral health services. As a result, Weber's performance on the *Follow-Up Within 30 Days* measure indicator improved from MY 2021 to MY 2022.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Weber had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, Coordination and Continuity of Care, and Provider Selection and Program Integrity standards. HSAG identified four ongoing required corrective actions related to the Coverage and Authorization of Services; Member Rights and Information; Grievance and Appeal System; and QAPIP, Practice Guidelines, and Health Information Systems standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Weber submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services

- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Weber's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Weber's provider network, HSAG recommended that Weber conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Weber, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Weber did not report any specific activities to address recommendations from the 2022 Annual EQR Technical Report for NAV.

In CY 2023, HSAG reevaluated Weber's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

CHIP MCOs Providing Both Physical and Mental Health Services

Molina Healthcare of Utah CHIP

Validation of Performance Improvement Projects

Molina CHIP's *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening* PIP received a *Met* score for 96 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG identified an opportunity for improvement related to achievement of significant improvement in PIP outcomes. In the CY 2023 submission, the health plan did not achieve any improvement.

Validation of Performance Measures

In CY 2022, HSAG recommended that Molina CHIP focus its improvement efforts on the following:

- Conducting a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance.
- Using results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure.

- Focusing on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Molina CHIP measures that fell below the national average rely on women coordinating preventive care for their children.

Molina CHIP reported the following improvement efforts in response to HSAG's CY 2022 recommendations:

- Molina CHIP incentivized providers to close HEDIS gaps with quarterly bonus payments (97 groups in 2021; 34 opt-in groups in 2022; 39 opt-in groups in 2023, 12 are new).
- Molina CHIP used omnichannel communication to educate and inform members regarding services, benefits, programs, etc.
- Molina CHIP used a vendor to reach out to members and offer reward fulfillment for closing HEDIS gaps.
- Molina CHIP collaborated with other ACOs in Utah to develop a well-child and immunization tracker postcard to promote to members through the well-child PIP. Molina CHIP promoted the tracker postcard through a relay message and added the postcard to its website and member portal.
- Molina CHIP hosted a luncheon for office staff members for closing HEDIS gaps through scheduling.
- Molina CHIP incentivized providers to close HEDIS gaps with an annual payout based on contract performance. HEDIS gap closure dictates the percentage of shared savings that providers receive.
- Molina CHIP made outbound calls to assist members with scheduling needed visits and/or finding a PCP.
- Molina CHIP called members with only a few well-child visits left to improve performance on the *Well-Child Visits in the First 30 Months of Life* measure indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Molina CHIP had successfully implemented interventions to address all outstanding required actions related to the Subcontractual Relationships and Delegation standard. HSAG identified seven ongoing required corrective actions related to the Coverage and Authorization of Services, Access and Availability, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Molina CHIP submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment

- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina CHIP's provider network, HSAG recommended that Molina CHIP conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Molina CHIP, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Molina CHIP reported that it performs a gap analysis for network adequacy no less than quarterly. Any identified gaps are then worked on to remediate them in a timely manner. Molina also uses Quest Analytics for provider network adequacy management and ongoing monitoring. Molina CHIP receives quarterly reports from CVS that pull pharmacy network adequacy data, as well as a weekly report that identifies any changes in the pharmacy network, including pharmacies added or terminated.

In CY 2023, HSAG reevaluated Molina CHIP's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

SelectHealth CHIP

Validation of Performance Improvement Projects

SelectHealth CHIP's *Well-Child Visits for CHIP Members* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, HSAG did not identify recommendations for SelectHealth CHIP to improve performance on HEDIS indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that SelectHealth CHIP had successfully implemented its interventions to address all required actions related to the Coverage and Authorization of Services, Grievance and Appeal System, and Provider Selection and Program Integrity standards. HSAG identified four ongoing required corrective actions related to the Access and Availability, Member Rights and Information, and Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, SelectHealth CHIP submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate SelectHealth CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding SelectHealth CHIP's provider network, HSAG recommended that SelectHealth CHIP conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with SelectHealth CHIP, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, SelectHealth CHIP reported several changes it will make to its provider reports submitted to HSAG to align with HSAG's provider crosswalk.

