State of Utah

Division of Medicaid and Health Financing

Bureau of Managed Health Care

Annual External Quality Review Report of Results

April 2021

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

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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 to prepare an annual technical report that describes the way data from external quality review (EQR) activities conducted in accordance with 42 Code of Federal Regulations (CFR) §438.358 were aggregated and analyzed. In May 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Medicaid managed care regulations, and in February 2018 the Children's Health Insurance Program (CHIP) was reauthorized via House Bill 195 and the Bipartisan Budget Act of 2018. This EQR technical report is presented to comply with 42 CFR §438.364 as articulated in the May 2016 regulations. The Utah Department of Health (UDOH) is the Utah State agency responsible for the administration of Utah's Medicaid program and CHIP. UDOH has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare this report. This is the sixth year HSAG has produced the EQR annual technical report of results for UDOH under the current EQRO contract.

To provide medical services in calendar year (CY) 2020, UDOH contracted with Medicaid managed care organizations (MCOs) to serve the Medicaid and CHIP populations, accountable care organizations (ACOs) to serve the Medicaid population, and prepaid mental health plans (PMHPs) that are prepaid inpatient health plans (PIHPs) to serve the Medicaid population. To provide dental services, UDOH contracted with two dental prepaid ambulatory health plans (PAHPs)—one serving the Medicaid population and one serving both the Medicaid and CHIP populations. Throughout this report, these entities may be referred to as "health plans" unless there is a need to distinguish a particular health plan type.

The Utah Managed Care Delivery System

Table 1-1—Summary of Health Plans in CY 2020 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
Twelve PMHPs; 11 PIHPs and one PAHP	1915(b) Prepaid Mental Health Plan (PMHP) waiver
Two CHIP MCOs	CHIP 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

UDOH has been operating the 1915(b) CHCD waiver program since 1982. Under this waiver, physical health care has been provided 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, UDOH expanded mandatory ACO enrollment to include nine rural counties. During CY 2020, UDOH contracted with the following ACOs:

Health Choice Utah (Health Choice)

Healthy U

Molina Healthcare of Utah (Molina)

SelectHealth Community Care (SelectHealth)

One MCO Operating Under 1915(a) Contracting Authority

In 2001, UDOH 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 who are dually diagnosed with a developmental disability and a mental illness. Enrollment into HOME is voluntary. In 2006, UDOH transformed HOME into a risk-based capitated MCO.

Four MCOs Operating Under an 1115 Demonstration Waiver

In 2020, UDOH contracted with its four ACOs to provide both physical health and behavioral health services to the Medicaid expansion population.

Health Choice Utah (Health Choice UMIC)

Healthy U (Healthy U UMIC)

Molina Healthcare of Utah (Molina UMIC)

SelectHealth Community Care (SelectHealth UMIC)

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

UDOH has been operating the 1915(b) PMHP waiver program since 1991. Under this waiver, behavioral health care has been provided through the PMHPs. Enrollment in the PMHPs is mandatory. In June 2020, the contracts with Valley Behavioral Health and the Utah County Department of Drug and Alcohol Prevention and Treatment ended. In September 2020, UDOH entered into a PMHP contract with Healthy U. This report represents EQR activities conducted with the following 12 PMHPs during CY 2020.

Bear River Mental Health (Bear River)

Central Utah Counseling Center (Central)

Davis Behavioral Health (Davis)

Four Corners Community Behavioral Health (Four Corners)

Healthy U

Northeastern Counseling Center (Northeastern)

Salt Lake County Division of Behavioral Health (Salt Lake)

Southwest Behavioral Health (Southwest)

Utah County Department of Drug and Alcohol Prevention and Treatment (Utah County)

Valley Behavioral Health (Valley)

Wasatch Behavioral Health (formerly Wasatch Mental 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 2019, UDOH contracted with the following CHIP MCOs:

Molina Healthcare of Utah (Molina)
SelectHealth

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 UDOH Quality Strategy provides a blueprint for advancing the State's commitment to improving quality health care delivered through the contracted health plans. Utah's primary system of health care delivery and payment is designed to improve the quality of care that Utah's Medicaid and CHIP members receive. The UDOH 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.

Utah's CY 2020 draft Managed Care Quality Strategy (the Strategy) addressed key elements required pursuant to 42 CFR §438.340 including, but not limited to, performance improvement projects (PIPs) to be implemented; the State's transition of care policy; the State's plan to identify, evaluate, and reduce health disparities; planned use of intermediate sanctions when appropriate; and arrangements for EQR.

While the Strategy effectively describes processes designed to improve the quality of care provided by the managed care health plans, HSAG recommends that stated goals be revised to be more clearly measurable and include performance targets and outcomes anticipated to be published on the State's website as required in accordance with §438.10(c)(3). HSAG also recommends that UDOH focus on two or three prioritized, measurable goals to achieve in each of the next three years until the Strategy is next assessed. UDOH might consider developing benchmarks for performance measures for which national averages are not available, such as customized Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] measures used for the PMHPs.

In several instances, the Strategy refers the reader to contract standards to demonstrate that the health plans are required to comply with the standards set forth. HSAG recommends expanding these sections to describe the contract standards and expectations for measurable outcomes related to these standards.

UDOH continues to develop innovative strategies for improving the quality of care and services to Utah Medicaid members. In September 2019, UDOH entered into a new contract with Healthy U to administer an additional PMHP. In January 2020, UDOH contracted with the four existing ACOs to administer a new integrated program to provide both physical and behavioral health care services to a specific population of Medicaid beneficiaries.

Purpose of the Report

This report provides the results of the four mandatory EQR activities completed in CY 2020. UDOH contracted with HSAG to conduct validation of PIPs (2012 EQR Protocol 3)[1-2]; validation of performance measures (EQR Protocol 2)[1-3]; an assessment of compliance with Medicaid managed care regulations

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-2] New CMS EQR Protocols were released October 2019 and posted to the CMS website in January 2020. PIP validation activities were already underway at this time; therefore, HSAG used *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 for conducting PIP validation activities in CY 2020.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf, Accessed on: Feb 22, 2021.

(EQR Protocol 3)[1-4] (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 regarding health care quality, timeliness, and access to care; 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.[1-5]

Timeliness

The National Committee for Quality Assurance (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."[1-6]

NCQA further states that the intent of utilization management 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.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf, Accessed on: Feb 22, 2021.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

[1-6] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

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 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).[1-7]

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

Validation of Performance Improvement Projects

For CY 2020, each health plan and PAHP submitted one PIP for validation for a total of 26 PIPs. Twenty-one of the 26 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles and use of appropriate quality improvement (QI) activities to support improvement of PIP outcomes.

Medicaid ACOs

Three of the four ACOs received an overall *Met* validation status for their PIP and achieved 100 percent of all the applicable evaluation elements on HSAG's PIP validation tool. Health Choice received an overall *Not Met* validation status with an 84 percent *Met* score on all the applicable evaluation elements.

Utah Medicaid Integrated Care (UMIC) Plans

All four UMIC plans received an overall *Met* validation status for their PIP and achieved 100 percent of all the applicable evaluation elements on HSAG's PIP validation tool.

CHIP MCOs

Both CHIP MCOs received an overall *Met* validation status for their PIP and achieved 100 percent of all the applicable evaluation elements on HSAG's PIP validation tool.

[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.

PMHPs and HOME

Ten of the 12 PMHPs and HOME received an overall *Met* validation status for their PIP. Salt Lake and Valley received an overall *Partially Met* validation status with 87 percent and 81 percent *Met* scores, respectively, on all the applicable evaluation elements.

Medicaid and CHIP Dental PAHPs

One PAHP, MCNA, received an overall *Met* validation status for its PIP. Premier's PIP received a *Not Met* validation status with a *Met* score for 84 percent of the applicable evaluation elements, and Premier CHIP received an overall *Partially Met* validation status with a *Met* score for 95 percent of the applicable evaluation elements.

Validation of Performance Measures

Medicaid ACOs

VALIDATION FINDINGS

All but one of the Medicaid ACOs' HEDIS compliance auditors determined that the health plans' information systems (IS) and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2020. The HEDIS auditor recommended that the health plan that did not meet all standards investigate the measures impacted and the underlying data to resolve the data issues causing the problem.

PERFORMANCE MEASURE RESULTS

All four ACOs exceeded the 2020 NCQA Quality Compass[1-8] average for the *Appropriate Treatment for Children With Upper Respiratory Infection, Childhood Immunization Status—Combination 3,* and *Immunizations for Adolescents—Combination 1* measures.

In addition, at least three of the four ACOs exceeded the 2020 NCQA Quality Compass Average for the *Controlling High Blood Pressure, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent BMI [body mass index]—Total,* and *Comprehensive Diabetes Care—HbA1C Testing* measures.

The following measure rates demonstrated the most need for improvement, as all four ACOs fell below the 2020 NCQA Quality Compass average: *Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening in Women—Total;* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

[1-8] Quality Compass® is a registered trademark of the NCQA.

In addition, at least three of the four ACOs fell below the 2020 NCQA Quality Compass Average for the *Well-Child Visits in the First 15 Months of Life* measure.

With performance consistently falling below the 2020 NCQA Quality Compass average for the ACOs for these measures, improvement efforts could be focused on increasing breast cancer, cervical cancer, and chlamydia screenings for women and required well-child visits for infants and young children.

CHIP MCOs

VALIDATION FINDINGS

One of the CHIP MCOs' HEDIS compliance auditors determined that the health plan's IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2020. For the remaining CHIP health plan, the HEDIS auditor recommended the health plan investigate the measures impacted by the unmet standard and the underlying data to resolve the data issues causing the problem.

PERFORMANCE MEASURE RESULTS

Both CHIP MCOs exceeded the 2020 NCQA Quality Compass average for the *Appropriate Treatment for Children With Upper Respiratory Infection, Childhood Immunization Status—Combination 3, Immunizations for Adolescents—Combination 1, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measures.

Both CHIP MCOs fell below the 2020 NCQA Quality Compass average for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. With performance falling below the 2020 NCQA Quality Compass average for both CHIP MCOs, improvement efforts could be focused on increasing required well-child visits for young children.

PMHPs and HOME

VALIDATION FINDING[1-9]

HSAG determined that 11 of the 12 PMHPs' IS and processes were compliant with IS standards and that the measures calculated by the PMHPs had a status of *Reportable* based on the reporting requirements for the 2020 performance measure validation (PMV).

One PMHP began providing services in September 2019 and did not have any data to report for the designated reporting period.

[1-9] Findings for individual health plans can be found in Section 2 of this report, "Evaluation of Utah Medicaid and CHIP Health Plans."

Table 1-2 describes the two rates that the plans reported for *Follow-Up After Hospitalization for Mental Illness (FUH)*.

Table 1-2—*FUH* Performance Measure Rates

Rate 1: Follow-Up Within 7 Days of Discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days.
Rate 2: Follow-Up Within 30 Days of Discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days.

PERFORMANCE MEASURE RESULTS

For reporting year (RY) 2020, the PMHPs and HOME calculated and reported the state-modified *FUH* measure. 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. 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.

Based on performance measure outcomes, six PMHPs exceeded the statewide PMHP average for both *FUH* indicators, and two PMHPs fell below the statewide average for both indicators. HOME and Healthy U were not included in or compared to the statewide PMHP average.

SUD PAHP

VALIDATION FINDINGS

For RY 2020, Utah County calculated and reported results for the state-modified *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure. Since Utah County used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. In addition, because Utah County was the only health plan that reported *IET* measure rates, HSAG could not compare the results. Utah County received a *DNR* rating as the PAHP's source code contained errors, its data validation and event categorization also reflected errors, and Utah County was not able to provide sufficient explanation or accurate revised rates to HSAG. Table 1-3 describes the two rates that the SUD PAHP reported for *IET*.

Table 1-3—*IET* Performance Measure Rates

Rate 1: Initiation of AOD Treatment	The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
Rate 2: Engagement of AOD Treatment	The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initial visit.

Medicaid and CHIP Dental PAHPs

VALIDATION FINDINGS

Each PAHP's HEDIS compliance auditor determined that each PAHP's IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2020.

PERFORMANCE MEASURE RESULTS

Each PAHP's performance for the Medicaid population exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit—2–3 Years of Age, 4–6 Years of Age, 7–10 Years of Age, 11–14 Years of Age, 15–18 Years of Age, 19–20 Years of Age, and Total* measure rates.

The PAHP's performance for the CHIP population exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit—2–3 Years of Age* measure rate but fell below the 2020 NCQA Quality Compass average for the *4–6 Years of Age*, *7–10 Years of Age*, *11–14 Years of Age*, *15–18 Years of Age*, *19–20 Years of Age,* and *Total* measure rates. These results indicate opportunities for improvement for Premier Access CHIP.

Compliance Monitoring

For CY 2020 compliance monitoring activities, HSAG conducted follow-up reviews on requirements that received a *Partially Met* or *Not Met* score in CY 2019 and full compliance reviews for health plans that were new in CY 2020. The new plans included the four UMIC health plans and the Healthy U PMHP that assumed PMHP services for Summit County starting in September 2020. HSAG reviewed a sample of credentialing, denial, appeal, and grievance records for all health plans.

Medicaid ACOs

The four ACOs came into compliance with most of the requirements in 2020; however, following the CY 2020 review, three of the four plans had ongoing findings in the Member Rights and Information standard. Molina had continued required corrective actions for the Grievance and Appeals standard, and Health Choice had continued required corrective actions for the Provider Participation and

Program Integrity standard. All four Medicaid ACO plans were required to complete a corrective action plan (CAP) to address the ongoing required corrective actions.

UMIC Plans

The four UMIC plans underwent a full review of all standards. While required corrective actions were identified in most standards, overall, the plans scored well in the Coordination and Continuity of Care, Subcontracts and Delegations, and Quality Assessment and Performance Improvement (QAPI) standards. All four UMIC plans were required to complete a CAP. The most common required actions related to accuracy and readability of member informational materials and compliance with Section 508 of Section 504 of the Rehabilitation Act.

MCO—HOME

For the CY 2020 compliance review, HOME had ongoing required corrective actions to address in the Member Rights and Information standard as a follow-up to the CY 2019 compliance review. In CY 2020, HSAG found full compliance with the requirements.

CHIP MCOs

The CHIP MCOs came into compliance with most of the requirements in 2020; however, following the CY 2020 review both CHIP health plans had ongoing required corrective actions in Member Rights and Information, and one health plan had continued required corrective actions in the Grievance and Appeals standard. Both CHIP health plans were required to complete a CAP to address the ongoing required corrective actions.

PMHPs

In CY 2020 HSAG conducted compliance monitoring activities for 12 PMHPs. Healthy U assumed PMHP services in Summit county as of September 2020; therefore, HSAG conducted a full review of all requirements. HSAG found full compliance with the Coordination and Continuity of Care and QAPI standards. Healthy U was required to complete a CAP for findings in all other standards.

In CY 2019 Central, Northeastern, and Salt Lake achieved full compliance; therefore, in CY 2020 HSAG only conducted a review of records for these health plans. The other PMHP health plans exhibited significant improvement from CY 2019 to 2020. Only one PMHP (Southwest) had ongoing required corrective actions in the Member Rights and Information standard that required a CAP following the CY 2020 follow-up compliance review activities.

Medicaid and CHIP Dental PAHPs

In CY 2019, MCNA achieved full compliance; therefore, HSAG only conducted a review of records for MCNA in CY 2020. Premier and Premier CHIP had ongoing required corrective actions identified in the

Member Rights and Information and Grievances and Appeals Standards following the CY 2019 review that HSAG found to be in full compliance in CY 2020. Premier CHIP had additional findings in CY 2019 in the Coverage and Authorization standard that HSAG found to be in compliance in CY 2020. Premier and Premier CHIP did not have any ongoing required corrective actions to address in CY 2020.

Validation of Network Adequacy

Overall, the Utah CY 2020 network adequacy validation (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 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. The results of the provider directory validation (PDV) analysis show wide variance in the percentage of sampled providers found in the online directory across different plans. Match percentages between the plan-submitted provider data and the online provider directory varied across health plans but were generally high except for provider county and provider specialty information.

Medicaid ACOs

Geographic network distribution analysis results indicate that the ACOs generally maintained a geographically accessible network, especially in the frontier counties. All ACOs encountered challenges in meeting the time/distance standards for the pediatric specialty providers. Except for county and specialty information, PDV for the ACOs found high match percentages between the submitted provider data and the online directories for the 66.9 percent of sampled providers found in the online directory.

UMIC Plans

The UMIC plans operated only in urban areas and met the majority of the time/distance standards for physical health providers including women's health and specialists. All UMIC plans encountered challenges in meeting the standards for behavioral health facilities and additional physical health facilities such as Mammography and Outpatient/Infusion Chemotherapy. Excluding county information, PDV for the UMIC plans found high match percentages between the submitted provider data and the online directories for the 54.9 percent of sampled providers found in the online directory.

MCO—HOME

Compared to other health plans, HOME had lower member-to-provider ratios but did not meet any time/distance standards at the statewide level for the pediatric specialty providers or behavioral health facilities. HSAG's PDV found the sampled provider in the corresponding online provider directory for 17.0 percent (62 providers) of the reviews and low match percentages for Provider Address 1, Provider ZIP Code, Provider County, and Provider Accepting New Patients fields.

CHIP MCOs

Geographic network distribution analysis results indicate that the CHIP MCOs generally maintained a geographically accessible network in urban counties while struggling to meet standards in rural and frontier counties and for behavioral health provider categories. Excluding county information, PDV for the CHIP MCOs found high match percentages between the submitted provider data and the online directories for the 65.9 percent of sampled providers found in the online directory.

PMHPs

The PMHPs operate regionally and have demonstrated a wide range in the percentage of members with access to providers. Based on the provider network reported by Wasatch, the PMHP did not meet the urban time/distance standard for any of the provider categories in any urbanicity. Conversely, Salt Lake met the time/distance standards for eight of the nine provider categories, indicating a high level of access for its members. HSAG's PDV for the PMHPs found wide variance in the percentage of sampled providers found in the online directory across the different plans.

Medicaid and CHIP Dental PAHPs

The Medicaid dental PAHPs and CHIP PAHP met the time/distance standards in all provider categories in frontier, rural, and urban areas, indicating that members have access to dental providers within the time/distance standards. Except for Provider Address 2, Provider Middle Name, and Provider County information for Premier and Premier CHIP plans, PDV for the PAHPs and CHIP PAHP found high match percentages between the submitted provider data and the online directories for the sampled providers found in the online directory.

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

Medicaid ACOs Providing Only Physical Health Services

Health Choice Utah (Health Choice)

Validation of Performance Improvement Projects

For CY 2020, Health Choice continued its PIP topic: *Breast Cancer Screening.*

Validation Results

Table 2-1 summarizes the validation findings for each stage validated for CY 2020. Overall, 84 percent of all applicable evaluation elements received a score of *Met.*

Table 2-1—CY 2020 Performance Improvement Project Validation Results for Health Choice (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Implementation	VII. Review the Data Analysis and Interpretation of Results	67% (2/3)	33% (1/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
	Implementation Total	**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	50% (1/2)	0% (0/2)	50% (1/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	**50% (1/2)**	**0% (0/2)**	**50% (1/2)**
Percentage Score of Applicable Evaluation Elements *Met*		**84% (16/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**90% (9/10)**		
Validation Status		***Not Met***		

Indicator Outcomes

For CY 2020, Health Choice submitted Remeasurement 1 data for its PIP.

For Remeasurement 1, Health Choice reported a breast cancer screening rate of 34.7 percent, a 6.1 percentage point increase over the baseline, which is not considered a statistically significant improvement ($p = 0.0643$).

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

Table 2-2—PIP—*Breast Cancer Screening*
Health Choice

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Remeasurement 1 Period 01/01/2019–12/31/2019		Sustained Improvement
Breast Cancer Screening	N: 104	28.6%	N: 157	34.7%	*Not Assessed*
	D: 363		D: 452		

*N–Numerator D–Denominator

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

Strengths

Health Choice designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Health Choice also reported the study indicator data accurately. Additionally, Health Choice's study topic addressed CMS' requirements related to outcomes—specifically, the quality, timeliness, and accessibility of care and services. Health Choice's PIP aims to increase the proportion of eligible members receiving a mammogram. According to the PIP documentation, breast cancer screenings are an important preventive measure as early detection improves survival rates, and Health Choice is currently performing below the national average on this measure; therefore, it is an important area for improvement.

Opportunities for Improvement and Recommendations

The PIP received an overall *Not Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 84 percent of overall evaluation elements across all activities completed and validated. This performance suggests a thorough application of the sound PIP design; however, there were opportunities for improvement throughout the Implementation stage, including the interpretation of study results, causal/barrier analysis process, and intervention evaluation results. The Remeasurement 1 results did not achieve statistically significant improvement over the baseline.

As the PIP progresses, HSAG recommends the following:

- Health Choice must document whether there were factors that threaten the validity of the reported remeasurement data.
- Health Choice must clearly and completely describe its QI processes and team used to identify and prioritize the documented barriers.
- Health Choice must report the impact of each intervention by completely documenting evaluation results and outcomes. The next steps for each intervention must be supported by the evaluation results.
- Health Choice must revisit its causal/barrier analysis at least annually to determine whether 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 study indicator outcomes.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the final audit report (FAR) for HEDIS 2020 based on CY 2019 data showed that Health Choice's HEDIS compliance auditor found Health Choice's IS and processes to be compliant with the applicable IS standards and reporting requirements for HEDIS 2020. 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 PMV results.

Performance Measure Outcomes

Table 2-3 shows Health Choice's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-3—Health Choice HEDIS 2020 Results

HEDIS Measure	Health Choice 2020 Rate	2020 NCQA Quality Compass Average
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)	NA	54.94%
Appropriate Treatment for Upper Respiratory Infection (URI)		
The percentage of children 3 months of age and older who with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months-17 years)	93.17%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**34.73%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**44.04%**	60.13%
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)	78.35%	70.28%
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**32.16%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	88.32%	88.22%

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

HEDIS Measure	Health Choice 2020 Rate	2020 NCQA Quality Compass Average
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)	**56.93%**	57.11%
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.	61.19%	60.75%
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)	83.80%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**65.93%**	75.22%
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.	77.50%	74.62%
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)	**56.93%**	76.92%
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. (Six or More Well-Child Visits)	**59.12%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**60.10%**	74.08%

*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.

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

Strengths

Health Choice exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement and Recommendations

Health Choice fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Health Choice exceeded the 2020 NCQA Quality Compass average for only six of the 14 applicable measure rates (42.86 percent), indicating several opportunities for improvement. Health Choice could focus its improvement efforts on preventive breast cancer, cervical cancer, chlamydia, and postpartum care screenings for women; well-child visits for infants and young children; documentation of BMI percentile for children ages 3 to 17; and appropriate management of diabetes.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Health Choice's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Health Choice's sample of credentialed providers included three advanced practice nurses, four physicians, a physical therapist, a physician assistant, and a certified social worker. HSAG reviewed a full sample of 10 prior authorization denial records. Health Choice submitted a sample of one grievance record and one prior authorization appeal record for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Health Choice submitted and through conducting a virtual, web-based review consisting of interviews with key Health Choice staff members.

Strengths

HSAG found that Health Choice demonstrated overall improvement from CY 2019 to CY 2020, specifically pertaining to requirements related to access to care and services. Concerning member information requirements, HSAG found that Health Choice improved its website to work toward achieving ongoing full compliance with accessibility guidelines pursuant to Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content. In addition, HSAG found that Health Choice had worked to incorporate additional fields into its provider directory to include information determined to be missing during CY 2018 and 2019 reviews (how to access the health plan's website, whether providers had participated in cultural competency training, and whether providers' offices have accommodations for people with physical disabilities).

HSAG found that for each provider credentialing file reviewed, Health Choice had obtained and reviewed a completed application, verified licensure and education, and checked applicants against federal exclusion databases prior to hire. HSAG found full compliance with the credentialing records.

HSAG also found that Health Choice provided denial decisions to members in writing through notices of adverse benefit determination (NABDs), which included the required information, within the required time frames. HSAG also found that Health Choice consistently used a provider with the appropriate clinical expertise to make medical necessity denial determinations. HSAG found full compliance with the prior authorization denial records.

HSAG reviewed the grievance record submitted and found that Health Choice had acknowledged the grievance in a timely manner and had resolved the grievance within the allotted 90-day time frame. HSAG also found that the resolution letter included the required information.

Opportunities for Improvement and Recommendations

HSAG found that while Health Choice had processes in place to include the required information in its provider directory, Health Choice had not yet updated many provider listings to include all required information. Health Choice stated that it continues outreach to providers who have not completed attestations. HSAG suggests that Health Choice continue its outreach to ensure that the directory includes comprehensive information for all providers.

In CY 2019, HSAG had evaluated Health Choice's searchable provider directory on Health Choice's website using the WAVE Web Accessibility Evaluation Tool (Wave.Webaim.org) accessibility tool and found 21 accessibility errors and 28 contrast errors. In CY 2020, HSAG again reviewed the online searchable provider directory and found 23 general errors and 85 contrast errors. To address this lingering issue, HSAG recommends that Health Choice's leadership develop a mechanism to ensure

that information for members maintained in the provider directory is complete and is readily accessible pursuant to 42 CFR §438.10 to properly accommodate members with visual impairments.

HSAG noted that one grievance (the full sample of reported grievances) over a five-month period is an unusually small quantity. HSAG suggests that Health Choice review its grievance collection policies and procedures to ensure it is properly tracking and documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

For the one appeal record submitted, Health Choice did not include evidence that an acknowledgement letter had been sent to the member, potentially indicating opportunities for improvement in the quality of and access to care for members.

VALIDATION OF NETWORK ADEQUACY

Table 2-4 displays the match percentage for provider information between the data submitted by Health Choice and all ACOs and the online provider directory. Table 2-5 reflects the percentage of providers who have the service listed as available on Health Choice's online directory as compared to all ACOs.

Table 2-4—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Health Choice and All ACOs

Provider Information	Health Choice			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	220	100.0%	0.0%	958	99.2%	0.8%
Provider Middle Name	220	99.5%	0.5%	958	97.7%	2.3%
Provider Last Name	220	100.0%	0.0%	958	99.8%	0.2%
Provider Address 1	220	92.7%	7.3%	958	90.5%	9.5%
Provider Address 2	220	92.7%	7.3%	958	90.3%	9.7%
Provider City	220	95.9%	4.1%	958	93.8%	6.2%
Provider State	220	100.0%	0.0%	958	99.5%	0.5%
Provider Zip Code	220	97.3%	2.7%	958	93.8%	6.2%
Provider County	220	0.0%	100.0%	958	0.7%	99.3%
Provider Specialty*	220	65.5%	34.5%	958	89.6%	10.4%
Provider Accepting New Patients	220	89.1%	10.9%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-5—Percentage of Provider Service Information Available in Online Directory for Health Choice and All ACOs

Available Services Information	Health Choice			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	220	22.3%	77.7%	958	47.5%	52.5%
Non-English Language Speaking Provider	220	100.0%	0.0%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	220	0.0%	100.0%	958	44.9%	55.1%
Provider Completed Cultural Competency Training	220	0.0%	100.0%	958	37.3%	62.7%
Provider URL	220	0.0%	100.0%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-6 displays the number and percent of provider categories wherein Health Choice met the time/distance standards at the statewide level.

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

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%
Prenatal Care (PNC)/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	15	88.2%
Specialists—Pediatric	17	2	11.8%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	0	0.0%

*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).

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

Strengths

Health Choice's PDV indicated that 62.9 percent of the sampled providers were found in the health plan's online provider directory. Of the providers found, Health Choice had higher match percentages compared to all ACOs except for provider county and specialty. Further, Health Choice was the only ACO which had an option for members to be able to request a paper form of the provider directory.

Geographic network distribution analysis indicated that Health Choice met time/distance standards for 94.8 percent of all provider domains in frontier counties and 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Additional Physical Health—Providers, Hospitals, Ancillary Facilities, and Behavioral Health—Adult provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Health Choice's online provider directory is critical for members to have timely access to appropriate health care providers. Health Choice had a substantially lower match rate for Provider Specialty (65.5 percent) compared to the other ACOs (range: 94.7 percent–99.6 percent). HSAG recommends that Health Choice frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Health Choice have an option for members to report errors using an email address or toll-free number conspicuously displayed on the website. Health Choice should assess including information about the provider uniform resource locator (URL) and additional provider services such as cultural competency training status and physical disability accommodation. Health Choice noted in its response to HSAG's CY 2019 compliance reviews that it will be including cultural competency and Americans with Disabilities Act (ADA) compliance beginning January 2021.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Health Choice should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Health Choice met the time/distance standards for 37 of the 58 (63.8 percent) provider categories. The provider categories that did not meet the standards are listed in the table below. Additionally, Health Choice did not report any Mammography or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Health Choice should continue to assess areas of inadequacy to identify providers who chose not to contract with Health Choice and the inability to identify the providers in the data using the standard definitions.

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

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Behavioral Health—Pediatric	Behavioral Health—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
Specialists—Adult	Endocrinology; Infectious Disease
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

*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).

Healthy U

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, submitted a new clinical PIP topic: *Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds.*

Validation Results

Table 2-8 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-8—CY 2020 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (15/15)**	**0% (0/15)**	**0% (0/15)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (24/24)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Healthy U reported baseline data for its PIP. The baseline rate for the percentage of members 3 to 6 years of age receiving a well-child visit during the measurement year was 63.7 percent.

Table 2-9 displays data for Healthy U's *Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds* PIP.

Table 2-9—PIP—*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*
Healthy U

Study Indicator Results			
Study Indicator	**Baseline (01/01/2018–12/31/2018)**		**Sustained Improvement**
The percentage of children 3–6 years of age who received one or more well-child visits with a primary care provider during the measurement year.	N: 247	63.7%	*Not Assessed*
	D: 388		

N–Numerator D–Denominator

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

Strengths

Healthy U designed a scientifically sound PIP. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process. Healthy U reported and analyzed its baseline data accurately. Healthy U also conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and have the potential to impact study indicator outcomes, and documented appropriate processes to evaluate the effectiveness of the interventions. Additionally, Healthy U's study topic addressed CMS' requirements related to outcomes—specifically, the quality of care and timeliness of services. Healthy U's PIP aims to increase the percentage of members ages 3 to 6 years old receiving annual well-child visits with a primary care provider (PCP).

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Healthy U must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Healthy U must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Healthy U must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Healthy U's HEDIS compliance auditor found Healthy U's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Healthy U contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Healthy U's FAR revealed that Healthy U's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results.

Performance Measure Outcomes

Table 2-10 shows Healthy U's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-10—Healthy U HEDIS 2020 Results

HEDIS Measure	Healthy U 2020 Rate	2020 NCQA Quality Compass Average
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)	**50.73%**	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.12%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**49.39%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**48.18%**	60.13%
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)	75.43%	70.28%
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**48.28%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	88.56%	88.22%
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)	58.64%	57.11%
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.	80.98%	60.75%

HEDIS Measure	Healthy U 2020 Rate	2020 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 by their 13th birthday. (Combination 1)	90.51%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	76.89%	75.22%
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.	**71.76%**	74.62%
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)	84.67%	76.92%
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. (Six or More Well-Child Visits)	**56.69%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**67.97%**	74.08%

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

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

Strengths

Healthy U exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Opportunities for Improvement and Recommendations

Healthy U fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Antidepressant Medication Management*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Healthy U exceeded the 2020 NCQA Quality Compass average for only eight of the 15 applicable measure rates (53.33 percent), indicating several opportunities for improvement. Healthy U could focus its improvement efforts on medication management; breast cancer, cervical cancer, and chlamydia preventive screenings for women; decreasing unnecessary back imaging; and increasing well-child visits for infants and young children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Healthy U's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Healthy U's sample of credentialed providers included a psychiatrist, a board-certified behavioral analyst (BCBA), a social worker, an advanced practice nurse, a physical therapist, a physician assistant, a family practice physician, an internal medicine physician, and a family practice nurse. HSAG reviewed a full sample of 10 prior authorization denial records and full samples of 10 for both the grievances and appeals record reviews for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Healthy U submitted and through conducting a virtual, web-based review consisting of interviews with key Healthy U staff members.

Strengths

Overall, HSAG found that Healthy U demonstrated improvement from CY 2019 to CY 2020. As it pertained to access to care, Healthy U had developed the comprehensive Assessment and Attestation Tool for ADA Compliance and had distributed the tool to its providers to collect information regarding

its network facilities' physical access, accommodations, and accessible equipment available for members with physical and mental disabilities. Healthy U updated its provider directory with the information it had obtained.

In CY 2020, Healthy U had expanded and enhanced cultural diversity training and activities to more broadly address diverse cultural characteristics, behaviors, and beliefs of its members; promote sensitivity and understanding of diverse cultures in delivery of services; and foster cultural competency among its providers, potentially positively impacting the quality of and access to care. Healthy U also tracked provider participation in trainings through provider attestation.

Pertaining to member information, Healthy U positively impacted access to care by:

- Improving the machine-readability of its member handbook and provider directory to assist members with visual impairments.
- Including taglines in large, 18-point font size and prevalent non-English languages describing how to request auxiliary aids and services.
- Including in taglines on written materials which are critical to obtaining services (i.e., provider directories, member handbooks, appeal and grievance notices, and denial and termination notices), how to access written translation, oral interpretation, the toll-free and teletypewriter/telecommunication device (TTY/TDD) phone numbers, the customer service phone number, and availability of materials in alternative formats.
- Including information on Healthy U's website notifying members that the information on the website is available in paper form without charge, upon request, and that the information would be provided within five business days.
- Adding required information to its provider directories, which included network pharmacies, the provider's website URL, whether the provider completed cultural competency training, and whether the provider's office has accommodations for people with physical disabilities.

During the period under review, Healthy U used two credentials verification organizations (CVOs). In each provider's credentialing file reviewed, Healthy U included primary source verification (PSV) reports provided by the CVOs and the provider's Council for Affordable Quality Healthcare, Inc. (CAQH) application. Healthy U processed the application and reviewed licensure, education, and federal exclusion database search results prior to hire. HSAG found full compliance with the credentialing files reviewed.

HSAG found that NABD letters to members and providers met timeliness requirements in all records reviewed. For grievances and appeals, HSAG also found that Healthy U sent all acknowledgement letters in a timely manner. In addition, HSAG found that grievance and appeal acknowledgement and resolution letters were simple, easy to understand, and included all required information.

While some grievance resolution letters contained minimal information about the grievance, Healthy U included information about its telephone calls with the member to provide evidence that additional

dialog took place and the discussion leading up to the resolution involved the member's input. HSAG found that all grievance resolution letters in the sample were sent in a timely manner.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had found that Healthy U did not have a process to verify that members received services which were represented as delivered to them. Following the review, Healthy U developed a process; however, by CY 2020, Healthy U reported that it had yet to implement the process. HSAG suggests that Healthy U promptly implement its survey as an additional layer to detect fraudulent billing practices.

HSAG found that the grievance resolution letter template included language stating that if the member was unsatisfied with the grievance resolution, he or she may contact Healthy U for a "second review." Healthy U staff members said that this second review was akin to an appeal following an NABD. While a member may reach out to Healthy U for more information about a grievance resolution, a formal process is not articulated in 42 CFR Part 438 for a member to appeal a grievance resolution. According to federal regulations, the grievance resolution is final. HSAG suggests that Healthy U remove this language from its grievance template.

HSAG found that NABD letters to the member often included language that was complex or included medical jargon. HSAG suggests that Healthy U strategize how to ensure that complex language and medical jargon are translated to easy-to-understand language before the letters are sent to the members.

In the sample of appeals, HSAG found that Healthy U sent one appeal resolution letter 35 days following the member's appeal request, which fell outside the 30-day appeal response required time frame, potentially indicating a negative impact in the timeliness domain.

VALIDATION OF NETWORK ADEQUACY

Table 2-11 displays the match percentage for provider information between the data submitted by Healthy U and all ACOs and the online provider directory. Table 2-12 reflects the percentage of providers who have the service listed as available on Healthy U's online directory as compared to all ACOs.

Table 2-11—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Healthy U and All ACOs

Provider Information	Healthy U			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	271	100.0%	0.0%	958	99.2%	0.8%
Provider Middle Name	271	100.0%	0.0%	958	97.7%	2.3%

Provider Information	Healthy U			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider Last Name	271	99.6%	0.4%	958	99.8%	0.2%
Provider Address 1	271	94.8%	5.2%	958	90.5%	9.5%
Provider Address 2	271	94.1%	5.9%	958	90.3%	9.7%
Provider City	271	95.6%	4.4%	958	93.8%	6.2%
Provider State	271	98.9%	1.1%	958	99.5%	0.5%
Provider Zip Code	271	95.6%	4.4%	958	93.8%	6.2%
Provider County	271	1.5%	98.5%	958	0.7%	99.3%
Provider Specialty*	271	95.2%	4.8%	958	89.6%	10.4%
Provider Accepting New Patients	271	93.7%	6.3%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-12—Percentage of Provider Service Information Available in Online Directory for Healthy U and All ACOs

Available Services Information	Healthy U			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	271	4.4%	95.6%	958	47.5%	52.5%
Non-English Language Speaking Provider	271	98.9%	1.1%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	271	35.1%	64.9%	958	44.9%	55.1%
Provider Completed Cultural Competency Training	271	66.8%	33.2%	958	37.3%	62.7%
Provider URL	271	44.3%	55.7%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-13 displays the number and percent of provider categories wherein Healthy U met the time/distance standards at the statewide level.

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

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Specialists—Pediatric	17	4	23.5%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	5	83.3%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	0	0.0%

*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).

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

Strengths

Healthy U's PDV indicated that 74.5 percent of the sampled providers were found in the health plan's online provider directory. Apart from county information, Healthy U's match rates exceeded 90 percent between submitted data and the online directory for all provider fields.

Geographic network distribution analysis indicated that Healthy U met the most time/distance standards statewide among the ACOs and met 91.4 percent of all provider categories in frontier counties. The health plan met 100 percent of the standards statewide for seven of the 11 provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Healthy U's online provider directory is critical for members to have timely access to appropriate health care providers. Compared to other ACOs, only 4.4 percent of Healthy U's providers had information on any practice limitations in the online provider directory. Healthy U needs to assess if this truly reflects the number of providers with practice limitations or a data issue. In CY 2019, as a result of its compliance reviews, HSAG recommended that Healthy U update its provider directory to include cultural competency training and physical disability accommodation information. The CY 2020 PDV found that while the percentage of providers with

cultural competency training information for Healthy U (66.8 percent) is higher than all ACOs, further improvements can be made for including both cultural competency training and ADA compliance. HSAG recommends that Healthy U frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Healthy U have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Healthy U should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Healthy U met the time/distance standards for 42 of the 58 (72.4 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-14. Additionally, Healthy U did not report any pediatric specialty providers for Allergy & Immunology, Ophthalmology, or Orthopedic Surgery categories in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Healthy U should continue to assess areas of inadequacy to identify providers who chose not to contract with Healthy U and the inability to identify the providers in the data using the standard definitions.

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

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy
Ancillary—Facilities	Pharmacy
Behavioral Health—Pediatric	Behavioral Health—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; 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).