In CY 2023, HSAG reevaluated SelectHealth CHIP's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

PAHPs Providing Medicaid Dental Services

Premier Access

Validation of Performance Improvement Projects

Premier Access' *School Based Care for Medicaid Members* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, HSAG did not identify recommendations for Premier Access to improve performance on HEDIS indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to address outstanding required actions from CY 2021. HSAG found that Premier Access had not implemented interventions to address outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standard areas that were found to be not fully compliant in CY 2021. HSAG identified 21 ongoing required corrective actions related to the standards listed above that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Premier Access submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for Premier Access related to NAV.

MCNA

Validation of Performance Improvement Projects

MCNA's *Annual Dental Visit* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. Even though the dental plan had significant clinical improvement with its interventions, the dental plan documented a decline in its performance indicator rates for a second consecutive year. In the 2023 submission, the dental plan continued to report a decline in performance indicator rates over the baseline.

Validation of Performance Measures

In CY 2022, HSAG did not identify recommendations for MCNA to improve performance on HEDIS indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to address outstanding required actions from CY 2021. HSAG found that MCNA had successfully implemented its interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards. HSAG identified two ongoing required corrective actions related to the Member Rights and Information and the Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, MCNA submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG conducted network capacity and geographic distribution analyses to evaluate MCNA's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding MCNA's provider network, HSAG recommended that MCNA conduct ongoing assessments of its provider network to identify those providers, if any, who chose not

to contract with MCNA, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

In response to HSAG's NAV recommendations, MCNA reported that it identified that the reason for not meeting the time/distance standard in San Juan County is due to a lack of pediatric dentists in that geographic area. However, MCNA currently has alternate care providers, such as general dentists, who provide specialty care to children in this area since it is within the scope of their license to do so. MCNA has also reported that it will continue searching for providers who may move to the San Juan County area and will take the opportunity to contract with them as they become available, as well as searching in neighboring states for any pediatric dentists that may be within the mileage standard if they are willing to treat Utah Medicaid membership.

In CY 2023, HSAG reevaluated MCNA provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

PAHP Providing CHIP Dental Services

Premier Access—CHIP

Validation of Performance Improvement Projects

Premier Access CHIP's *School Based Care for CHIP Members* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2022 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2022.

Validation of Performance Measures

In CY 2022, HSAG did not identify recommendations for Premier Access CHIP to improve performance on HEDIS indicators.

Compliance Monitoring

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Premier Access CHIP had not implemented interventions to address outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standard areas that were found to be not fully compliant in CY 2021. HSAG identified 21 ongoing required corrective actions related to the standards listed above that were not adequately addressed and required a continued CAP. Following the CY 2022 compliance review, Premier Access CHIP submitted a CAP and evidence of compliance to address requirements found to be not fully compliant.

In CY 2023, HSAG began a new three-year compliance review cycle that included a review of the following standard areas as detailed in Section 2 of this report:

- Enrollment and Disenrollment
- Member Rights and Confidentiality
- Emergency and Poststabilization Services
- Coverage and Authorization of Services
- Practice Guidelines
- Grievance and Appeal System

Validation of Network Adequacy

In CY 2022, HSAG did not identify opportunities for improvement or recommendations for Premier Access CHIP related to NAV.

Appendix D. Summary of PIP Interventions by Health Plan Type and PIP Topic

Table D-1 on the following page includes information about interventions each health plan implemented for PIP topics submitted for validation in CY 2023.