Molina Healthcare of Utah (Molina)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Molina submitted a new clinical PIP topic: *Medicaid Comprehensive Diabetic Care—Eye Exams.*

Validation Results

Table 2-15 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-15—CY 2020 Performance Improvement Project Validation Results for Molina (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI. Review the Data Collection Procedures	100% (4/4)	0% (0/4)	0% (0/4)
	Design Total	**100% (16/16)**	**0% (0/16)**	**0% (0/16)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (25/25)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Molina reported baseline data.

For the baseline measurement period, Molina reported that 52.3 percent of diabetic members 18 to 75 years of age had either a retinal or dilated eye exam, a negative retinal or dilated exam in the prior measurement year, or a bilateral eye enucleation.

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

Table 2-16—PIP—*Medicaid Comprehensive Diabetic Care—Eye Exams*
Molina

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2018–12/31/2018)**		**Sustained Improvement**
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received a retinal eye exam.	N: 215	52.3%	*Not Assessed*
	D: 411		

N–Numerator D–Denominator

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

Strengths

Molina designed a scientifically sound PIP. The technical design of the PIP was sufficient to measure outcomes and allowed for the successful progression to the next stage of the PIP process. Molina reported and analyzed its baseline data accurately. Molina conducted appropriate QI processes to identify barriers. The implemented interventions were logically linked to the barriers and appear to have the potential to impact study indicator outcomes. Additionally, Molina's study topic addressed CMS' requirements related to outcomes—specifically, the quality, and timeliness of care and services. Molina's PIP aims to improve the eye exam screening rates for its diabetic population ages 18 to 75. For patients with diabetes, regular follow-up with early detection and treatment of vision-threatening retinopathy enables the prevention of visual loss due to diabetic retinopathy.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Molina must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Molina must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with all applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. 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 results.

Molina contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

Performance Measure Outcomes

Table 2-17 shows Molina's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-17—Molina HEDIS 2020 Results

HEDIS Measure	Molina 2020 Rate	2020 NCQA Quality Compass Average
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)	NA	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	93.26%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**40.00%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**54.99%**	60.13%
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)	72.02%	70.28%
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**41.14%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	**88.08%**	88.22%
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)	**52.07%**	57.11%
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.	**60.58%**	60.75%

HEDIS Measure	Molina 2020 Rate	2020 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 by their 13th birthday. (Combination 1)	84.43%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**74.70%**	75.22%
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.	**73.21%**	74.62%
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)	79.32%	76.92%
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. (Six or More Well-Child Visits)	68.86%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**66.18%**	74.08%

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

Strengths

Molina exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement and Recommendations

Molina fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Molina exceeded the 2020 NCQA Quality Compass average for only five of the 14 applicable measure rates (35.71 percent), indicating several opportunities for improvement. Molina could focus its improvement efforts on breast cancer, cervical cancer, chlamydia, and postpartum care preventive screenings for women; controlling high blood pressure; appropriate diabetes care; well-child visits for young children; and decreasing unnecessary back imaging.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Molina's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Molina's sample of credentialed providers included a physician assistant, a nurse practitioner, a licensed professional counselor, licensed social workers, an orthopedist, an audiologist, a behavioral analyst, an orthopedist, and an obstetrician. HSAG reviewed a full sample of 10 prior authorization denial records and a full sample of 10 grievance records. Molina submitted a sample of nine appeal records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Molina submitted and through conducting a virtual, web-based review consisting of interviews with key Molina staff members.

Strengths

For the CY 2020 compliance follow-up review, HSAG found that overall Molina demonstrated improvement from CY 2019 to CY 2020, specifically pertaining to access to care. Concerning member information, HSAG found that Molina began using an accessibility product, User1st's uRemediate, which has a website application to invert the colors on a page or change to grayscale to help with color contrast. This product also offers an option to better support the viewer's screen reader.

HSAG found that for each provider credentialing file, Molina included all required documentation to demonstrate that it obtained a credentialing application, verified licensure and education, and searched federal exclusion databases prior to appointment. HSAG found full compliance with the credentialing record review.

HSAG reviewed NABD letters and found that Molina had sent all acknowledgement and resolution letters submitted to the members in a timely manner. Molina also demonstrated appropriate procedures for extensions and expedition requests.

Opportunities for Improvement and Recommendations

HSAG found that the prior authorization denial records did not meet the requirements of §438.10 related to format and readability, potentially indicating opportunities for improvement related to the access to and quality and timeliness of care. For example, the Guidelines for Appealing a Medical Denial was written using a font size smaller than the required 12-point font and included the following incorrect information:

- Language requiring members to follow an oral request for an appeal with a written request within five days.
- Language stating that Molina would process expedited appeals within three business days, instead of the required 72 hours.
- Outdated language regarding the continuation of services during an appeal or State fair hearing.

HSAG noted that Molina referred to all denial letters as "notices of action," which is an obsolete term for CMS. NABD is the current term CMS uses for adverse benefit determinations related to 42 CFR §438.404.

HSAG also found that the NABD letters and appeal resolution letters were often confusing, unclear, or written in language that was above a sixth-grade reading level. HSAG suggests that Molina's leadership team review the appeal procedures to ensure compliance with all requirements and incorporate a monitoring system to initiate supervisor review of letters for content and ease of understanding prior to mailing.

HSAG found that internal documentation of some grievances lacked important details. HSAG suggests that Molina work toward more complete documentation in its system notes. HSAG also noted that

grievance topics indicated that lagging eligibility updates in the pharmacy system occurred frequently and suggests that Molina consider investigating this pattern.

In CY 2018, HSAG had reviewed Molina's provider directory content and found that Molina did not include the following information in the provider directory located on its website: website URLs for providers; information concerning whether the provider completed cultural competency training; or whether the provider's office had accommodations for people with physical disabilities, including offices, exam rooms, and equipment. HSAG's review of Molina's provider directory again in CY 2019 revealed the same findings. In CY 2020, HSAG found that Molina's online provider directory did not include website URLs for providers or information concerning whether the provider completed cultural competency training, potentially negatively impacting the quality of and access to care. HSAG suggests that Molina develop a strategy to ensure its provider directory includes all required information.

In CY 2018, HSAG found that Molina's appeal process included provisions that the member must complete a written appeal request within five days of the oral request or the member would lose the right to appeal. In CY 2019, HSAG found that Molina had revised its policy to remove the statement that members may "lose their right to appeal" but did not remove the artificial time frame of five days. Molina's documents stated, "The written, signed Appeal must be received within five working days from the date of the oral Appeal. If the Aggrieved Person does not follow up with a written, signed Appeal, the Contractor has no further obligation to take action on the Aggrieved Persons Appeal." The Preamble to the Medicaid managed care regulations clarifies this topic wherein CMS states that a time limit cannot be imposed on the member's written response to an oral appeal request.

HSAG recommended that Molina's policy stress that Molina will work with the member to provide any assistance needed in filing a written appeal following an oral appeal, to comply with 42 CFR §438.406(a). HSAG also suggests that Molina review 42 CFR §438 Subpart F and revise sections of the Appeals policy, such as Section I. Right to Appeal a Grievance. There seemed to be some confusion regarding the definitions of a "NABD," "notice of action," "grievance," and "appeal." HSAG suggested that Molina remove the outdated term "notice of action" and ensure that the definition for "NABD" is aligned with the federal definition. A table in Molina's Appeal procedure indicated that a member has 30 days to file a request for a State fair hearing rather than the time frame of 120 days (from the appeals resolution). Within its policies, Molina stated that there is an option, sometimes, for a member to appeal a grievance, which is not accurate. HSAG suggested that senior leadership who oversee appeals and grievances thoroughly review policies and procedures to ensure consistency with the federal regulations.

VALIDATION OF NETWORK ADEQUACY

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

Table 2-18 displays the match percentage for provider information between the data submitted by Molina and all ACOs and the online provider directory. Table 2-19 reflects the percentage of providers who have the service listed as available on Molina's online directory as compared to all ACOs.

Table 2-18—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Molina and All ACOs

Provider Information	Molina			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	277	97.5%	2.5%	958	99.2%	0.8%
Provider Middle Name	277	98.6%	1.4%	958	97.7%	2.3%
Provider Last Name	277	100.0%	0.0%	958	99.8%	0.2%
Provider Address 1	277	94.9%	5.1%	958	90.5%	9.5%
Provider Address 2	277	91.0%	9.0%	958	90.3%	9.7%
Provider City	277	97.5%	2.5%	958	93.8%	6.2%
Provider State	277	100.0%	0.0%	958	99.5%	0.5%
Provider Zip Code	277	96.4%	3.6%	958	93.8%	6.2%
Provider County	277	1.1%	98.9%	958	0.7%	99.3%
Provider Specialty*	277	99.6%	0.4%	958	89.6%	10.4%
Provider Accepting New Patients	277	86.6%	13.4%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-19—Percentage of Provider Service Information Available in Online Directory for Molina and All ACOs

Available Services Information	Molina			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	277	93.5%	6.5%	958	47.5%	52.5%
Non-English Language Speaking Provider	277	98.2%	1.8%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	277	59.2%	40.8%	958	44.9%	55.1%

Available Services Information	Molina			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Provider Completed Cultural Competency Training	277	0.4%	99.6%	958	37.3%	62.7%
Provider URL	277	1.8%	98.2%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-20 displays the number and percent of provider categories wherein Molina met the time/distance standards at the statewide level.

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

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	16	94.1%
Specialists—Pediatric	17	3	17.6%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	1	100.0%

*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).

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

Strengths

Molina's PDV indicated that 76.1 percent of the sampled providers were found in the health plan's online provider directory. Molina had more than a 90 percent match between submitted data and the online directory information for all provider fields except Provider County and Provider Accepting New Patients. Additionally, the information on the Molina website noted that the most recent update to the website and paper directory was October 25, 2020, when HSAG reviewed the websites on October 26, 2020.

Geographic network distribution analysis indicated that Molina met most of the time/distance standards in rural counties (74.1 percent) and 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Hospitals, Behavioral Health—Adult, and Behavioral Health—Pediatric provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Molina's online provider directory is critical for members to have timely access to appropriate health care providers. HSAG recommends that Molina frequently update its online provider directory with the required, accurate provider information and have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website. HSAG also recommends that Molina include provider information on cultural competency training and provider URLs since less than 2 percent of sampled providers included information on these services.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Molina should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Molina met the time/distance standards for 38 of the 58 (65.5 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-21. Additionally, Molina did not report any pediatric specialty providers for Dermatology or Ophthalmology and did not include any Mammography facilities or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Molina should continue to assess areas of inadequacy to identify providers who chose not to contract with Molina and the inability to identify the providers in the data using the standard definitions.

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

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
Ancillary—Facilities	Pharmacy
PCP—Pediatric	PCP—Midlevel—Pediatric
Specialists—Adult	Infectious Disease
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Otolaryngology, 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).

SelectHealth Community Care (SelectHealth)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, SelectHealth continued its PIP topic: *Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday .*

Validation Results

Table 2-22 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-22—CY 2020 Performance Improvement Project Validation Results for SelectHealth (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

SelectHealth progressed to reporting Remeasurement 3 data in CY 2020. For Remeasurement 3, the percentage of 13-year-old female Medicaid members who had two doses of HPV vaccine prior to their 13th birthday was 33.3 percent. This rate is 1.7 percentage points lower than the Remeasurement 2 rate; however, SelectHealth maintained a statistically significant increase ($p = 0.0014$) of 6.6 percentage points over the baseline rate.

SelectHealth was able to sustain statistically significant improvement over the baseline rate for two remeasurement periods. It should be noted that there was a change in the HEDIS 2018 *Immunizations for Adolescents (IMA)* measure numerator specifications (i.e., a two-dose HPV vaccination series was added instead of a three-dose series). This change may impact the comparability of Remeasurement 2 and Remeasurement 3 data to the baseline rate.

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

Table 2-23—PIP—*HPV Vaccine Prior to 13th Birthday for Female Medicaid Members*
SelectHealth

Study Indicator	Baseline Period 01/01/2015–12/31/2015		Remeasurement 1 01/01/2016–12/31/2016		Remeasurement 2 01/01/2017–12/31/2017		Remeasurement 3 01/01/2018–12/31/2018		Sustained Improvement
The percentage of 13-year-old female Medicaid members who had 2 doses of human papillomavirus (HPV) vaccine prior to their 13th birthday	N: 257	26.7%	N: 308	26.6%	N: 371	35.0%*	N: 353	33.3%*	*Achieved*
	D: 961		D: 1,157		D: 1,060		D: 1,060		

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

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

Strengths

SelectHealth designed a scientifically sound project and reported and analyzed its Remeasurement 3 data accurately. SelectHealth conducted appropriate QI processes to identify and prioritize barriers; implemented interventions that were logically linked to the barriers; and was successful in achieving a statistically significant, sustained improvement in the study indicator rate over the baseline. Additionally, SelectHealth's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. SelectHealth's PIP aims to improve HPV vaccination rates in its female adolescent Medicaid population. By increasing the percentage of 13-year-old female Medicaid members who had two doses of HPV vaccine prior to their 13th birthday, the health plan increases the likelihood of desired health outcomes of its members through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

HSAG recommends the following:

- Since SelectHealth has demonstrated sustained improvement in this PIP, the health plan should consult with UDOH on next steps.
- Considering the changes to the HEDIS specifications, if SelectHealth decides to continue with the current PIP topic, it should redetermine the baseline measurement period to allow for comparability of remeasurement data to the baseline.

- SelectHealth must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that SelectHealth's HEDIS compliance auditor found SelectHealth's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. SelectHealth contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of SelectHealth's FAR revealed that SelectHealth's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results.

Performance Measure Outcomes

Table 2-24 shows SelectHealth's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-24—SelectHealth HEDIS 2020 Results

HEDIS Measure	SelectHealth 2020 Rate	2020 NCQA Quality Compass Average
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)	**50.88%**	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.84%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**50.02%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**57.66%**	60.13%
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	73.41%	70.28%

HEDIS Measure	SelectHealth 2020 Rate	2020 NCQA Quality Compass Average
chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)		
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**38.01%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	91.67%	88.22%
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)	65.36%	57.11%
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.	76.12%	60.75%
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 by their 13th birthday. (Combination 1)	86.93%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	79.56%	75.22%
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.	74.76%	74.62%
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)	90.46%	76.92%
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. (Six or More Well-Child Visits)	**65.36%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**67.00%**	74.08%

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

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

Strengths

SelectHealth exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Opportunities for Improvement and Recommendations

SelectHealth fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Antidepressant Medication Management*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

SelectHealth exceeded the 2020 NCQA Quality Compass average for only nine of the 15 applicable measure rates (60.00 percent), indicating several opportunities for improvement. SelectHealth could focus its improvement efforts on medication management; breast cancer, cervical cancer, and chlamydia preventive screenings for women; and well-child visits for infants and young children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed SelectHealth's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access

requirements. SelectHealth's sample of credentialed providers included physician assistants, a licensed professional counselor, licensed social workers, a physical therapist, a psychologist, an orthopedist, and a nurse practitioner. HSAG reviewed a full sample of 10 records for both the grievance and appeals record reviews. SelectHealth submitted a sample of four service authorization denial records for review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records SelectHealth submitted and through conducting a virtual, web-based review consisting of interviews with key SelectHealth staff members.

Strengths

Overall, HSAG found that SelectHealth demonstrated improvement from CY 2019 to CY 2020, specifically pertaining to access to care. Concerning member information, HSAG found that SelectHealth's searchable online provider directory included all required information. HSAG noted that the searchable online directory contained information about whether providers had participated in cultural competency training and whether providers' offices had accommodations for members with physical disabilities.

Based on a review of provider agreements in CY 2018 and CY 2019, HSAG had found that provider agreements lacked provisions that the provider agrees to make available for audit, evaluation, or inspection—by the State, CMS, the U.S. Department of Health and Human Services (HHS) inspector general, and the comptroller general (or designees)—its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to Medicaid members and pertaining to any aspect of services and activities performed or amounts payable under the Contractor's contract with the State. For the CY 2020 review, SelectHealth submitted evidence that its provider agreements included associated regulatory language as defined in 42 CFR §438.230(c).

HSAG found that for each credentialing file reviewed, SelectHealth obtained an application, verified licensure and education, and conducted searches of federal exclusion databases prior to appointment. HSAG found that in all prior authorization denial records SelectHealth demonstrated timely determinations. In one of the files HSAG reviewed, SelectHealth demonstrated appropriate and timely use of an extension.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had found that SelectHealth's provider directories (print and electronic) did not include the provider's website URL and did not indicate whether the provider had completed cultural competency training or if the office had accommodations for members with physical disabilities. In CY 2020 HSAG found that the searchable directory continued to lack provider URLs and the portable document format (PDF) directory lacked cultural competency information about providers as well as URLs. HSAG suggested that SelectHealth develop a procedure to resolve this long-standing issue.

During review of the service authorization denial records, HSAG found that SelectHealth sent the same extension letter to both the member and the provider, which requested additional information and did not clarify medical terminology in the member letter. In addition, the member was not informed of the right to grieve the extension. HSAG suggests that SelectHealth establish a process to review letters that are sent to members to ensure clarity and appropriate readability grade level.

HSAG reviewed the appeal records and found that two acknowledgement letters were not sent in a timely manner and that two resolution letters were not written at an easy-to-understand grade level (i.e., a sixth-grade level to the extent possible). In addition, HSAG found that one appeal was not assigned to a reviewer in a timely manner and therefore did not meet timely resolution requirements. HSAG suggested that SelectHealth examine its appeal response procedures to improve the timeliness and quality experience for its members.

During the grievances record review, HSAG also found that SelectHealth did not send three grievance acknowledgement letters to members in a timely manner. HSAG reviewed notes in the system and letters to the member and found that members who called in a grievance were offered an opportunity to file a "formal" grievance. If they chose not to, then SelectHealth did not perform a follow-up or investigation and closed the case. Federal regulations state that the Medicaid managed care plan must accept grievances orally or in writing, according to 42 CFR §438.402(c)(3)(i). SelectHealth must accept a grievance regardless of how the member submits it and may not put an additional burden on the member to follow up in writing. SelectHealth must consider the initial verbal expression of dissatisfaction the grievance. HSAG noted that SelectHealth may have confused the process for filing a grievance orally with the process for filing an appeal orally. HSAG noted that it was likely that SelectHealth missed many grievances and consequently did not investigate their associated quality of service issues during the period under review. Within the files reviewed, HSAG found evidence of further confusion between grievances and appeals, as some members were offered the opportunity to file an appeal following the review of a quality of service issue. In addition, HSAG removed one appeal file from the grievance record review that SelectHealth had misidentified as a grievance. HSAG strongly recommends that SelectHealth's management team review 42 CFR §438 Subpart F–Grievance and Appeal System and retrain staff on grievance and appeal identification and processing.

VALIDATION OF NETWORK ADEQUACY

Table 2-25 displays the match percentage for provider information between the data submitted by SelectHealth and all ACOs and the online provider directory. Table 2-26 reflects the percentage of providers who have the service listed as available on SelectHealth's online directory as compared to all ACOs.

Table 2-25—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for SelectHealth and All ACOs

Provider Information	SelectHealth			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	190	99.5%	0.5%	958	99.2%	0.8%
Provider Middle Name	190	91.1%	8.9%	958	97.7%	2.3%
Provider Last Name	190	99.5%	0.5%	958	99.8%	0.2%
Provider Address 1	190	75.3%	24.7%	958	90.5%	9.5%
Provider Address 2	190	81.1%	18.9%	958	90.3%	9.7%
Provider City	190	83.7%	16.3%	958	93.8%	6.2%
Provider State	190	98.9%	1.1%	958	99.5%	0.5%
Provider Zip Code	190	83.7%	16.3%	958	93.8%	6.2%
Provider County	190	0.0%	100.0%	958	0.7%	99.3%
Provider Specialty*	190	94.7%	5.3%	958	89.6%	10.4%
Provider Accepting New Patients	190	8.4%	91.6%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-26—Percentage of Provider Service Information Available in Online Directory for SelectHealth and All ACOs

Available Services Information	SelectHealth			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	190	71.1%	28.9%	958	47.5%	52.5%
Non-English Language Speaking Provider	190	92.1%	7.9%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	190	90.0%	10.0%	958	44.9%	55.1%
Provider Completed Cultural Competency Training	190	92.1%	7.9%	958	37.3%	62.7%
Provider URL	190	34.7%	65.3%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-27 displays the number and percent of provider categories wherein SelectHealth met the time/distance standards at the statewide level.