Table D-1—Health Plan Interventions by Health Plan Type and PIP Topic

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Medicaid ACOs Providing Physical Health Services			
Health Choice	*Well-Child Visits in the First 30 Months of Life*	1. Percentage of members with six or more well-child visits on different dates of service on or before the 15-month birthday. 2. Percentage of members with two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	• Well-child visit schedule cards to be sent out to members 0–30 months of age to educate on the well-child visit schedule and be used as a tracker for the dates of the well-child visits. • Conduct member outreach to remind parents of well-child visit gaps in care and answer questions related to well-child visits.
Healthy U	*Improving Access to Well Visits in the First 15 and 30 Months of Life*	1. The percentage of eligible members who received six or more well-child visits with a PCP by 15 months of age. 2. The percentage of eligible members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	• In partnership with DHHS and other Medicaid ACOs, Healthy U developed a "Well Child Visit Record Card" to educate parents on the importance of obtaining timely well-child visits. The physical card also serves as a reminder to parents of the child's upcoming well visits by including a space to write the child's name, the child's doctor, and the date of well visit between birth and 30 months of age. The card is available in both English and Spanish. • The card was finalized at the end of June 2023 and was sent to parents with children in the target age group in July 2023.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Molina	*Well-Child Visits in the First 30 Months of Life*	1. The percentage of members who had six or more well-child visits with a PCP during the first 15 months of life. 2. The percentage of members who had two or more well-child visits with a PCP between ages 15–30 months.	• Partner with a vendor to provide outreach, education, service attestation, and gift card fulfillment for completing well-child visits. Provide a report of members missing well-child visits to the vendor. • Collaborate with other Medicaid ACOs to disseminate well-child visit card and tracker. The card includes information on the importance of well-child visits and lists required visits/time frames with space to track visits. • Missing services lists disseminated to providers who opt-in to pay-for-quality (P4Q) program, showing which members need well-child visits. Providers are offered a bonus for closing gaps.
SelectHealth CC	*Well-Child Visits in the First 30 Months of Life for Medicaid Legacy*	1. The percentage of eligible members who received six or more well-child visits with a primary care provider by 15 months of age. 2. The percentage of eligible members who received two or more well-child visits with a primary care provider on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	• Health plan developed a well-child visits card mailing to remind members to schedule a well-child visit.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Medicaid MCOs Providing Physical Health, Mental Health, and SUD Services			
Health Choice Utah	*Follow-Up After Hospitalization for Mental Illness*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days 2. Follow-Up After Hospitalization for Mental Illness within 30 Days	• The behavioral health case manager used discharge documents with face sheets and the clinical health information exchange (cHIE) to find better contact information for the member and made three attempts to reach out and encourage follow-up care. Additionally, a member portal was developed to contact members identified as meeting the criteria for the *Follow-Up After Hospitalization for Mental Illness* measure. • The performance improvement coordinator (PIC) team works with the case management team to encourage outreach to the member or the member's inpatient case manager prior to discharge to ensure a discharge plan was in place and also to update member contact information. • Obtaining admit, discharge, and transfer alerts from the cHIE will help to identify measure-eligible discharges. A process flow was created for review and execution of outreach based on this new data.
Healthy Outcomes Medical Excellence (HOME)	*Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic*	Percentage of HOME enrollees (20 years and older) who received at least one annual physical examination during measurement year.	• The case managers and providers explain the importance of annual physical examination for timely management of concerns that may exacerbate to critical presentation of issues. The front desk staff and case managers use the non-routine encounters as an opportunity to speak with the members and schedule annual physical examination, if due for one. • HOME coder met with the providers to educate them on the importance of correct coding and billing for annual physical visits to capture services delivered.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Healthy U Integrated	*Improving Adults' Access to Preventive/Ambulatory Care Services*	The percentage of members 20 year of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	• The health plan is conducting a phone outreach campaign to educate members on the importance of identifying a PCP and making an appointment to see that provider annually. Members who do not have an attributed PCP are the target of both the letter and phone outreach. • The health plan has signed a contract with a new member engagement vendor that has the capability to conduct text messaging and IVR campaigns. The first text messaging campaign was launched in the third quarter of 2022 and served two purposes: − Gain members' consent to contact them via text messaging. − Provide additional messaging in the IVR call about the importance of having a PCP for members who do not have an attributed PCP. In addition, these members are asked if they would like to receive a follow-up email with additional resources for finding a PCP. If a member respond "yes," an email is sent to the member.
Molina Healthcare of Utah UMIC	*Follow Up After Hospitalization for Mental Illness*	The percentage of discharges for members 6 years of age 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 practitioner.	• Partner with Molina Care Connections to offer members an opportunity to meet telephonically with a licensed clinical social worker (LCSW) and complete a follow-up visit within 30 days of hospitalization.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
SelectHealth CC UMIC	*7-Day Follow-Up after Hospitalization for Mental Illness for Medicaid Integration Members*	Percentage of Medicaid Integration members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within 7 days after discharge.	• Care manager identifies admitted members and works with patient navigator to connect with the member and to verify that a seven-day follow-up appointment has been scheduled before discharge. (Discontinued) • Monthly interdisciplinary care team meetings were established to talk about individual cases and find solutions to access issues. (Discontinued) • Health plan is working to develop an option to expand the Travel Safety Net. • Developed a process so that if the BH Navigator encounters a SelectHealth BH provider refusing to schedule a seven-day follow-up appointment, they can notify SelectHealth to address the issue. • The hospital BH Navigators call the members within 24 hours of discharge to go over the appointment date and any barriers that may have arisen. The BH Navigators make three attempts to call the members. • A subgroup led by a physician is looking at expanding the BH network with new BH providers who have the availability to offer different care delivery options such as in home services, telehealth, and clinic hours. • SelectHealth care managers go onsite weekly to meet with the BH Navigators and see the members to discuss the care management process and assist with any barriers that could impact the members attending their follow-up appointments.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Medicaid PMHPs Providing Mental Health Services			
			•
Bear River	*Youth Outcome Questionnaires (YOQ) or Outcome Questionnaires (OQ)*	1a. Frequency of OQ completed by each member in a year. 1b. Frequency of YOQ completed by each member in a year. 2a. Percentage of OQ reports reviewed by clinician within three days. 2b. Percentage of YOQ reports reviewed by clinician within three days.	• Training clinicians on opening the OQ/YOQ in the electronic health record every time they meet with a member. This will be done during monthly staff meetings and on an individual basis if the clinician is not applying the training given during the staff meetings. • The process was changed to include OQ/YOQ during each individual or family therapy session.
Central	*Inpatient Readmission Rates*	The percentage of psychiatric discharges from the denominator that did not have a psychiatric readmission within 12 months.	• Implement a standardized care approach wherein all Medicaid enrollees will not only have a primary therapist assigned to the case, but also an additional and specific case manager who will make frequent/weekly outreach to individuals discharged from inpatient settings for one year following discharge. • New mobile crisis outreach team (MCOT) was developed and started. MCOT will respond to crisis situations throughout the six-county area that Central covers.
Davis	*Access to Care*	1. Percentage of initial appointments scheduled within 7 calendar days from first contact.	• Recovery Support Services (RSS) outreaches members to attempt to schedule a follow-up appointment. • The Substance Treatment Program director monitors clinical staff availability. The director follows up when a clinical staff member is unavailable within the time frames.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	• Walk-in evaluation clinic option offered to members who schedule but do not attend the initial appointments.
Four Corners	*Improving the Completion of Substance Use Recovery Evaluator (SURE) Survey*	The percentage of completed SURE surveys.	The health plan had not progressed to identifying barriers and interventions at the time of the PIP submission.
Healthy U Behavioral	*Improving Follow-Up After Hospitalization*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days 2. Follow-Up After Hospitalization for Mental Illness within 30 Days	• For members hospitalized at Huntsman Mental Health Institute (HMHI), the University of Utah Health Plan (UUHP) care management team reaches out to the HMHI discharge planner via SmartWeb or email to ensure that a follow-up appointment has been scheduled within seven days after discharge. If needed, UUHP care managers assist the discharge planner in finding available in-network providers to see members. • Upon notification of hospital admission, UUHP will provide care management support to hospitalized members to ensure timely follow-up visits after discharge. Care management support involves identifying and mitigating the specific barriers for each member that may prevent the member from attending a follow-up visit. • Conduct chart reviews no less than quarterly to assess for performance on newly developed intervention-specific evaluation metrics. Use results for process improvement and for providing feedback and education to staff.