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

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Specialists—Pediatric	17	3	17.6%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	3	50.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	1	100.0%

*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).

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

Strengths

While SelectHealth's PDV indicated that only 53.7 percent of the sampled providers were found in the health plan's online provider directory, the provider specialty information matched the submitted data for the majority of providers found online. Additionally, over 90 percent of the sampled providers found in the online directory included service information on cultural competency, physical disability accommodation, and whether the provider speaks non-English languages.

Geographic network distribution analysis indicated that SelectHealth met 96.6 percent of the time/distance standards in the frontier counties and 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Hospitals, Ancillary Facilities, Behavioral Health—Adult, and Behavioral Health—Pediatric provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in SelectHealth's online provider directory is critical for members to have timely access to appropriate health care providers. 41.2 percent of the sampled providers were

not found in the SelectHealth's online provider directory. Additionally, 5.1 percent of the provider locations were not found in the directory. Even among providers found online, SelectHealth had a lower match rate for Provider Address 1 (75.3 percent) and providers accepting new patients (8.4 percent) compared to the other ACOs. HSAG recommends that SelectHealth frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that SelectHealth have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. SelectHealth should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, SelectHealth met the time/distance standards for 39 of the 58 (67.2 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-28. While failure to meet some of the standards might result from lack of providers, SelectHealth should continue to assess areas of inadequacy to identify providers who chose not to contract with SelectHealth and the inability to identify the providers in the data using the standard definitions.

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

Provider Domain	Provider Category
Additional Physical Health—Facilities	Laboratory; Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
PCP—Pediatric	PCP—Midlevel - Pediatric
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, 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).

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

Health Choice

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Health Choice submitted its new clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness.*

Validation Results

Table 2-29 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-29—PIP—*Follow-Up After Hospitalization for Mental Illness*
Health Choice

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	Implementation Total	**Not Assessed**		
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	**Not Assessed**		
	Percentage Score of Applicable Evaluation Elements *Met*	**100% (8/8)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100% (5/5)**		
	Validation Status	***Met***		

Indicator Outcomes

Health Choice had not progressed to reporting data in this validation cycle.

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

Strengths

Health Choice designed a scientifically sound project. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Additionally, Health Choice's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Health Choice must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.
- Health Choice must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Health Choice's Utah Medicaid Integrated Care (UMIC) line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have the CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Health Choice's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards.

For the CY 2020 compliance monitoring activities, HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Health Choice's sample of credentialed providers included four nurse practitioners, a physical therapist, an audiologist, two primary care physicians, an ophthalmologist, and a physician assistant. HSAG reviewed a full sample of 10 prior authorization denial records. Health Choice submitted a sample of one appeal record and two grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Health Choice submitted and through conducting a virtual, web-based review consisting of interviews with key Health Choice staff members.

Strengths

Health Choice provided evidence of a utilization management (UM) program that operated effectively to process authorization requests and decisions in a timely manner, ensure consistent authorization decision-making processes, and uphold nationally recognized clinical practice guidelines (CPGs).

Health Choice described two major software implementations within the UM department: 1) updated InterQual criteria sets, and 2) enhancements to the CareRadius platform that improved the overall layout and speed of the system and added survey tools, including a discharge survey that automatically

tasked the transition of care (TOC) team with following up with the member, potentially positively impacting the quality and access to care.

Health Choice provided HSAG with evidence that during the period under review, Health Choice ensured that covered services were made available and accessible to members in a timely manner. Within its provider manual and provider agreements, Health Choice described medically necessary covered services that participating providers furnish. Health Choice provided its Network Monitoring policy which described methods for monitoring the size and sufficiency of the network. Health Choice demonstrated analysis of time and distance standards through its GeoAccess reports, which were run every six months. In addition, Health Choice network services representatives were assigned counties to maintain provider counts, oversee coverage issues, and actively recruit providers where access disparities may exist.

Health Choice described an effective "Safety Net" care management structure and mechanisms to coordinate between teams and ensure member care. These systems included software such as CareRadius, Med/MC for claims data, and a national community resource database. Health Choice provided an example of staff members using the national community resource database to support a member's transition out of state by connecting the member to local resources in the member's new place of residence. Health Choice outlined plans to partner with the Department of Public Health and develop disease management programs for diabetes, asthma, and congestive heart failure.

Health Choice had policies and procedures that described the organization's commitment to promoting and protecting member rights. Within the procedures, Health Choice identified several mechanisms to ensure that staff and providers took into account member rights. Mechanisms included annual staff training on member rights, member and provider newsletters, provider agreements, onboarding processes for new employees and newly contracted providers, and monitoring member complaints.

Health Choice's Compliance Plan and Fraud, Waste, and Abuse (FWA) policy addressed a code of conduct, designation of a compliance officer and compliance committee, compliance training for employees and some providers, effective lines of communication and reporting, and dedicated staff with processes for investigation of potential FWA. The provider manual informed providers of Health Choice's mechanisms to screen for, prevent, and report FWA and provided a link to the Office of Inspector General (OIG) website for more information. Health Choice's compliance program activities and FWA monitoring were interrelated. Health Choice staff members described provisions for reporting potential FWA to the State; suspension of payments to providers for allegation of fraud; and reporting to the State any overpayments identified and recovered, member circumstances affecting member eligibility (including death and change of residence), and termination of provider agreements.

Health Choice's Quality Assessment and Performance Improvement (QAPI) program involved a matrixed partnership including clinical services, medical directors, and overarching guidance through recent NCQA accreditation. Health Choice provided evidence through policies, procedures, and supporting interviews that substantiated compliance with the QAPI program's ability to assess performance and engage in improvement activities.

Health Choice's Quality staff members described a pattern variation analysis that explored differences in providers, members, and other data characteristics. These analyses helped Health Choice identify high and low performers in the provider network. Health Choice collaborated with high performers to gain insights regarding best practices. When low performers were identified, Health Choice was able to provide additional training and support. For example, reports indicated low breast cancer screening rates; upon further investigation, Health Choice was able to identify an underserved immigrant population accessing services at federally qualified health centers (FQHCs). Health Choice provided additional translation support at these locations and increased member education efforts to build understanding regarding the importance of breast cancer screenings.

Opportunities for Improvement and Recommendations

Health Choice refers to the outdated term "notice of action" (NOA) in multiple documents, which is the previous terminology for NABD. HSAG strongly suggests that all related documentation be updated to include the current terminology, NABD, to align with State and federal guidelines as well as reduce confusion.

Pertaining to coverage and authorization of services, Health Choice's definition of "medical necessity" was not inclusive of the required criteria, potentially negatively affecting the quality of and access to care.

Two of the 10 denial records included benefit determination and reasons that were not clearly described. Health Choice explained that this was due to a staff member's writing error. In both instances the staff member wrote a determination explanation that was inconsistent with the actual service requested (i.e., back pain versus neck pain). Additionally, Health Choice did not include appeal information in the NABD letters. HSAG found some instances wherein a clinical term was included at the beginning of the letter and the corresponding acronym appeared at the bottom of the letter; however, the two were not clearly linked, potentially negatively impacting the quality of service and access to care. HSAG suggests that Health Choice implement a process to review NABD letters prior to sending them to the member.

The cultural competency training Health Choice developed for its providers to explain how to promote the benefits of health care services lacked information about health care attitudes, beliefs, and practices that affect access to health care services. HSAG recommends strengthening the cultural competency training.

Health Choice's Member Rights and Responsibilities policy did not include that the member will receive information on treatment alternatives. In addition, HSAG evaluated Health Choice's website and several documents available on the website (i.e., the provider directory, member handbook, and drug formulary) for accessibility and found many errors indicating barriers to accessibility for members with visual impairments. In addition, the website did not have a notification that electronic information is available to members in paper form, without charge, upon request, and provided within five business days from the request.

Health Choice's provider directories did not contain the provider's website URL; an indicator to identify whether a provider has completed cultural competency training; or whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. Health Choice's provider directories also did not include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services (including written translation, oral interpretation, and the toll-free and TTY/TDD customer service number) and availability of materials in alternative formats.

During the appeal record review, HSAG found that in one file a registered nurse (RN) (rather than a pharmacist or an individual with an appropriate pharmacy background) reviewed the decision to deny a pharmaceutical request. This file was out of compliance with timeliness requirements for processing the appeal and for sending an extension notice in a timely manner. In addition, the extension letter did not inform the member of the right to file a grievance about the extension or to go directly to a State fair hearing due to Health Choice failing to adhere to timeliness requirements. For another record that resulted in Health Choice issuing an extension, Health Choice did not provide evidence to show how the delay was in the member's interest. In this case the delay was due to an internal error, and Health Choice should have provided an expedited resolution as soon as it became aware of the delay. HSAG strongly suggests that senior leadership review these discrepancies and ensure that appropriate systems are in place for members to receive a timely notification of appeal resolutions.

Within its policies, Health Choice stated that standard oral member appeals must be followed by a written letter or completed Member Appeal Form "within five business days from the date of the oral appeal." Health Choice cannot put an artificial time limit or constraint on a member to follow an oral appeal with a written appeal. In addition, if a member needs assistance with completing a written appeal following the oral request, Health Choice must provide assistance according to 42 CFR §438.406(a)(1).

Health Choice's written provider agreement did not specify that CMS, the HHS inspector general, and the comptroller general (or designees) will have availability to audit, evaluate, or inspect its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic services.

Upon review of Health Choice's provider manual and provider agreement, HSAG discovered that neither contained the required information about the grievance and appeal processes and the State fair hearing system.

VALIDATION OF NETWORK ADEQUACY

Table 2-30 displays the match percentage for provider information between the data submitted by Health Choice and all MCOs (excluding HOME) and the online provider directory. Table 2-31 reflects the percentage of providers who have the service listed as available on Health Choice's online directory as compared to all MCOs (excluding HOME).

Table 2-30—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Health Choice and All MCOs

Provider Information	Health Choice			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	152	99.3%	0.7%	809	98.6%	1.4%
Provider Middle Name	152	99.3%	0.7%	809	94.7%	5.3%
Provider Last Name	152	99.3%	0.7%	809	99.5%	0.5%
Provider Address 1	152	87.5%	12.5%	809	91.1%	8.9%
Provider Address 2	152	90.1%	9.9%	809	91.7%	8.3%
Provider City	152	90.8%	9.2%	809	94.4%	5.6%
Provider State	152	97.4%	2.6%	809	99.4%	0.6%
Provider Zip Code	152	89.5%	10.5%	809	92.5%	7.5%
Provider County	152	0.0%	100.0%	809	0.2%	99.8%
Provider Specialty*	152	65.1%	34.9%	809	91.6%	8.4%
Provider Accepting New Patients	152	85.5%	14.5%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-31—Percentage of Provider Service Information Available in Online Directory for Health Choice and All MCOs

Available Services Information	Health Choice				All MCOs (excluding HOME)			
	Total	Percentage Shown	Percentage Not Shown	Percentage Pending	Total	Percentage Shown	Percentage Not Shown	Percentage Pending
Any Practice Limitations*	152	19.1%	80.3%	0.7%	809	65.8%	34.1%	0.1%
Non-English Language Speaking Provider	152	99.3%	0.7%	0.0%	809	91.6%	8.4%	0.0%
Provider Accommodates Physical Disabilities	152	0.7%	98.7%	0.7%	809	43.8%	56.1%	0.1%
Provider Completed Cultural Competency Training	152	0.7%	98.7%	0.7%	809	41.8%	58.1%	0.1%
Provider URL	152	0.0%	100.0%	0.0%	809	14.1%	85.9%	0.0%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-32 displays the number and percent of provider categories wherein Health Choice met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-32—Compliance With Time/Distance Standards by Provider Domain—Health Choice

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)
PCP—Adult	2	1	50.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	3	3	100.0%
Behavioral Health—Facilities	4	1	25.0%

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

Strengths

While 54.2 percent of the sampled providers could not be found in the online directory, Health Choice was the only MCO which had an option for members to be able to request a paper form of the provider directory. Additionally, Health Choice noted that the most recent update to the website and paper directory was in October 2020.

Geographic network distribution analysis indicated that Health Choice met time/distance standards for 86.4 percent of all provider categories and 100 percent of the standards for PNC/Women's Health Providers, Specialists—Adult, Additional Physical Health—Providers, Hospitals, Ancillary—Facilities, and Behavioral Health—Adult provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Health Choice's online provider directory is critical for members to have timely access to appropriate health care providers. Health Choice's PDV indicated that only 42.2 percent of the sampled providers were found in the health plan's online provider directory. Additionally, Health Choice had a substantially lower match rate for Provider Specialty (65.1 percent) compared to the other MCOs, and county information was not present for any of the sampled records. HSAG recommends that Health Choice frequently update its online provider directory with the

required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Health Choice include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Health Choice should also assess including information on provider URL and additional provider services such as cultural competency training status and physical disability accommodation.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Health Choice should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, all MCOs encountered challenges in meeting the time/distance standards for Additional Physical Health—Facilities and Behavioral Health—Facilities provider domains. The provider categories that did not meet the standards are listed in Table 2-33. Additionally, Health Choice did not report any Mammography facilities or Outpatient Infusion/ Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Health Choice should continue to assess areas of inadequacy to identify providers who chose not to contract with Health Choice and the inability to identify the providers in the data using the standard definitions.

Table 2-33—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
PCP—Adult	PCP—Medical—Adult

Healthy Outcomes Medical Excellence (HOME)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, HOME continued its PIP topic: *Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus.*

Validation Results

Table 2-34 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-34—CY 2020 Performance Improvement Project Validation Results for HOME (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

The purpose of this PIP is to decrease the HbA1c level in the identified pre-diabetic study cohort (i.e., an HbA1c between 5.7 to 6.4) to an HbA1c level less than 5.7. For the baseline, HOME identified the study cohort members based on their most recent HbA1c reading during CY 2017. A total of 103 pre-diabetic members were identified in the study cohort. Since all members included in the study are pre-diabetic, the rate for the study indicator during baseline was 0.0 percent. For Remeasurement 1, HOME reported that three members were dropped from the study cohort due to disenrollment; therefore, the Remeasurement 1 denominator for the cohort was 100. During CY 2018, the most recent HbA1c reading for 43 members in the study cohort was less than 5.7. For Remeasurement 2, HOME reported that 15 additional members were dropped from the study cohort due to disenrollment; therefore, the study denominator for the cohort was 85. During CY 2019, the most recent HbA1c reading for 36 members was less than 5.7. Even though the Remeasurement 2 rate was 0.7 percentage points below the Remeasurement 1 rate, it represented a statistically significant improvement over the baseline.

Table 2-35 displays data for HOME's *Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus* PIP.

Table 2-35—PIP—*Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus*
HOME

Study Indicator	Baseline Period 01/01/2017–12/31/2017		Remeasurement 1 01/01/2018–12/31/2018		Remeasurement 2 01/01/2019–12/31/2019		Sustained Improvement
Percentage of HOME enrollees in the identified pre-diabetic study cohort, who had a most recent HbA1c < 5.7 in the measurement period.	N: 0	0.0%	N: 43	43.0%*	N: 36	42.3 %*	*Yes*
	D: 103		D: 100		N: 85		

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

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

Strengths

HOME designed a scientifically sound PIP. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process. HOME conducted appropriate QI processes to identify barriers and implemented interventions that were logically linked to the barriers. HOME sustained a statistically significant increase in the study indicator rate over the baseline for two consecutive remeasurement periods. HOME's study topic addressed CMS' requirements related to outcomes, specifically, the quality and timeliness of, and access to care and services. HOME's PIP aims to decrease the HbA1c level in the identified pre-diabetic study cohort (i.e., an HbA1c level between 5.7 to 6.4) to an HbA1c level less than 5.7.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- HOME has demonstrated sustained improvement in this PIP. The health plan should consult with UDOH on the next steps for this PIP.
- HOME must continue to revisit the causal/barrier analysis and QI processes at least annually to reevaluate barriers and develop new interventions as needed.
- HOME must build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that HOME's HEDIS compliance auditor found HOME's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. HOME contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of HOME's FAR revealed that HOME's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results

Performance Measure Outcomes

Table 2-36 presents HOME's reporting year (RY) 2020 performance measure results.

Table 2-36—HOME RY 2020 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	50.00%
Follow-Up Within 30 Days	97.37%

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

Strengths

HOME demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. HOME also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for HOME related to PMV; however, HOME may want to consider focusing on improving follow-up care post hospital discharge.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance follow-up review, HSAG reviewed requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of initial provider credentialing records, member grievances, service authorization denials, and appeals for alignment with the quality, timeliness, and access domains. HSAG reviewed a full sample of 10 initial credentialing

files for the period under review. HOME provided a sample of six prior authorization denial records, nine appeal records, and one grievance record for the period under review.

HSAG determined findings based on a desk review of the documents HOME submitted and through conducting a virtual, web-based review consisting of interviews with key HOME staff members.

Strengths

Overall findings for HOME indicated improvement from CY 2019 to CY 2020. Concerning member information, in CY 2018, HSAG had found that HOME had not advised members that information on its website is available in paper form without charge upon request and would be provided within five business days. During the CY 2019 interview, HSAG determined that this was not corrected. For the CY 2020 review, HSAG found that HOME included a statement on its website indicating that information on its website is available in paper form without charge, upon request, and would be provided within five business days.

HSAG found full compliance with HOME's credentialing records and found that four of the six prior authorization denial records included all required information and were sent in a timely manner. HSAG also found full compliance with eight of the nine appeals files, as HOME had included all required information in the acknowledgements and resolutions to the members and had sent them in a timely manner. HSAG reviewed HOME's one grievance file and found that HOME had met all grievance processing requirements.

Opportunities for Improvement and Recommendations

In HOME's prior authorization denial files HSAG found that two records in the submission did not include a NABD letter to the member. The final correspondence HSAG identified in each of the two files was a letter to the durable medical equipment (DME) supplier requesting additional information. In one case, HSAG found that the letter date was also listed as the denial date in the member's medical record, without any notice going to the member. HSAG suggests that HOME review the denial response process to ensure that all members receive a NABD notification, and specifically assess the process wherein DME is denied. HSAG also found that one appeals record was missing the acknowledgement and resolution letters to the member.

HSAG noted that one grievance over a five-month period is an unusually small amount. HSAG suggested that HOME review its grievance collection policies and procedures to ensure that HOME is tracking and appropriately documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-37 displays the match percentage for provider information between the data submitted by HOME and the online provider directory. Table 2-38 reflects the percentage of providers who have the service listed as available on HOME's online directory.

Table 2-37—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for HOME

Provider Information	Total	Match Percentage	Unmatched Percentage
Provider First Name	62	98.4%	1.6%
Provider Middle Name	62	64.5%	35.5%
Provider Last Name	62	98.4%	1.6%
Provider Address 1	62	35.5%	64.5%
Provider Address 2	62	75.8%	24.2%
Provider City	62	67.7%	32.3%
Provider State	62	90.3%	9.7%
Provider Zip Code	62	48.4%	51.6%
Provider County	62	0.0%	100.0%
Provider Specialty*	62	80.6%	19.4%
Provider Accepting New Patients	62	8.1%	91.9%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-38—Percentage of Provider Service Information Available in Online Directory for HOME

Available Services Information	Total	Percentage Shown	Percentage Not Shown	Percentage Pending
Any Practice Limitations*	62	4.8%	95.2%	0.0%
Non-English Language Speaking Provider	62	90.3%	9.7%	0.0%
Provider Accommodates Physical Disabilities	62	0.0%	98.4%	1.6%
Provider Completed Cultural Competency Training	62	0.0%	100.0%	0.0%
Provider URL	62	38.7%	61.3%	0.0%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-39 displays the number and percent of provider categories wherein HOME met the time/distance standards at the statewide level.