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	1. Percentage of inpatient discharges where members received a formal covered service per the HEDIS [Healthcare Effectiveness Data and Information Set] protocol or a documented "Caring Contact" (i.e., documented "outreach") 1 to 3 business days post discharge. 2. Percentage of inpatient discharges where members received a personalized Safety Plan 1–7 days post discharge with or through Northeastern Counseling. 3. Percentage of inpatient discharges where members received a Columbia Suicide Severity Risk Screening 1–7 days post inpatient discharge. 4. Percentage of inpatient discharges where members received a formal covered service or a documented "Caring Contact" (i.e., documented "outreach") 31 to 60 days post inpatient discharge.	• In-person training of all the staff members that the three-business-day follow-up requirement applies to anyone being discharged from an inpatient unit and clinicians need to complete a safety plan and CSSR-S on the first service post-discharge from the inpatient unit. Email summary of the training is sent to the staff members three times during a year. Email new providers that are not trained face-to-face within 30 days of the provider's start date. Three in-person trainings were done in CY 2022. • Train clinicians and suicide prevention specialists regarding service and/or Caring Contact expectations (i.e., within 31 to 60 days) that include the following: – Tracking in Credible and on the tracking, spreadsheet is required for 31- to 60-day follow-up and Caring Contacts. – Members who choose to follow up with providers other than Northeastern must still have Caring Contacts within the time frames of this project, including 31 to 60 days. – Members who do not show up for an appointment or who do not cancel the appointment with support staff members are to be contacted by the clinician or suicide prevention specialist within the time frames of this project and are to use the Caring Contact follow-up service in the EMR to document those actions 31 to 60 days post-inpatient discharge. Two in-person trainings were done in CY 2022. • The clinical director, suicide prevention specialist, and back-up specialist have developed a spreadsheet to track inpatient discharges as they occur with daily follow-up. A marker in the EMR has also been added for inpatient discharge members, which remains in place for 60 days post-inpatient discharge.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
			• The clinical services note used for hospital discharge follow-up has been altered to include “Was this Individual just discharged from an Inpatient Psychiatric Hospital?” Answering “yes” brings up a reminder that “You Must Complete the following for this visit: 1. Columbia Suicide Severity Risk Screening 2. Safety Plan” • Whenever possible, scheduling should include a full 60 minutes for therapist FUH services. (New intervention) • Provide authorization calendar access to the prevention worker as another resource to ensure the lists accuracy. (New intervention)
Optum/Tooele	*Increasing Youth Engagement in Treatment Service in Tooele County*	1. Percentage of eligible members 17 years or younger, who received at least one behavioral health service during the measurement period. 2. Percentage of eligible members 17 years or younger, who received at least one family peer support service during the measurement period.	• Implementation of an information campaign targeting youth directly and those who support youth to inform them of the available services and to increase youth engagement in treatment services. Information campaign includes posting English and Spanish flyers on social media sites of the selected network providers. Flyers will also be posted in several community locations such as libraries, coffee houses, arcades, skate parks, etc. (Discontinued) • Optum will partner with the Tooele County School District to implement a youth booth or provider table during two of the Tooele County School District’s annual, quarterly behavioral health screening events. The booth/provider table will include resources to help youth access support services and to engage in available services. Also, Optum will target school counselors and teachers at Tooele County School District’s back-to-school events where resources will be provided to engage youth in available services.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
			• Two certified family peer support specialists will be added to the provider network. (Discontinued) • Optum will implement and host a monthly training for all Tooele County in-network providers. The training will include FPSS recruiting, provider education about FPSS services, trainings and certifications, and resources to ensure FPSSs are rendering services as outlined in the Utah Medicaid Manual.
Salt Lake	*Follow-Up After Hospitalization for Adults Aged 18-64*	1. The percentage of eligible members aged 18–64 years who received at least one behavioral health service within seven days after discharge from inpatient hospitalization for treatment of mental illness. 2. The percentage of eligible members aged 18–64 years who received at least one behavioral health service within 30 days after discharge from inpatient hospitalization for treatment of mental illness.	• The Optum Clinical Team will monitor discharge planning by inpatient facility. Incomplete or insufficient discharge plans will be referred to the Optum Care Coordination Team which will prioritize contact with the member within 72 hours of discharge to arrange services. • Facilitate quarterly meetings with in-network inpatient facilities and review year-to-date *Follow-Up After Hospitalization for Mental Illness* data. Identify and respond to real-time barriers linking members to care. • Create and distribute a resource guide for the purpose of assisting inpatient facilities with connecting members to timely and appropriate follow-up care.
Southwest	*Increased Number of PMHP Clients Receiving Peer Support Services*	The percentage of eligible members who received at least one peer support service during the measurement period.	• Hired a peer support supervisor and created a peer support policy. Identified staff with similar experience and included them in certified peer support training. This will facilitate an increase of peer support services.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
			• Train all staff members with lived experience as a certified peer support staff and send them to multiple in-person and virtual conferences and trainings. The training is a clear intervention that is needed as the staff members are now able to provide peer support services. • Train all teams and therapists at all locations in addition to the peer support team about peer support services and how to refer clients to receive these services. This intervention will provide all the therapists with the benefits of the services, along with how to refer clients and take advantage of peer support.
Wasatch	*Increasing SURE Utilization in Substance Use Disorder*	The percentage of members diagnosed with a primary SUD who receive treatment at one of the eligible substance use treatment programs and who complete the SURE questionnaire each month.	• SUD division director and program managers will receive reports each month outlining the total number of administrations of SURE in SUD services. Progress toward the goal of improving administration of SURE will be discussed at least monthly at a meeting of Wasatch's executive team and program managers. Results from the previous month for SUD programs will be compared and discussed. Program managers for SUD services will provide information about their administration of SURE or lack thereof each month in their monthly reports to the executive director. • In-person training will be given to SUD clinicians and case managers in administering and interpreting SURE. Video training will also be given to care team assistants in SUD services.
Weber	*Treating Anxiety and Depression with EBT*	Percent of members with an anxiety or depression diagnosis who are participating in the Unified Protocol.	• Two clinical quality supervisors with be certified as supervisors/trainers in the Unified Protocol. • Twelve clinicians will be trained/certified in the Unified Protocol.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
CHIP MCOs Providing Both Physical Health and Mental Health Services			
Molina CHIP	*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*	The percentage of members 3–17 years of age who had an outpatient visit with a PCP [primary care physician] or OB/GYN [obstetrician/gynecologist] and who had evidence of BMI percentile documentation during the measurement year.	Conducted targeted outreach to six high-volume pediatric groups to disseminate monthly reports of children in need of well-child visits. Incentives were offered for gap closure. In mid-2022, the number of high-volume providers participating in the intervention increased to 17. • Disseminate a missing services list to value-based contracting (VBC) groups and conduct monthly discussions with providers for support. • Research billing code issue reasons. Collaborate with various health plan staff members to develop mitigation strategies. Educate providers regarding coding issues and resolutions.
SelectHealth CHIP	*Well-Child Visits for CHIP Members*	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecology (OB/GYN) practitioner during the remeasurement year.	For the identified population without a PCP, provide an incentive to schedule a well-child visit (WCV).
PAHPs Providing Medicaid Dental Services			
Premier Access	*School Based Care for Medicaid Members*	Percentage of Premier Access Medicaid members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	• Send text messages containing educational information and a link to an electronic consent form. • Mailed materials containing educational information and a quick response (QR) code linking to an electronic consent form. (Discontinued)

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
MCNA	*Annual Dental Visit*	1. The percentage of members ages 1–20 who had at least one dental visit during the measurement year. This measure was selected by the plan using nationally recognized CMS 416 specifications. 2. The percentage of members ages 21 and older who had at least one dental visit during the measurement year. This measure was selected by the dental plan using like criteria to the nationally recognized CMS 416 specifications for members under age 21.	• Care gap alerts: MCNA member service representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls, which indicates the member is overdue for a preventive dental visit. The MSR offers to locate a provider if the member does not already have one and performs a three-way call, if necessary, with the provider office to schedule an appointment. • Automated outbound call campaigns: Conduct outbound calls to members who have not had a dental checkup within the last six months to encourage them to schedule an appointment. • Text messages: Send text messages once a month to members who have no claims history on file. Members will continue to receive a text message until an encounter is received.
PAHP Providing CHIP Dental Services			
Premier Access CHIP	*School Based Care for CHIP Members*	Percentage of Premier Access CHIP members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	• Send text messages containing educational information and a link to an electronic consent form. • Mailed materials containing educational information and a quick response (QR) code linking to an electronic consent form.