Table 2-39—Compliance With Time/Distance Standards by Provider Domain—HOME

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PNC/Women's Health Providers	2	1	50.0%
Specialists—Adult	17	16	94.1%
Specialists—Pediatric	17	0	0.0%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	5	83.3%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	3	1	33.3%
Behavioral Health—Pediatric	2	1	50.0%
Behavioral Health—Facilities	4	0	0.0%

*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).

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

Strengths

Geographic network distribution analysis indicated that HOME met time/distance standards for 86.2 percent and 84.6 percent of all provider categories in frontier and urban counties, respectively. Additionally, HOME met 100 percent of the standards for PCP—Adult, Additional Physical Health—Providers, and Hospitals provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in HOME's online provider directory is critical for members to have timely access to appropriate health care providers. HOME's PDV indicated that only 17.0 percent of the sampled providers were found in the health plan's online provider directory. The match percentage for address fields were low for the providers found on HOME's online directory. Information on physical disability accommodation and cultural competency training was also not included in HOME's online directory. HSAG recommends that HOME frequently update its online provider directory with the required, accurate provider information and fix the issues related to search options. HSAG also recommends that HOME have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. HOME should continue to assess the accuracy of the category assigned to each provider in the submitted data for

accurate network adequacy results. The provider categories that did not meet the standards are listed in Table 2-40. HOME did not report any pediatric specialty providers in the data for Allergy & Immunology, Pediatric; Ophthalmology, Pediatric; or Orthopedic Surgery, Pediatric categories. Additionally, HOME did not report any Outpatient Infusion/Chemotherapy facilities in the provider data. HOME did not meet any time/distance standards at the statewide level for the pediatric specialty providers and behavioral health facilities. While failure to meet some of the standards might result from lack of providers, HOME should continue to assess areas of inadequacy to identify providers who chose not to contract with HOME and the inability to identify the providers in the data using the standard definitions.

Table 2-40—Provider Categories That Failed to Meet Time/Distance Standards—HOME*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy
Ancillary—Facilities	Pharmacy
Behavioral Health—Adult	Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
PNC/Women's Health Providers	OBGYN—Medical
Specialists—Adult	Infectious Disease
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).

Healthy U

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Healthy U submitted a new clinical PIP topic: *Improving Adults' Access to Preventive/Ambulatory Care Services*.

Validation Results

Healthy U submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-41—CY 2020 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (8/8)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Healthy U had not progressed to reporting data in this validation cycle.

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

Strengths

Healthy U designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study topic selected by Healthy U addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and, access to care and services. The PIP submitted by Healthy U aims to increase the percentage of adult members receiving annual ambulatory or preventive care visits with a physician.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Healthy U must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- Healthy U must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Healthy U's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Healthy U's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Healthy U's sample of credentialed providers included two doctors of osteopathic medicine, a licensed social worker, an advance practice RN specializing in gerontology, radiologists, a neurologist, a marriage and family therapist, an orthopedic surgeon, a behavioral analyst, and a physical therapist. Healthy U submitted a sample of two prior authorization denial records, two appeal records, and three grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Healthy U submitted and through conducting a virtual, web-based review consisting of interviews with key Healthy U staff members.

Strengths

Healthy U described a matrixed UM structure that collaborated with medical management, operations, and other teams frequently. Workflows for pre-service, post-service, and TOC teams were well outlined and upheld requirements. Healthy U used Epic software throughout the organization, which ensured cohesive processes across teams to receive and process authorizations. The Drug Utilization Review Board maintained a diverse clinical membership in line with federal requirements and conducted annual oversight to review and update clinical standards, positively impacting Healthy U's quality of care. Healthy U used InterQual consistently to make UM decisions and operated under well-documented policies and procedures to ensure timely initial and continuing authorizations. Furthermore, Healthy U conducted extensive interrater reliability (IRR) testing throughout the year. This training was further supported by a monthly physician meeting known as the "Review Roundup" where trends and learning opportunities were discussed.

Healthy U maintained and monitored a network of providers sufficient to provide access to covered health services for members, including those with limited English proficiency or physical or mental disabilities. Healthy U had mechanisms to ensure that all covered services were available and accessible to members in a timely manner.

Healthy U showcased a diverse care management program that included adult, pediatric, mom and baby, and other specialty subpopulations. The Care Management department clearly demonstrated engagement in data-driven decision making. Staff described a risk stratification methodology used to identify members who may need additional care management supports. Based on recent coronavirus disease 2019 (COVID-19) changes to health care operations, Healthy U worked to transition providers to telemedicine platforms. One example included the asthma care management program moving to an "e-Asthma" approach which allowed members and providers to remain in contact virtually. Through the e-Asthma program, providers were able to identify ongoing supports needed, such as deploying high efficiency particulate air (HEPA) filters to members' houses.

Healthy U maintained policies and procedures that clearly delineated processes for members to file appeals and grievances, and for Healthy U staff members to review and process member grievance and appeal request submissions. Healthy U described the procedures for accepting and reviewing grievances and appeals. The process described aligned with Healthy U's policies.

Healthy U's submission of supporting documentation and evidence of access standards included policies, procedures, the provider manual, sample provider agreements, sample credentialing applications, the Compliance Plan, the FWA Compliance Plan, annual credentialing reviews, provider-specific communications, and a credentialing review worksheet. HSAG reviewed all submissions and found that most of the documents substantiated compliance with provider selection, credentialing, and compliance program requirements.

Healthy U presented a robust QAPI program that included collaboration between various departments and levels of leadership. Healthy U maintained an enterprise data warehouse (EDW) that integrated referrals and admit, discharge, and transfer (ADT) feeds, and provided staff members the ability to gain insights regarding specific member populations.

Additionally, the Quality team mentioned it was currently laying groundwork with stakeholders to eventually implement value-based payments. Healthy U also discussed plans to launch text messaging and email capabilities in March 2021.

Furthermore, Healthy U submitted detailed workflows and desktop procedures regarding the claims processing system. These documents outlined quality assurance measures taken to maintain accuracy, including auditing 3 percent of internal claims and 15 percent of claims that did not auto-adjudicate. Healthy U targeted 99 percent financial accuracy and 97 percent processing accuracy, and staff members attested to consistently meeting these goals.

Opportunities for Improvement and Recommendations

Upon desk review, HSAG found that multiple documents referred to notices of action (NOAs), which does not reflect current contract terminology. HSAG recommends that Healthy U update all related documents to reflect the current NABD terminology to align with State and federal guidelines and reduce confusion. Healthy U's Clinical Practice Guidelines policy and UM Program Description both included definitions of "medically necessary services"; however, these definitions did not include all required criteria, which could negatively impact the quality of services.

Healthy U documented and described a process for consulting with providers during the authorization review period. However, Healthy U also engaged in a denial reconsiderations process which did not adhere to State and federal denial and appeal guidelines. The Peer-to-Peer (P2P) Review Request Form and associated process were described as being used after the denial letter is mailed to the member. It is the intent of the State and federal regulations that after the NABD has been mailed, any additional actions and decisions then fall under the appeal process. Furthermore, the denial reconsiderations process did not include additional member notices. It is the intent of the State and federal regulations that the member be informed regarding denial and appeal decisions. Also related to provider consultation, the Pharmacy Authorization policy stated that "incomplete requests or requests received without all necessary supporting documentation may be denied for lack of documentation." While Healthy U's policy stated that expedited authorization decisions must be determined no later than 72 hours after receipt of the request, the NABD letters incorrectly stated three business days. One denial record review sample included clinical language that was not easy to understand (e.g., "rectal adenocarcinoma," "neoadjuvant," and "ganglion impar neurolysis"), negatively impacting the access domain.

Although Healthy U submitted a sample of three grievances for review, HSAG determined that two of the grievances were indeed appeals. Hence, Healthy U reported that it filed one grievance during this time period. HSAG recommends that Healthy U conduct an analysis of it processes, including those of call center staff, to ensure that all grievances and appeals are classified and accounted for appropriately so that Healthy U can track and trend them and initiate QI interventions as warranted. Further, a pharmacist overturned a "grievance" involving a pharmacy denial over the phone, demonstrating that Healthy U did not follow appeal procedures. Notes stated that the pharmacist overturned the denial because the medication was "very low cost," even though "the provider had not submitted the required information and the quantity requested was above suggested amounts." HSAG suggests that Heathy U evaluate this specific incident to determine the root cause of the issue.

While Healthy U defined "grievance" appropriately in policies and procedures, it was evident that customer service staff members were unable to delineate the difference between a grievance and an appeal. Healthy U submitted a sample of three grievances for HSAG to review as part of a sample of records. Upon review, HSAG determined that two of the grievances were actually appeals (a call requesting that Healthy U overturn a pharmacy denial and physical therapy denial). In one case the member called to dispute a denied request for authorization of medication. The customer service

representative contacted a pharmacist to review the denial. According to comments Healthy U provided from a note taken during the call, the pharmacist overturned the denial; and "although the provider had not submitted the required information and the quantity requested was above suggested amounts," the pharmacist overturned the denial because the medication was "very low cost." Healthy U staff did not follow the process for reviewing a denial. Healthy U must ensure that staff follow its process for resolving appeals for every appeal and that staff members are trained appropriately in the policies and processes.

HSAG noted that one grievance (the adjusted sample of reported grievances) over a five-month period is an unusually small quantity. HSAG suggests that Healthy U review its grievance collection policies and procedures to ensure it is accounting for all member-submitted grievances, including those resolved quickly or that require little or no investigation.

Healthy U refers subcontractors to the provider manual for information about grievance and appeal processes and the State fair hearing system at the time they enter into a contract. HSAG reviewed the provider manual and identified that the information provided was not clear and did not accurately describe the grievance and appeal processes and the State fair hearing system. For example, Healthy U's provider directory included language that written appeals must follow oral appeals within five business days or the member's appeal will be closed. HSAG also observed that some terms were not consistent with UDOH contract language and federal regulations. For example, the provider manual referred to the adverse decision of a preservice authorization as a "notice of action."

Healthy U did not have a written policy and procedure that addressed conducting checks on employees and other individuals and entities to ensure that it does not employ an individual or entity excluded from participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act.

HSAG reviewed three of Healthy U's delegation agreements, none of which incorporated language regarding the right of the State, CMS, the HHS inspector general, the comptroller general, or their designee to audit, evaluate, and inspect aspects pertaining to the services and activities performed or determination of amounts payable under Healthy U's contract with the State.

VALIDATION OF NETWORK ADEQUACY

Table 2-42 displays the match percentage for provider information between the data submitted by Healthy U and all MCOs (excluding HOME) and the online provider directory. Table 2-43 reflects the percentage of providers who have the service listed as available on Healthy U's online directory as compared to all MCOs (excluding HOME).

Table 2-42—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Healthy U and All MCOs

Provider Information	Healthy U			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	200	100.0%	0.0%	809	98.6%	1.4%
Provider Middle Name	200	96.5%	3.5%	809	94.7%	5.3%
Provider Last Name	200	99.5%	0.5%	809	99.5%	0.5%
Provider Address 1	200	97.0%	3.0%	809	91.1%	8.9%
Provider Address 2	200	90.5%	9.5%	809	91.7%	8.3%
Provider City	200	98.0%	2.0%	809	94.4%	5.6%
Provider State	200	100.0%	0.0%	809	99.4%	0.6%
Provider Zip Code	200	96.5%	3.5%	809	92.5%	7.5%
Provider County	200	0.0%	100.0%	809	0.2%	99.8%
Provider Specialty*	200	99.0%	1.0%	809	91.6%	8.4%
Provider Accepting New Patients	200	100.0%	0.0%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-43—Percentage of Provider Service Information Available in Online Directory for Healthy U and All MCOs

Available Services Information	Healthy U			All MCOs (excluding HOME)		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	200	59.0%	41.0%	809	65.8%	34.1%
Non-English Language Speaking Provider	200	91.0%	9.0%	809	91.6%	8.4%
Provider Accommodates Physical Disabilities	200	41.0%	59.0%	809	43.8%	56.1%
Provider Completed Cultural Competency Training	200	93.5%	6.5%	809	41.8%	58.1%
Provider URL	200	30.5%	69.5%	809	14.1%	85.9%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-44 displays the number and percent of provider categories wherein Healthy U met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-44—Compliance With Time/Distance Standards by Provider Domain—Healthy U

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
PCP—Adult	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	5	83.3%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	3	2	66.7%
Behavioral Health—Facilities	4	3	75.0%

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

Strengths

While 44.8 percent of the sampled providers could not be found in the online directory, Healthy U's match rates for all required provider fields except Provider Address 2 and Provider County exceeded 95 percent. Additionally, 100 percent of the sampled providers had a match on Provider First Name, Provider State, and whether the provider accepted new patients, and 93.5 percent of the provider records online included service information on cultural competency training.

Geographic network distribution analysis indicated that Healthy U met the most time/distance standards (90.9 percent) statewide among the MCOs and met 100 percent of the standards for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Additional Physical Health—Providers, and Hospitals provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Healthy U's online provider directory is critical for members to have timely access to appropriate health care providers. Healthy U's PDV indicated that only 53.3 percent of the sampled providers were found in the health plan's online provider directory. Only 41 percent of the sampled providers found in the online directory had information on physical disability accommodation, and 30.5 percent of the providers had a provider URL. HSAG recommends that Healthy U frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Healthy U have an option

for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Healthy U should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Healthy U met the time/distance standards for 40 of the 44 (90.9 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-45. All MCOs encountered challenges in meeting the time/distance standards for Additional Physical Health—Facilities and Behavioral Health—Facilities provider domains. While failure to meet some of the standards might result from lack of providers, Healthy U should continue to assess areas of inadequacy to identify providers who chose not to contract with Healthy U and the inability to identify the providers in the data using the standard definitions.

Table 2-45—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy
Ancillary—Facilities	Pharmacy
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	General Hospitals with a Psychiatric Unit

Molina

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020 validation, Molina submitted a new clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness*.

Validation Results

Molina submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-46—CY 2020 Performance Improvement Project Validation Results for Molina (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
	Implementation Total	**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (7/7)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Molina had not progressed to reporting data in this validation cycle.

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

Strengths

Molina designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The PIP topic selected by Molina addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Molina must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- Molina must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Molina's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Molina's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Molina's sample of credentialed providers included nurse practitioners, physician assistants, a dermatologist, a podiatrist, a physical therapist, a marriage and family therapist, and a licensed social worker. HSAG reviewed a sample of 10 prior authorization denial records and 10 grievance records. Molina submitted a full sample of seven appeal records.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Molina submitted and through conducting a virtual, web-based review consisting of interviews with key Molina staff members.

Strengths

Molina maintained policies that detailed an effective UM program which included a standardized IRR process which was conducted annually and followed the NCQA 8/30 sampling approach. In addition, Molina described that it conducted a monthly review of local RN authorizations.

A strength associated with the access and quality domains was Molina's extensive policies and procedures that described how Molina delivers and coordinates care for its member populations. Initial screening and comprehensive assessments were embedded in Molina's documentation system. Members identified as having care management needs as a result of the initial screening were referred to a nurse for the diagnosis-based comprehensive assessment(s). Molina used a stratification algorithm to determine case management and care planning activities. Members in need of coordination due to TOCs were referred to a separate team for TOC management.

Pertaining to the quality domain of care, Molina had adequate policies that addressed privacy requirements in 45 CFR parts 160 and 164. Policies and procedures addressed release of information for sharing records, disclosure requirements, access limitations, minimum access necessary, and technical and physical access safeguards.

Molina had policies and procedures that clearly articulated Molina's intent to respect member rights and to ensure that staff members and providers protect member rights. Molina used the member handbook and member newsletters on its website to help members understand the Medicaid program and benefits available. Molina provided evidence of adequate processes for ensuring member materials are readily accessible (compliant with Section 508 of Section 504 of the Rehabilitation Act). Member materials such as the member handbook and the Guide to Accessing Quality Health Care were written in a manner that could be easily understood and were available in Utah's prevalent alternative language and alternative formats. Molina also provided evidence of having a process for language interpretation services. The provider directory search page provided options for members to change the view to achieve readily accessible (508 compliant) results, positively impacting members' access to care.

Molina provided policies and procedures as evidence of a comprehensive compliance program to detect and prevent FWA. During the interview Molina described processes for routine internal monitoring and auditing of compliance risks, which aligned with policies and met requirements. Molina also had processes in place to conduct random sampling of members to ensure that services represented as being provided were actually provided to members.

Within its Compliance Training policy, Molina stated that it would train employees on Molina's Compliance Plan, Code of Conduct, and Anti-Fraud Plan, and that training would be conducted within 60 days from the date of hire and annually thereafter. Molina's staff members affirmed this policy during the interview. Molina maintained a centralized toll-free hotline and Internet-based reporting system available 24 hours a day, seven days a week to enable employees, members, providers, vendors, subcontractors, and related entities to report instances of suspected noncompliance, violations of State or federal law, and violations of government or company policies and procedures.

Opportunities for Improvement and Recommendations

Based on HSAG's record review, Molina processed all denials in a timely manner, despite noted turnover during early 2020. However, HSAG found the following issues with the denials, potentially negatively impacting the quality, timeliness, and access domains of care.

HSAG identified inconsistencies linked to the corporate UM process. Denial records included four instances wherein services were denied due to lack of information; however, HSAG did not see evidence of a documented consultation with the provider to seek additional information. Molina's policies outlined three outreach attempts as part of the UM procedure; however, Molina did not uphold this process consistently in practice. Molina must ensure staff at both the local and corporate levels are following UM policies and procedures and engaging in provider outreach, when appropriate.

Furthermore, Molina should use extensions to gather additional information from providers when in the member's best interest.

- Molina did not always list the reason for the NABD in language that was easy to read.
- Molina included a requirement that members needed to submit a written appeal within five days following an oral request for an appeal.
- Molina indicated that expedited appeals may take three calendar days to resolve instead of the current 72-hour time frame.
- Molina did not have language clarifying that the member, health care provider, or authorized representative may submit a request for an expedited appeal.

Molina conducted a network adequacy analysis for all provider types outlined within the State contract, except behavioral health. The network adequacy report used standards less strict than those outlined in the State contract to measure time and distance adequacy for Washington County. The network adequacy report indicated that Washington, Davis, and Weber counties did not have any pharmacy providers, Utah County had one pharmacy provider, and Salt Lake County had only three pharmacy providers. Molina must ensure that its behavioral health and pharmacy provider networks and the providers in Washington County meet the State time and distance standards.

Molina provided evidence that it considered some of the required elements in establishing and maintaining its network; however, Molina did not present sufficient evidence to address all required elements, including:

- The anticipated Medicaid enrollment.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area.
- The number of network providers accepting/not accepting new Medicaid members.
- The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, or other technology solutions.

Molina's policies and procedures described a process of making three phone attempts to reach newly enrolled members, then mailing a hard copy assessment to any member not successfully reached by phone. During the on-site interview, Molina's team leader for the team responsible for this process confirmed the process for phone call attempts; however, the team leader stated that Molina does not send any written communication to the members following the three phone attempts. HSAG recommends that Molina develop a mechanism to improve its process and ensure that Molina's policies and procedures are consistent with its operational practices. Doing so may increase the number of members who receive an initial screening within 90 days of enrollment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Molina received most grievances through phone calls, and member services addressed the grievances. HSAG noted a general lack of clarity in the way the call center documented acknowledgements and resolutions in the records and recommends that Molina develop and train call center staff to ensure that members are informed of their rights and are aware of the grievance process.

Molina provided the member handbook and other critical member materials via the website. The member welcome letter informed members where to find the handbook. While Molina provided material describing a process to ensure 508 compliance of the website, results of HSAG's testing using the WAVE Web Accessibility Evaluation Tool revealed that the Medicaid Integrated Care landing page and the Member Resources page showed 53 and 55 errors, respectively. Molina must refine its procedures to better ensure 508 compliance of its website to ensure that members successfully obtain required member materials. Molina did not provide evidence of how it informs members that they may request information about physician incentive plans. Molina must develop a process to make physician incentive plans available to members upon request.

Molina's policies did not include the complete State and federal definitions of "adverse benefit determination," "appeal," and "grievance." Molina's Member Grievance and Medical Appeals policy incorrectly described a NABD as "a determination that the enrollee disagrees with" and used the term "aggrieved person" when describing the appeal process. Further, processes indicated that a grievance could result in an appeal or State fair hearing, when only a NABD can lead to an appeal. HSAG also noticed the general lack of clarity between these definitions in policy and in practice. HSAG found one sample record wherein Molina had incorrectly routed an appeal to be processed as a grievance. Lastly, HSAG noted that the terms "NABD," "grievance," and "appeal" were used interchangeably in the member handbook. Molina must update its internal policies and procedures to include the complete and accurate federal definitions of "NABD" and "grievance." Furthermore, HSAG recommends working with UDOH to clarify these definitions in the member handbook to further support the quality of services Molina provides and access to care.

HSAG found that in two of the appeal samples, members were encouraged to withdraw their appeals due to a delay in Molina obtaining the signed appeal letter following an oral appeal, which could potentially negatively impact access to care. Instead of explaining the extension process and exercising this option, Molina instead encouraged members to "withdraw" the appeal and resubmit. Staff members indicated the withdrawal process was common and an existing report showed withdrawn appeals. This report indicated that a total of four appeals were withdrawn and only one case wherein the member followed up and received an overturned outcome. Notably, one of the withdrawn requests was for a surgery. In an instance identified within the grievance records, staff should have offered an appeal; however, staff members incorrectly routed the issue through the grievance system. HSAG recommends that Molina's leadership update its policies and procedures to clarify that staff members must assist members through all reasonable means to complete grievances and appeals. Molina should clarify policies and procedures to include extensions when appropriate and remove references to "withdrawal" and "resubmission" processes thereby decreasing barriers for members' access to exercising the right to appeal and potentially to receiving services.

Molina's procedural documentation incorrectly stated that an appeal needed to be filed in writing within five days of an oral appeal, or within 30 days, and the provider manual listed the time frame for filing an appeal as 180 days. HSAG recommends that Molina ensure documents reflect that a member has 60 days from the NABD to file an appeal, to improve timely access to service.

Molina submitted a sample extension template letter that did not include notification of the member's right to grieve the extension. Molina should update policies, procedures, and templates to include this language.

VALIDATION OF NETWORK ADEQUACY

Table 2-47 displays the match percentage for provider information between the data submitted by Molina and all MCOs (excluding HOME) and the online provider directory. Table 2-48 reflects the percentage of providers who have the service listed as available on Molina's online directory as compared to all MCOs (excluding HOME).

Table 2-47—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Molina and All MCOs

Provider Information	Molina			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	259	96.5%	3.5%	809	98.6%	1.4%
Provider Middle Name	259	97.3%	2.7%	809	94.7%	5.3%
Provider Last Name	259	100.0%	0.0%	809	99.5%	0.5%
Provider Address 1	259	92.3%	7.7%	809	91.1%	8.9%
Provider Address 2	259	95.0%	5.0%	809	91.7%	8.3%
Provider City	259	95.4%	4.6%	809	94.4%	5.6%
Provider State	259	100.0%	0.0%	809	99.4%	0.6%
Provider Zip Code	259	93.8%	6.2%	809	92.5%	7.5%
Provider County	259	0.0%	100.0%	809	0.2%	99.8%
Provider Specialty*	259	100.0%	0.0%	809	91.6%	8.4%
Provider Accepting New Patients	259	81.1%	18.9%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-48—Percentage of Provider Service Information Available in Online Directory for Molina and All MCOs

Available Services Information	Molina			All MCOs (excluding HOME)		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	259	97.3%	2.7%	809	65.8%	34.1%
Non-English Language Speaking Provider	259	99.6%	0.4%	809	91.6%	8.4%
Provider Accommodates Physical Disabilities	259	51.0%	49.0%	809	43.8%	56.1%
Provider Completed Cultural Competency Training	259	0.4%	99.6%	809	41.8%	58.1%
Provider URL	259	0.0%	100.0%	809	14.1%	85.9%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-49 displays the number and percent of provider categories wherein Molina met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-49—Compliance With Time/Distance Standards by Provider Domain—Molina

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
PCP—Adult	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	3	3	100.0%
Behavioral Health—Facilities	4	3	75.0%

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

Strengths

Molina's PDV indicated that 69.1 percent of the sampled providers were found in the health plan's online provider directory. Apart from provider information related to Provider County and Provider Accepting New Patients fields, Molina's match rate between submitted data and the online directory information exceeded 90 percent for all provider fields. Additionally, Molina's website noted that the most recent update to the paper directory was in October 2020 when HSAG reviewed the websites on October 26, 2020.

Geographic network distribution analysis indicated that Molina met 88.6 percent of the statewide time/distance standards and met 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Hospitals, and Behavioral Health—Adult provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Molina's online provider directory is critical for members to have timely access to appropriate health care providers. HSAG recommends that Molina frequently update its online provider directory with the required, accurate provider information and have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website. HSAG also recommends that Molina include provider information on cultural competency training, physical disability accommodation, and provider URL, since less than 2 percent of sampled providers found online included information about these services.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Molina should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Molina met the time/distance standards for 39 of the 44 (88.6 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-50. Additionally, Molina did not report any Mammography facilities or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Molina should continue to assess areas of inadequacy to identify providers who chose not to contract with Molina and the inability to identify the providers in the data using the standard definitions.

Table 2-50—Provider Categories That Failed to Meet Time/Distance Standards—Molina

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
Ancillary—Facilities	Pharmacy
Behavioral Health—Facilities	Behavioral Health Hospital

SelectHealth

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, SelectHealth submitted its clinical PIP topic: *7–Day Follow–Up After Hospitalization for Mental Illness for Medicaid Integration Members.*

Validation Results

Table 2-51 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met.*

Table 2-51—CY 2020 Performance Improvement Project Validation Results for SelectHealth (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
	Implementation Total	**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (7/7)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

SelectHealth had not progressed to reporting data in this validation cycle.

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

Strengths

SelectHealth designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The PIP topic selected by SelectHealth addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- SelectHealth must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- SelectHealth must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

SelectHealth's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

SelectHealth's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. SelectHealth's sample of credentialed providers included a psychiatrist, nurses, a physician assistant, licensed social workers, psychologists, and a certified counselor. HSAG reviewed a sample of 10 prior authorization denial records and a sample of 10 appeal records. SelectHealth submitted a sample of two grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records SelectHealth submitted and through conducting a virtual, web-based review consisting of interviews with key SelectHealth staff members.

Strengths

SelectHealth's policies, procedures, submitted evidence, and interviews all supported a detailed UM process. SelectHealth staffed and structured its UM department in a way that resulted in systematic, timely reviews of authorization requests. SelectHealth further supported its UM department via a software platform that allowed staff members to store and disseminate information. The denial record review confirmed that SelectHealth mailed NABD letters in a timely manner, engaged medical professionals in a consistent review of documentation when needed, and made support staff available over weekends to ensure it met turnaround times for expedited requests and outpatient drug authorizations. A diverse UM department membership aligned with federal requirements, and staff participated in both the Drug Utilization Review Board and pharmacy and therapeutics committees. These committees were active and made timely decisions regarding formulary changes.

SelectHealth provided evidence that it delivers and coordinates care for its UMIC population. SelectHealth had embedded initial screening and comprehensive assessments in its care management documentation system (CareRadius). SelectHealth provided a Collaborative Care Program description that described levels of care management based on a predictive modeling program used to determine outreach efforts to minimize care gaps and determine care planning goals. SelectHealth staff members described best practices for ensuring members were connected with care managers and a PCP. These included allowing existing providers to serve UMIC members for up to 90 days following enrollment, using a vendor to outreach to members with care gaps, and recently developing a program (at the time of the virtual audit) designed to reach out to members to ensure they know how to choose a PCP and encouraging them to do so.

SelectHealth used a vendor, Eliza, to place initial automated calls to members. SelectHealth staff members reported that the Eliza system made six attempts to reach members. Staff members also reported that if a member were identified as needing care management services based on care gaps and the assigned care manager was unable to reach the member, SelectHealth would send a letter encouraging the member to contact the care manager.

SelectHealth had adequate policies that addressed privacy requirements in 45 CFR parts 160 and 164. Policies and procedures addressed release of information for sharing records, disclosure requirements, access limitations, minimum access necessary, and technical and physical access safeguards.

SelectHealth had a designated team and policies and procedures for addressing grievances and appeal requests. SelectHealth's documentation system captured all the required elements, including the credentials of the decision maker, and allowed staff to ensure that decision makers had not been involved in the original denial decision and had the appropriate clinical expertise. SelectHealth had completed all appeals HSAG reviewed during the virtual audit and had sent notice to the members according to the required time frames.

During the period under review, SelectHealth maintained policies that guided the processes for building and maintaining its provider network. During the interview, SelectHealth's medical staff and provider data director described the processes for initial credentialing and recredentialing that aligned with SelectHealth's policies and were compliant with federal regulations and State contract requirements. HSAG reviewed a sample of credentialing records and found full compliance with requirements, including evidence that SelectHealth obtained and reviewed the application for appointment, verified licensure and education, and conducted searches against federal exclusion lists prior to appointment for each provider file reviewed.

SelectHealth presented extensive evidence through policy, procedures, interviews, and live demonstration during the virtual audit which supported a comprehensive QAPI program. SelectHealth monitored service utilization, member outcomes, satisfaction, and key performance measures through various interconnected software and reporting platforms. SelectHealth discussed sharing timely data with providers via dashboards aimed to support the medical home model. SelectHealth used these dashboards to engage low-performing providers in improvement efforts, congratulate high-performing

providers, and analyze gaps in care where additional outreach was needed. Staff members described that data sharing "goes both ways," meaning SelectHealth was both sending and receiving key information through secure data exchanges to develop a comprehensive view of the UMIC population. Additionally, SelectHealth was in the beginning phases of implementing behavioral health performance measures and was actively working with UDOH to gather a more complete view of pharmacy data.

Opportunities for Improvement and Recommendations

Within the denial records, HSAG identified five instances wherein a member received a verbal denial regarding an out-of-network (OON) provider. In conjunction with other findings regarding network adequacy and member information related to the provider directory, this finding suggests that SelectHealth should analyze its network and outreach providers to join the integrated health plan.

SelectHealth described a mechanism to extend authorization decision timelines to obtain additional provider information; however, HSAG found SelectHealth's outreach during the standard 14-calendar-day time frame to be minimal. In one record review, SelectHealth made only one outreach attempt prior to the extension, and SelectHealth sent the denial decision letter as its second provider contact. Staff members stated that SelectHealth outreached to providers to request documents within 24 hours prior to the time frame expiring. If SelectHealth did not receive the requested documentation within 24 hours, it would immediately issue an extension. HSAG recommends that SelectHealth enhance its policies and procedures to use the standard authorization time frame more effectively prior to issuing extensions.

Through its record review, HSAG also noted five instances wherein a member requested OON providers, but SelectHealth's advocate team mislabeled these requests as denials. Based on the prevalence of these instances, HSAG recommends that SelectHealth assess the existing provider network and develop a process of recruiting these OON providers, when suitable.

Although SelectHealth sent all observed denials to members in a timely manner, its Preauthorization Notification Standards policy incorrectly described the urgent authorization timeline as three days instead of 72 hours. Additionally, while staff correctly described the time frames for sending denials, the Preauthorization Notification Standards policy described a process of "stopping the clock" when discussing extensions, which could negatively impact the timely access to care.

Most denial letters were easy to read at the sixth-grade reading level; however, three samples did include clinical terminology without common-language explanations. HSAG encourages SelectHealth to consider a method, such as an editorial review prior to the release of critical member letters, to ensure that member letters are easy to understand and meet language requirements outlined in 42 CFR §438.10(c).

Although SelectHealth's grievance and appeals policies correctly defined the term "grievance," its operational practices were such that not all grievances seemed to be captured and tracked as grievances, potentially impacting the quality of services. In addition, documentation in the grievance

files HSAG reviewed indicated that members are "offered" the opportunity to file a grievance or a "formal grievance." Requiring members to complete a second step after expressing dissatisfaction may discourage members from continuing to discuss issues or may prevent subsequent phone calls to grieve. Further, while policies and procedures accurately included provisions for acknowledging grievances, SelectHealth's process impeded members from receiving acknowledgment that they had filed a grievance (i.e., placed a call expressing dissatisfaction). The process of offering the grievance filing indicated that SelectHealth did not consider the initial call of complaint the grievance or acknowledge it as such. In addition, the documentation in the grievance records did not include evidence that the member was contacted either verbally or in writing to provide resolution. HSAG suggests that senior grievance and appeal leadership develop a process to ensure that, at the point the member expresses dissatisfaction, SelectHealth staff members log and track the contact and treat it as a grievance, including documentation of acknowledgement and resolution.

HSAG's review of attachments to the appeal resolution letters sent to the members identified many errors, including incorrect information regarding the continuation of benefits. The attachment did not notify members that they may have to pay for any continued services if the denial is upheld and did not clarify that although the request for continued services must be made withing 10 days of the NABD or before the effective date of the termination or reduction of services, the appeal may still be submitted up to 60 days from the date of the NABD. Further, while SelectHealth submitted policies outlining the process for extensions of the appeal time frame, the policy and record review did not provide evidence that SelectHealth had operationalized a process for notifying the member of the right to grieve the extension.

Member satisfaction survey results included low scores in terms of members "reaching their personalized goals." HSAG encourages SelectHealth to continue working with members to ensure they are engaged with understanding their individualized treatment goals.

Pertaining to the access and timeliness of care, HSAG reviewed the NAV report SelectHealth submitted and found that the network for Washington County was not evaluated against the time and distance standards set forth in the Utah contract. In addition, SelectHealth did not consider pharmacy providers when evaluating the network. SelectHealth did not show evidence that it provided family planning services or monitored them for sufficiency. During the interview, staff members discussed the availability of family planning providers, but SelectHealth reported that it did not monitor the network for timely access to these providers during the review period. While the Access and Availability Guidance document SelectHealth supplied outlined standards for timely access, SelectHealth did not have specific provisions in the document to take corrective action when a provider or provider's office failed to comply.

SelectHealth did not have a policy that described the process for ensuring that members receive notice of any significant change in the required informational materials at least 30 days prior to the change. In addition, staff were unable to articulate the process SelectHealth uses to inform members of significant changes. HSAG suggests that SelectHealth develop a mechanism to provide members

written notice of any significant change in the information required in §438.10(g) at least 30 days before the intended effective date of the change.

SelectHealth submitted its Medicaid Compliance & FWA Workplan, which did not include language with specific procedures for disclosing prohibited affiliations, ownership, and excess payments. The Medicaid Agreement Addendum included an overarching statement indicating that if SelectHealth becomes insolvent or bankrupt, members are not liable for any of SelectHealth's debts. However, the statement did not include the additional language required in 42 CFR §438.106. Further, SelectHealth's written delegation agreements did not include all required language.

VALIDATION OF NETWORK ADEQUACY

Table 2-52 displays the match percentage for provider information between the data submitted by SelectHealth and all MCOs (excluding HOME) and the online provider directory. Table 2-53 reflects the percentage of providers who have the service listed as available on SelectHealth's online directory as compared to all MCOs (excluding HOME).

Table 2-52—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for SelectHealth and All MCOs

Provider Information	SelectHealth			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	198	99.5%	0.5%	809	98.6%	1.4%
Provider Middle Name	198	85.9%	14.1%	809	94.7%	5.3%
Provider Last Name	198	99.0%	1.0%	809	99.5%	0.5%
Provider Address 1	198	86.4%	13.6%	809	91.1%	8.9%
Provider Address 2	198	89.9%	10.1%	809	91.7%	8.3%
Provider City	198	92.4%	7.6%	809	94.4%	5.6%
Provider State	198	99.5%	0.5%	809	99.4%	0.6%
Provider Zip Code	198	88.9%	11.1%	809	92.5%	7.5%
Provider County	198	1.0%	99.0%	809	0.2%	99.8%
Provider Specialty*	198	93.4%	6.6%	809	91.6%	8.4%
Provider Accepting New Patients	198	26.8%	73.2%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-53—Percentage of Provider Service Information Available in Online Directory for SelectHealth and All MCOs

Available Services Information	SelectHealth			All MCOs (excluding HOME)		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	198	67.2%	32.8%	809	65.8%	34.1%
Non-English Language Speaking Provider	198	75.8%	24.2%	809	91.6%	8.4%
Provider Accommodates Physical Disabilities	198	70.2%	29.8%	809	43.8%	56.1%
Provider Completed Cultural Competency Training	198	75.3%	24.7%	809	41.8%	58.1%
Provider URL	198	26.8%	73.2%	809	14.1%	85.9%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-54 displays the number and percent of provider categories wherein SelectHealth met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-54—Compliance With Time/Distance Standards by Provider Domain—SelectHealth

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
PCP—Adult	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	3	50.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	3	2	66.7%
Behavioral Health—Facilities	4	2	50.0%

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

Strengths

While SelectHealth's PDV indicated that only 54.5 percent of the sampled providers were found in the health plan's online provider directory, the provider specialty information matched with the submitted

data for the majority of the providers found online. Additionally, the health plan had the highest percentage of sampled providers found in the online directory who included service information on physical disability accommodation (70.2 percent).

Geographic network distribution analysis indicated that SelectHealth met 84.1 percent of the time/distance standards and met 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Hospitals, and Ancillary—Facilities provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in SelectHealth's online provider directory is critical for members to have timely access to appropriate health care providers. 40.2 percent of the sampled providers were not found in SelectHealth's online provider directory. Additionally, 5.2 percent of the provider locations were not found in the directory. Even among providers found online, SelectHealth had a lower match rate for providers accepting new patients (26.8 percent) compared to the other MCOs. HSAG recommends that SelectHealth frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that SelectHealth have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. SelectHealth should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, SelectHealth met the time/distance standards for 37 of the 44 (84.1 percent) provider categories. The provider categories that did not meet the standards are listed Table 2-55. While failure to meet some of the standards might result from lack of providers, SelectHealth should continue to assess areas of inadequacy to identify providers who chose not to contract with SelectHealth and the inability to identify the providers in the data using the standard definitions.

Table 2-55—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth

Provider Domain	Provider Category
Additional Physical Health—Facilities	Laboratory; Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit

Medicaid PIHP and PAHP PMHPs Providing Mental Health and/or Substance Use Disorder Services

Bear River Mental Health Services (Bear River)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Bear River submitted its PIP topic: *Suicide Prevention.*

Validation Results

Table 2-56 summarizes the validation findings for each stage validated for CY 2020. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 2-56—CY 2020 Performance Improvement Project Validation Results for Bear River (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
	Implementation Total	**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**95% (19/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Bear River progressed to reporting Remeasurement 4 results for the two study indicators.

The baseline rate for the percentage of eligible members who received the Columbia-Suicide Severity Rating Scale (C-SSRS) screening was 7.9 percent, which increased to 27.6 percent for Remeasurement 1, 54.1 percent for Remeasurement 2, and 55.9 percent for Remeasurement 3. For Remeasurement 4, the Study Indicator 1 rate of 52.7 percent decreased from the Remeasurement 3 rate by 3.2 percentage points; however, Bear River sustained the statistically significant increase ($p < 0.0001$) of 44.8 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 36.2 percent, which increased to 77.6 percent for Remeasurement 1 and then decreased to 59.5 percent for Remeasurement 2, following by an increase to 83.5 percent for Remeasurement 3. For Remeasurement 4, the Study Indicator 2 rate of 86.7 percent was 3.2 percentage points above the Remeasurement 3 rate and sustained the statistically significant increase ($p < 0.0001$) of 50.5 percentage points over the baseline.

Bear River was able to sustain statistically significant improvement over the baseline for four consecutive measurement periods for both study indicators.

Table 2-57 displays data for Bear River's *Suicide Prevention* PIP.

Table 2-57—PIP—*Suicide Prevention*
Bear River

Study Indicator	Baseline Period 01/01/2015–12/31/2015		Remeasurement 1 01/01/2016–12/31/2016		Remeasurement 2 01/01/2017–12/31/2017		Remeasurement 3 01/01/2018–12/31/2018		Remeasurement 4 01/01/2019–12/31/2019		Sustained Improvement
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 218	7.9%	N: 820	27.6%*	N: 1,440	54.1%*	N: 1,857	55.9%*	N: 1,450	52.7%*	*Yes*
	D: 2,746		D: 2,966		D: 2,660		D: 3,323		D: 2,751		
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 38	36.2%	N: 342	77.6%*	N: 261	59.5%*	N: 222	83.5%*	N: 346	86.7%*	*Yes*
	D: 105		D: 441		D: 439		D: 266		D: 399		

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

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

Strengths

Bear River designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Bear River reported and analyzed its Remeasurement 4 data accurately. Bear River conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers, and had a positive impact on the study indicator outcomes. Additionally, Bear River's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Bear River's PIP aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions based on level of risk. By increasing the percentage of members who received a C-SSRS screening during a face-to-face outpatient visit and the percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan, the health plan increases the likelihood of desired health outcomes of its members through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

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 activities completed and validated. Bear River was able to sustain improvement for three consecutive measurement periods for both study indicators.

HSAG recommends the following:

- Bear River has demonstrated sustained improvement in this PIP for four consecutive remeasurement periods. The health plan should consider a new PIP topic for next year's submission in consultation with UDOH.
- Bear River must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Bear River should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-58 presents Bear River's measurement year (MY) 2020 performance measure results.

Table 2-58—Bear River MY 2020 *FUH* Results

Indicator	Bear River Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	60.16%	52.33%
Follow-Up Within 30 Days	69.92%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Bear River demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Bear River also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Bear River provided HSAG a detailed case listing of the numerator and denominator cases. There was an additional case listed, and during PSV it was identified that the case was a result of retroactive eligibility. Consequently, HSAG recommends that in the future, Bear River submit the case listing at the same time they submit the State's custom rate template.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Bear River's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Bear River's sample of credentialed providers included a certified mental health counselor and two licensed social workers. HSAG reviewed a full sample of 10 grievance records. Bear River reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Bear River submitted and through conducting a virtual, web-based review consisting of interviews with key Bear River staff members.

Strengths

In CY 2020 Bear River submitted a revised NABD template letter which indicated a corrected time frame (120 days from the appeal resolution) for a member to file for a State fair hearing, potentially positively impacting the quality and timeliness of care. In CY 2019, HSAG had reviewed Bear River's Medicaid provider directory and found that it was not up to date with Bear River's current Medicaid provider list (created October 2018). In addition, the provider directory only included a blanket statement for providers' linguistic capabilities. Following the review, Bear River developed a mechanism to ensure that the information included in the paper provider directory is updated at least monthly, that electronic provider directories are updated no later than 30 calendar days after Bear River receives updated provider information, and that these directories include linguistic capabilities and languages (including American Sign Language) offered by each provider or provider's office. Bear River submitted a link to its online provider directory which included a current list of providers and their linguistic capabilities.

For both CY 2018 and 2019, HSAG had found that Bear River did not have a method to ensure members received the services for which providers were billing. For the CY 2020 compliance review, Bear River submitted a spreadsheet that demonstrated its method to query a sample of members

monthly to determine whether they received services that network providers or employed providers represented as having been delivered. HSAG reviewed the spreadsheet and found compliance with the requirement.

HSAG reviewed a sample of initial credentialing files and found that Bear River had obtained an application, verified education and licensure, and checked the providers against federal exclusion lists prior to hire. HSAG found full compliance with the credentialing records.

HSAG reviewed a sample of grievances and found that each grievance was acknowledged immediately and resolved within the allotted 90-day time frame, and that each resolution letter included the required information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement as a result of the follow-up compliance review.

VALIDATION OF NETWORK ADEQUACY

Table 2-59 displays the match percentage for provider information between the data submitted by Bear River and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-59—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Bear River and All PMHPs

Provider Information	Bear River			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	32	93.8%	6.3%	364	97.3%	2.7%
Provider Middle Name	32	84.4%	15.6%	364	85.7%	14.3%
Provider Last Name	32	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	32	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	32	100.0%	0.0%	364	93.7%	6.3%
Provider City	32	100.0%	0.0%	364	95.6%	4.4%
Provider State	32	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	32	96.9%	3.1%	364	97.5%	2.5%
Provider County	32	62.5%	37.5%	364	24.5%	75.5%

Table 2-60 displays the number and percent 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.

Table 2-60—Compliance With Time/Distance Standards by Urbanicity—Bear River

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Bear River	9	2	22.2%	2	22.2%	0	0.0%

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

Strengths

Bear River's PDV indicated that 100 percent of the sampled providers were found in the health plan's online provider directory. Additionally, the health plan had 100 percent match percentages for Provider Last Name and all address fields except ZIP Code and Provider County. Bear River also included a last updated date on the provider online directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Bear River's online provider directory is critical for members to have timely access to appropriate health care providers. Bear River should continue to frequently update its online provider directory with the required, accurate provider information. HSAG recommends that Bear River have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Bear River should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Bear River did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-61. While failure to meet some of the standards might result from lack of providers, Bear River should continue to assess areas of inadequacy to identify providers who chose

not to contract with Bear River and the inability to identify the providers in the data using the standard definitions.

Table 2-61—Provider Categories That Failed to Meet Time/Distance Standards—Bear River*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Central Utah Counseling Center (Central)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Central submitted its new clinical PIP topic: *Inpatient Readmission Rates*.

Validation Results

Table 2-62 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-62—CY 2020 Performance Improvement Project Validation Results for Central (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
	Implementation Total	**100% (4/4)**	**0% (0/4)**	**0% (0/4)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (12/12)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (7/7)**		
Validation Status		***Met***		

Indicator Outcomes

Central had not progressed to reporting baseline data during this validation cycle.

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

Strengths

Central designed a scientifically sound project and implemented system interventions that were related to barriers identified through QI processes and have the potential to drive improvement toward the desired outcomes. Central's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Central's PIP aims to improve processes and outcomes of members' mental health care and to decrease readmission to inpatient psychiatric hospitals within 12 months of discharge.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Central must ensure that it follows the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.

- Central must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Central must have a process in place for evaluating each PIP intervention and its impact on the study indicator and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-63 presents Central's MY 2020 performance measure results.

Table 2-63—Central MY 2020 *FUH* Results

Indicator	Central Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	**42.00%**	52.33%
Follow-Up Within 30 Days	78.00%	67.11%

Rates in **red** font indicate the rate fell below the statewide PMHP average.
*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Central demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Central also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information. Central implemented conditional formatting with its spreadsheet, which assisted Central staff in identifying which members were to be included in the rate calculation.

Opportunities for Improvement and Recommendations

Central's rates for members hospitalized for mental illness who received a follow-up visit within seven days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Central focus on improvement efforts designed to ensure that members receive a Central-furnished service within seven days following discharge from a hospitalization.

HSAG did not identify any recommendations as a result of the PMV process.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations. As such, for the CY 2020 review, HSAG did not conduct a review of federal regulations or State contract requirements.

HSAG did, however, request and review a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Central's sample of credentialed providers included a certified mental health counselor, a case manager, and a social worker. Central submitted a sample of one grievance record for the period under review. Central reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Central submitted and through conducting a virtual, web-based review consisting of interviews with key Central staff members.

Strengths

During the period under review, Central conducted initial credentialing for three new providers. The providers included a social worker, a skills group aide, and a therapist. HSAG reviewed the personnel files for each provider. HSAG found that Central had collected an application, verified licensure and education (as appropriate), and checked the providers against federal exclusion lists prior to hire. HSAG found full compliance with the credentialing files reviewed.

During the period under review, Central reported receiving one grievance. The grievance came from a member who called to complain about being treated unfairly. Central used an internal form to document the grievance. The form included all required information. Central resolved the grievance with the member in a timely manner.

Opportunities for Improvement and Recommendations

HSAG noted that one grievance (the full sample of reported grievances) over a five-month period is an unusually small quantity. HSAG suggests that Central review its grievance collection policies and procedures to ensure it is properly tracking and documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-64 displays the match percentage for provider information between the data submitted by Central and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-64—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Central and All PMHPs

Provider Information	Central			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	19	89.5%	10.5%	364	97.3%	2.7%
Provider Middle Name	19	89.5%	10.5%	364	85.7%	14.3%
Provider Last Name	19	94.7%	5.3%	364	98.9%	1.1%
Provider Address 1	19	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	19	42.1%	57.9%	364	93.7%	6.3%
Provider City	19	100.0%	0.0%	364	95.6%	4.4%
Provider State	19	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	19	100.0%	0.0%	364	97.5%	2.5%
Provider County	19	0.0%	100.0%	364	24.5%	75.5%

Table 2-65 displays the number and percent 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.

Table 2-65—Compliance With Time/Distance Standards by Urbanicity—Central

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Central	9	2	22.2%	2	22.2%	0	0.0%

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

Strengths

While Central's PDV indicated that only 67.9 percent of the sampled providers were found in the health plan's online provider directory, the health plan's website clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan had a 100 percent match between submitted data and the online provider directory for Provider Address 1, City, State, and Zip Code fields.

Opportunities for Improvement and Recommendations

Accurate provider information in Central's online provider directory is critical for members to have timely access to appropriate health care providers. In CY 2020, 25 percent of the sampled providers could not be found in the online directory, and an additional 7.1 percent of the provider locations could not be found in the health plan's online directory. Central should continue to frequently update its online provider directory with the required, accurate provider information. HSAG also recommends that Central include the last updated date on its provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Central should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Central did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-66. While failure to meet some of the standards might result from lack of providers, Central should continue to assess areas of inadequacy to identify providers who chose not to contract with Central and the inability to identify the providers in the data using the standard definitions.

Table 2-66—Provider Categories That Failed to Meet Time/Distance Standards—Central*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Davis Behavioral Health (Davis)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Davis submitted its new clinical PIP topic: *Access to Care.* The PIP submitted by Davis 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

Table 2-67 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-67—CY 2020 Performance Improvement Project Validation Results for Davis (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
	Implementation Total	**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (15/15)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (8/8)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Davis progressed to reporting baseline results. 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. 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.

Table 2-68 displays data for Davis's *Access to Care* PIP.

Table 2-68—PIP—*Access to Care*
Davis

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2019–12/31/2019)**		**Sustained Improvement**
1. Percentage of initial appointments scheduled within 7 calendar days from first contact.	N: 126	29.4%	*Not Assessed*
	D: 428		
2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	N: 195	86.3%	*Not Assessed*
	D: 226		

N–Numerator D–Denominator

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

Strengths

Davis designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Davis reported baseline data accurately, used appropriate QI processes, and implemented interventions that have the potential to drive improvement toward the desired outcomes. Davis's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of, and access to care and services.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Davis must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Davis must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Davis must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-69 presents Davis's MY 2020 performance measure results.

Table 2-69—Davis MY 2020 *FUH* Results

Indicator	Davis Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	70.15%	52.33%
Follow-Up Within 30 Days	82.84%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Davis demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Davis also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Although HSAG did not identify any specific opportunities for improvement or recommendations for Davis, and Davis's *FUH* rates were above the statewide PMHP average, continued opportunities to improve rates exist.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Davis's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Davis's sample of credentialed providers included two nurses, a certified mental health counselor, a social work intern, a physician prescriber, a health service technician, and four licensed social workers. Davis reported 11 grievances for the period under review; however, Davis later determined that two of the grievances were not from Medicaid members. HSAG reviewed the nine remaining Medicaid member grievance records. Davis reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Davis submitted and through conducting a virtual, web-based review consisting of interviews with key Davis staff members.

Strengths

HSAG reviewed a full sample of 10 initial credentialing files and found that for all files, Davis provided evidence that applicants' names were searched against the federal exclusion database prior to hire.

Of the nine grievance records reviewed, HSAG found that Davis had acknowledged and resolved all grievances in a timely manner. HSAG found full compliance with Davis's grievance submission.

In CY 2019, HSAG reviewed Davis's online provider directory for its employed providers and found that the directory only included a list of the provider names and professional designations. In CY 2020, Davis provided evidence that it had updated the provider directory for its contracted and employed providers to include all required demographic information concerning its network providers.

Opportunities for Improvement and Recommendations

Pertaining to the credentialing record review, HSAG found that for the clinical mental health counselor, Davis did not verify the provider's education and licensure until after the provider was hired. HSAG recommends that Davis conduct a periodic review of its credentialing records to ensure that all requirements are met.

VALIDATION OF NETWORK ADEQUACY

Table 2-70 displays the match percentage for provider information between the data submitted by Davis and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-70—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Davis and All PMHPs

Provider Information	Davis			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	83	96.4%	3.6%	364	97.3%	2.7%
Provider Middle Name	83	98.8%	1.2%	364	85.7%	14.3%
Provider Last Name	83	97.6%	2.4%	364	98.9%	1.1%
Provider Address 1	83	83.1%	16.9%	364	92.9%	7.1%
Provider Address 2	83	97.6%	2.4%	364	93.7%	6.3%
Provider City	83	98.8%	1.2%	364	95.6%	4.4%
Provider State	83	98.8%	1.2%	364	99.7%	0.3%
Provider Zip Code	83	97.6%	2.4%	364	97.5%	2.5%
Provider County	83	45.8%	54.2%	364	24.5%	75.5%

Table 2-71 displays the number and percent 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.

Table 2-71—Compliance With Time/Distance Standards by Urbanicity—Davis

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Davis	9	6	66.7%	0	0.0%	3	33.3%

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

Strengths

While Davis's PDV indicated that 83.8 percent of the sampled providers were found in the health plan's online provider directory, the health plan's website clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan's match rate between submitted data and the online provider directory for all fields exceeded 90 percent except for Provider Address 1 and Provider County.

Opportunities for Improvement and Recommendations

Accurate provider information in Davis's online provider directory is critical for members to have timely access to appropriate health care providers. In CY 2020, 13.1 percent of the sampled providers could not be found in the online directory, and an additional 3 percent of the provider locations could not be found in the health plan's online directory. Davis should continue to frequently update its online provider directory with the required, accurate provider information. HSAG also recommends that Davis include the last updated date on its provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Davis should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Davis did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements for members in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the

standards are listed in Table 2-72. While failure to meet some of the standards might result from lack of providers, Davis should continue to assess areas of inadequacy to identify providers who chose not to contract with Davis and the inability to identify the providers in the data using the standard definitions.

Table 2-72—Provider Categories That Failed to Meet Time/Distance Standards—Davis*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Four Corners Community Behavioral Health (Four Corners)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Four Corners submitted its new clinical PIP topic: *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*. The PIP submitted by Four Corners aims to improve processes and outcomes to ensure members with an opioid use disorder (OUD) are getting the support and outreach needed to maintain engagement and participation in treatment.

Validation Results

Table 2-73 summarizes the validation findings for the Design stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-73—CY 2020 Performance Improvement Project Validation Results for Four Corners (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	Implementation Total	**Not Assessed**		
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	**Not Assessed**		
	Percentage Score of Applicable Evaluation Elements *Met*	**100% (8/8)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100% (5/5)**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2020, Four Corners had not progressed to reporting data in this validation cycle.

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

Strengths

Four Corners designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Four Corners' study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of, and access to care and services.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Four Corners must ensure that it follows the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.

- To impact the Remeasurement 1 study indicator rate, Four Corners should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Four Corners must document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Four Corners must implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Four Corners must have a process in place for evaluating each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-74 presents Four Corners' MY 2020 performance measure results.

Table 2-74—Four Corners MY 2020 *FUH* Results

Indicator	Four Corners Rate*	Statewide PMHP Average**
Follow-Up Within 7 Days	**37.50%**	52.33%
Follow-Up Within 30 Days	**50.00%**	67.11%

*Anything with a small denominator is likely to be subject to wild swings in performance and interpretations should be made with caution.
**Statewide Average excludes HOME which falls into the MCO section above.
Rates in **red** font indicate the rate fell below the statewide PMHP average.

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

Strengths

Four Corners demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Four Corners also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Four Corners' rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Four Corners focus on improvement efforts designed to ensure that members receive a Four Corners-furnished service within seven days and within 30 days following discharge from a hospitalization.

HSAG did not identify any recommendations as a result of the PMV process.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Four Corners' CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Four Corners' sample of credentialed providers included a licensed practical nurse and a peer support specialist. Four Corners reported four grievances for the period under review. Four Corners reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Four Corners submitted and through conducting a virtual, web-based review consisting of interviews with key Four Corners staff members.

Strengths

In CY 2018, upon review of the member handbook and other written member information, HSAG found that Four Corners did not include taglines in large print (18 point) and prevalent non-English languages. In CY 2019, HSAG identified the taglines but noted that they were not in large print (18-point) font. For CY 2020, Four Corners updated its member handbook to include the taglines in 18-point font.

During the prior compliance monitoring reviews, HSAG found that Four Corners did not have a provider directory in written or electronic form. In CY 2020, HSAG found that Four Corners maintained a comprehensive provider list on its website, which included all required elements.

HSAG reviewed a sample of initial credentialing files and found that Four Corners had collected an application, verified education and licensure, and checked the providers against federal exclusion lists prior to hire. HSAG found full compliance with the credentialing records.

Four Corners submitted four grievances representing the full sample for the period under review. HSAG reviewed the grievances and found that Four Corners acknowledged and resolved each grievance within the allotted time frame and included the required information in the resolution letter.

Opportunities for Improvement and Recommendations

Pertaining to the grievance record review, HSAG suggests that Four Corners consider a way to document the grievance acknowledgement more prominently in the grievance file. HSAG suggests that Four Corners consider whether it is capturing all grievances, as four is not many for a five-month period.

VALIDATION OF NETWORK ADEQUACY

Table 2-75 displays the match percentage for provider information between the data submitted by Four Corners and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-75—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Four Corners and All PMHPs

Provider Information	Four Corners			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	22	95.5%	4.5%	364	97.3%	2.7%
Provider Middle Name	22	68.2%	31.8%	364	85.7%	14.3%
Provider Last Name	22	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	22	95.5%	4.5%	364	92.9%	7.1%
Provider Address 2	22	95.5%	4.5%	364	93.7%	6.3%
Provider City	22	100.0%	0.0%	364	95.6%	4.4%
Provider State	22	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	22	100.0%	0.0%	364	97.5%	2.5%
Provider County	22	13.6%	86.4%	364	24.5%	75.5%

Table 2-76 displays the number and percent 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.

Table 2-76—Compliance With Time/Distance Standards by Urbanicity—Four Corners

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Four Corners	9	3	33.3%	3	33.3%	0	0.0%

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

Strengths

While Four Corners' PDV indicated that 88 percent of the sampled providers were found in the health plan's online provider directory, the health plan's website clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan's match rates between submitted data and the online provider directory for all fields exceeded 95 percent except for Provider Middle Name and Provider County.

Opportunities for Improvement and Recommendations

Accurate provider information in Four Corners' online provider directory is critical for members to have timely access to appropriate health care providers. Four Corners should continue to frequently update its online provider directory with the required, accurate provider information. HSAG also recommends that Four Corners include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Based on HSAG's feedback from CY 2019 compliance reviews, Four Corners responded that the provider directory has been updated to include whether the providers will accept new members, and the cultural and linguistic capabilities offered by the provider or provider's office. However, these fields were not assessed in the CY 2020 PDV for the PMHPs.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Four Corners should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Four Corners did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements for members in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-77. While failure to meet some of the standards might

result from lack of providers, Four Corners should continue to assess areas of inadequacy to identify providers who chose not to contract with Four Corners and the inability to identify the providers in the data using the standard definitions.

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

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Healthy U

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Healthy U submitted its new clinical PIP topic, *Improving Follow-up After Hospitalization for Mental Illness*, for its Summit County PMHP members.

Validation Results

Table 2-78 summarizes the validation findings for the Design stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-78—CY 2020 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
	Implementation Total	**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (8/8)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Healthy U had not progressed to reporting baseline data during this validation cycle.

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

Strengths

Healthy U designed a scientifically sound project. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Healthy U's PIP topic addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Healthy U must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- Healthy U must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

Healthy U's PMHP program began providing services to members in September 2019 and did not have any members who met the discharge criteria for the *FUH-UT* measure during the measurement period due to enrollment specifications. However, the PMHP demonstrated the IS and processes necessary to collect, calculate, and report complete and accurate results that would lead to an "R" audit designation even though Healthy U did not report any rates (i.e., denominator or numerator).

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

Strengths

Healthy U demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Healthy U also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Healthy U.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Healthy U's behavioral health line of business, providing coverage in Summit County, initiated operations in September 2019. As such, HSAG conducted a full review of all standards. For the CY 2020 compliance monitoring activities, HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Healthy U's sample of credentialed providers included a licensed social worker, advance practice RNs, physicians, a behavioral analyst, and a marriage and family therapist. Healthy U submitted a full sample inclusive of one prior authorization denial record and reported that it did not have any appeals or grievances for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Healthy U submitted and through conducting a virtual, web-based review consisting of interviews with key Healthy U staff members.

Strengths

Healthy U described a matrixed UM structure that collaborated with medical management, operations, and other teams frequently. Workflows for pre-service, post-service, and TOC teams were well outlined and upheld requirements. Healthy U used Epic software throughout the organization, which ensured cohesive processes across teams to receive and process authorizations. Healthy U used InterQual consistently to make UM decisions and operated under well-documented policies and procedures to ensure timely initial and continuing authorizations. Furthermore, Healthy U conducted extensive IRR testing throughout the year. This training was further supported by a monthly physician meeting known as the "Review Roundup" where trends and learning opportunities are discussed.

Healthy U maintained and monitored a network of providers sufficient to provide access to covered health services for members, including those with limited English proficiency or physical or mental disabilities. Healthy U had mechanisms to ensure that all covered services were available and accessible to members in a timely manner.

Healthy U showcased a diverse care management program that included adult, pediatric, mom and baby, and other specialty subpopulations. The Care Management department clearly demonstrated engagement in data-driven decision making. Staff described a risk stratification methodology used to identify members who may need additional care management supports. Despite an overall influx of members, Healthy U reported that wait times to see a therapist decreased from weeks to days since implementation of the PMHP line of business.

Healthy U maintained policies and procedures that clearly delineated processes for members to file appeals and grievances, and for Healthy U staff members to review and process member grievance and appeal request submissions. Healthy U described the procedures for accepting and reviewing grievances and appeals. The process described aligned with Healthy U's policies.

Healthy U's submission of supporting documentation and evidence included policies, procedures, provider manual, sample provider agreements, sample credentialing applications, Compliance Plan and FWA Compliance Plan, annual credentialing reviews, different provider letters, and a credentialing review worksheet. HSAG reviewed all submissions and found that most of the documents substantiated compliance with provider selection, credentialing, and compliance program requirements.

Healthy U presented a robust QAPI program that included collaboration between various departments and levels of leadership. Healthy U maintained an EDW that integrated referrals and ADT feeds, and provided staff members the ability to gain insights regarding specific populations.

Additionally, the Quality team mentioned it was currently laying groundwork with stakeholders to eventually implement value-based payments. Healthy U also discussed plans to launch text messaging and email capabilities in March 2021.

Furthermore, Healthy U submitted detailed workflows and desktop procedures regarding the claims processing system. These documents outlined quality assurance measures taken to maintain accuracy, including auditing 3 percent of internal claims and 15 percent of claims that did not auto-adjudicate. Healthy U targeted 99 percent financial accuracy and 97 percent processing accuracy, and staff members attested to consistently meeting these goals.

Opportunities for Improvement and Recommendations

Upon desk review, HSAG found that multiple documents referred to NOAs, which does not reflect current contract terminology. HSAG recommends that Healthy U update all related documents to reflect the current NABD terminology to align with State and federal guidelines and reduce confusion. Healthy U's Clinical Practice Guidelines policy and UM Program Description both included definitions of "medically necessary services"; however, these definitions did not include all required criteria, negatively affecting the quality domain.

Healthy U documented and described a process for consulting with providers during the authorization review period. However, Healthy U also engaged in a denial reconsiderations process which did not adhere to State and federal denial and appeal guidelines. The Peer-to-Peer (P2P) Review Request Form and associated process were described as being used after the denial letter is mailed to the member. It is the intent of federal regulations that after the NABD has been mailed, any additional actions and decisions then fall under the appeal process. Furthermore, the denial reconsiderations process did not include additional member notices. It is the intent of federal regulations that the member be informed regarding denial and appeal decisions. Also related to provider consultation, the Pharmacy Authorization policy stated that "incomplete requests or requests received without all necessary supporting documentation may be denied for lack of documentation." While Healthy U's policy stated that expedited authorization decisions must be determined no later than 72 hours after receipt of the request, the NABD letters incorrectly stated three business days.

Within its provider manual and Appeals policy, Healthy U stated that the member must follow an oral appeal request with a written, signed appeal (unless the request is for expedited resolution); however, the provider manual also included a time frame for when written appeals must follow oral appeals (within five business days) or the member's appeal "will be closed." HSAG suggested that Healthy U remove the five-day time frame from the provider manual.

Healthy U refers subcontractors to the provider manual for information about grievance and appeal processes and the State fair hearing system at the time they enter into a contract. HSAG reviewed the provider manual and identified that the information provided was not clear and did not accurately describe the grievance and appeal processes and the State fair hearing system. HSAG also observed

that some terms were not consistent with UDOH contract language. For example, the provider manual referred to the adverse decision of a preservice authorization as a "notice of action."

Healthy U did not have a written policy and procedure that addressed conducting checks on employees and other individuals and entities to ensure that it does not employ individuals or entities excluded from participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act.

HSAG reviewed three of Healthy U's delegation agreements, none of which incorporated language regarding the right of the State, CMS, the HHS inspector general, the comptroller general, or their designee to audit, evaluate, and inspect aspects pertaining to the services and activities performed or determination of amounts payable under Healthy U's contract with the State.

VALIDATION OF NETWORK ADEQUACY

Table 2-79 displays the match percentage for provider information between the data submitted by Healthy U and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-79—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Healthy U and All PMHPs

Provider Information	Healthy U			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	4	100.0%	0.0%	364	97.3%	2.7%
Provider Middle Name	4	100.0%	0.0%	364	85.7%	14.3%
Provider Last Name	4	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	4	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	4	100.0%	0.0%	364	93.7%	6.3%
Provider City	4	100.0%	0.0%	364	95.6%	4.4%
Provider State	4	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	4	100.0%	0.0%	364	97.5%	2.5%
Provider County	4	0.0%	100.0%	364	24.5%	75.5%

Table 2-80 displays the number and percent of provider categories wherein Healthy U met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-80—Compliance With Time/Distance Standards by Urbanicity—Healthy U

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Healthy U	9	3	33.3%	4	44.4%	0	0.0%

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

Strengths

Healthy U's online provider directory noted that updates to the directories occur five days per week, excluding weekends, holidays, or interruptions due to upgrades, system maintenance, or unplanned outages.

Opportunities for Improvement and Recommendations

Accurate provider information in Healthy U's online provider directory is critical for members to have timely access to appropriate health care providers. Only four of the sampled 59 providers (6.8 percent) were found on Healthy U's online provider directory. Healthy U should evaluate its submitted provider data and the online provider directory to identify areas of discrepancy. The health plan should also provide an option for its members to request a paper form of the provider directory and include an email address or toll-free number for members to report errors.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Healthy U should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Healthy U did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-81. While failure to meet some of the standards might result from lack of providers, Healthy U should continue to assess areas of inadequacy to identify providers who chose not to contract with Healthy U and the inability to identify the providers in the data using the standard definitions.

Table 2-81—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Northeastern Counseling Center (Northeastern)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Northeastern submitted its new 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

Table 2-82 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-82—CY 2020 Performance Improvement Project Validation Results for Northeastern (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
	Implementation Total	**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (9/9)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Northeastern progressed to reporting baseline data. The PIP includes four performance indicators.

- 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.
- 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.
- The baseline rate for the percentage of inpatient discharges wherein members received a C-SSRS one to seven days post-discharge was 26.9 percent.
- 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.

Table 2-83 displays data for Northeastern's *Inpatient Post Discharge Engagement and Suicide Intervention* PIP.

Table 2-83—PIP—*Inpatient Post Discharge Engagement and Suicide Intervention*
Northeastern

Study Indicator Results			
Study Indicators	**Baseline (01/01/2019–12/31/2019)**		**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%	*Not Assessed*
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%	*Not Assessed*
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%	*Not Assessed*
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%	*Not Assessed*

N–Numerator D–Denominator

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

Strengths

Northeastern designed a scientifically sound PIP and conducted appropriate QI processes to identify and prioritize barriers, and to implement interventions that were logically linked to the barriers and have the potential to impact the study indicator outcomes. Northeastern's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Northeastern must report the measurement periods consistently throughout the submission.

- Northeastern must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Northeastern must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-84 presents Northeastern's MY 2020 performance measure results.

Table 2-84—Northeastern MY 2020 *FUH* Results

Indicator	Northeastern Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	63.33%	52.33%
Follow-Up Within 30 Days	73.33%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Northeastern demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Northeastern also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Northeastern based on *FUH* rates exceeding the Statewide PMHP Average; however, opportunities exists for Northeastern to continue to focus improvement efforts on increasing *FUH* rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations for

Northeastern. As such, for the CY 2020 review, HSAG did not conduct a follow-up review of federal regulations or State contract requirements.

HSAG did, however, request and review a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Northeastern's sample of credentialed providers included a case manager and four social workers. Northeastern submitted a sample consisting of five grievance records for the period under review. Northeastern reported that it did not have any prior authorization denials and that it had one appeal during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Northeastern submitted and through conducting a virtual, web-based review consisting of interviews with key Northeastern staff members.

Strengths

HSAG reviewed the five credentialing files and found that all providers completed an application prior to hire. Three of the files pertained to social work students, and one file involved a case manager. HSAG found that Northeastern had searched all providers against the federal exclusion databases and had completed all credentialing activities prior to hire. HSAG found full compliance with these files.

For the appeal record reviewed, the member had submitted the appeal following a retrospective claim denial, not related to a denial of service prior authorization. Northeastern responded to the appeal in a timely manner. HSAG found full compliance with the appeal requirements.

HSAG reviewed the five grievances and found that the acknowledgement and resolutions were timely and included all required elements. HSAG found full compliance with the requirements.

Opportunities for Improvement and Recommendations

HSAG noted that five grievances (the full sample of reported grievances) over a five-month period was a small quantity. HSAG suggests that Northeastern review its grievance collection policies and procedures to ensure it is properly tracking and documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-85 displays the match percentage for provider information between the data submitted by Northeastern and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-85—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Northeastern and All PMHPs

Provider Information	Northeastern			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	20	95.0%	5.0%	364	97.3%	2.7%
Provider Middle Name	20	55.0%	45.0%	364	85.7%	14.3%
Provider Last Name	20	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	20	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	20	95.0%	5.0%	364	93.7%	6.3%
Provider City	20	100.0%	0.0%	364	95.6%	4.4%
Provider State	20	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	20	100.0%	0.0%	364	97.5%	2.5%
Provider County	20	0.0%	100.0%	364	24.5%	75.5%

Table 2-86 displays the number and percent 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.

Table 2-86—Compliance With Time/Distance Standards by Urbanicity—Northeastern

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Northeastern	9	2	22.2%	0	0.0%	0	0.0%

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

Strengths

Northeastern's online provider directory clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan's match rate between submitted data and the online

provider directory for all fields met or exceeded 95 percent except for Provider Middle Name and Provider County for the sampled providers who were found in the online directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Northeastern's online provider directory is critical for members to have timely access to appropriate health care providers. Over 48 percent of the sampled providers could not be found in Northeastern's online directory. Northeastern should evaluate its submitted provider data and the online provider directory to identify areas of discrepancy. HSAG recommends that Northeastern report the last updated date on its online provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Northeastern should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Northeastern only met the time/distance standards for two of the provider categories in the frontier areas and none in the rural or urban areas. The provider categories that did not meet the standards are listed in Table 2-87. While failure to meet some of the standards might result from lack of providers, Northeastern should continue to assess areas of inadequacy to identify providers who chose not to contract with Northeastern and the inability to identify the providers in the data using the standard definitions.

Table 2-87—Provider Categories That Failed to Meet Time/Distance Standards—Northeastern*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Salt Lake County Division of Mental Health (Salt Lake)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Salt Lake submitted its PIP topic: *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County.* Salt Lake aims to improve behavioral health outcomes by increasing member engagement and retention in OUD treatment by providing medication-assisted treatment (MAT) services.

Validation Results

Table 2-88 summarizes the validation findings for each stage validated for CY 2020. Overall, 87 percent of all applicable evaluation elements received a score of *Met.*

Table 2-88—CY 2020 Performance Improvement Project's Validation Results for Salt Lake County (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	50% (1/2)	50% (1/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	67% (2/3)	33% (1/3)	0% (0/3)
	Design Total	**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
	Implementation Total	**100% (6/6)**	**0% (0/6)**	**0% (0/6)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**87% (13/15)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**75% (6/8)**		
Validation Status		***Partially Met***		

Indicator Outcomes

Salt Lake reported baseline data during this validation cycle. The baseline rate for the percentage of members diagnosed with an OUD, who initiated substance use disorder (SUD) treatment, and who may have received MAT services was 75.0 percent. The baseline rate for the percentage of members who received MAT services and remained in treatment longer than six months was 28.4 percent.

Table 2-89 displays data for Salt Lake's PIP.

Table 2-89—PIP—*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*
Salt Lake

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2019–12/31/2019)**		**Sustained Improvement**
1. Percentage of members who have been diagnosed with an OUD and who may have received MAT services.	N: 66 D: 88	75.0%	*Not Assessed*
2. Percentage of members who received MAT services and remained in treatment longer than 6 months.	N: 25 D: 88	28.4%	*Not Assessed*

N–Numerator D–Denominator

Salt Lake—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Salt Lake reported baseline data accurately according to the documented study design, used appropriate QI processes, and implemented interventions that have the potential to drive improvement toward the desired outcomes. Salt Lake's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Salt Lake's PIP aims to improve behavioral health outcomes by increasing member engagement and retention in OUD treatment by providing MAT services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Partially Met* validation status, with a *Met* score for 75 percent of critical evaluation elements and 87 percent of overall evaluation elements across all activities completed and validated. Salt Lake has opportunities for improvement to accurately define the study indicators and the data collection process for Study Indicator 2.

As the PIP progresses, HSAG recommends the following:

- Salt Lake should clarify whether Study Indicator 1 is focused on OUD members receiving MAT services or screening/evaluation for MAT services. In addition, the health plan should not use "may have" terminology in describing Study Indicator 1.
- Salt Lake should provide a clear, step-by-step narrative regarding the data collection process for Study Indicator 2.
- Salt Lake must update the narrative interpretation of data to discuss changes in the study indicator rates over the baseline and include statistical testing results.
- Salt Lake must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Two of the three interventions address barriers toward study indicator data collection. Salt Lake must ensure that in addition to improving data collection, the PIP interventions address barriers toward improving member care.
- Salt Lake must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-90 presents Salt Lake's MY 2020 performance measure results.

Table 2-90—Salt Lake MY 2020 *FUH* Results

Indicator	Salt Lake Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	**41.23%**	52.33%
Follow-Up Within 30 Days	**59.58%**	67.11%

Rates in **red** font indicate the rate fell below the statewide PMHP average.
*Statewide Average excludes HOME which falls into the MCO section above.

Salt Lake—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Salt Lake demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Salt Lake also had appropriate processes to receive and process claims and encounters.

Opportunities for Improvement and Recommendations

Salt Lake's rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Salt Lake focus on improvement efforts designed to ensure that members receive a Salt Lake-furnished service within seven days and 30 days following discharge from a hospitalization.

HSAG also recommends that Salt Lake County provide additional oversight of Optum's operations and provide additional training to Optum's staff to ensure the rate calculation reflects the directive and definitions provided by UDOH.

In addition, HSAG recommends additional code or supplemental documentation to better define the creation of key variables that support rate production. This will facilitate source code review in the future and ensure Salt Lake develops source code in alignment with measure specifications. HSAG also recommends extracting additional information from myAvatar as it relates to performance indicators, specifically adding the discharge date to provide clarification for calculation of rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Salt Lake—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations for Salt Lake. As such, for the CY 2020 review, HSAG did not conduct a follow-up review of federal regulations or State contract requirements.

HSAG did, however, request and review a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Salt Lake's sample of credentialed providers included a psychologist and six social workers. HSAG reviewed a sample of 10 prior authorization denial records and 10 appeal records. Salt Lake reported having three grievances during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Salt Lake submitted and through conducting a virtual, web-based review consisting of interviews with key Salt Lake staff members.

Strengths

Salt Lake submitted initial credentialing files for the period under review that were detailed and well-organized. HSAG found that, for each provider file reviewed, Salt Lake had collected an application, verified licensure and education, and checked the providers against federal exclusion databases prior to hire. HSAG found full compliance with the credentialing files reviewed.

HSAG reviewed the prior authorization denial files and found that most files pertained to members seeking additional inpatient days after a set of previously approved days had expired. In some cases, the inpatient days were denied following prior authorization, and in other cases, Salt Lake denied claims that were submitted after a hospitalization that was not pre-approved. Salt Lake reviewed and made a decision about prior authorizations for hospital stays within hours of receipt and immediately followed up with the requesting provider by telephone. Salt Lake sent its NABD letter to the member and the provider after the decision was made. The NABD letters contained all required information. HSAG found full compliance with the denial files reviewed.

HSAG reviewed a sample of 10 appeals of retroactive claims denials. Salt Lake upheld most denial decisions; however, a few were overturned in whole or in part. HSAG reviewed the appeal resolution letters and found that all required information had been included. Salt Lake clearly indicated in the resolution letter to the member that the member was not responsible for payment, as applicable. Salt Lake sent all appeal resolution letters in a timely manner. HSAG found full compliance with the appeal records reviewed.

HSAG reviewed the grievance records and found that each grievance was acknowledged and resolved within the allotted time frame of 90 days, and that the resolution letter included the required information.

Opportunities for Improvement and Recommendations

HSAG noted that three grievances over a five-month period is an unusually small amount. Salt Lake noted that it has conducted ongoing training with staff to ensure that member-generated concerns of all levels are entered into the complaints database and investigated, even those that are resolved during the initial telephone contact. HSAG suggests that Salt Lake continue its ongoing review to ensure that all grievances are captured and documented.

VALIDATION OF NETWORK ADEQUACY

Table 2-91 displays the match percentage for provider information between the data submitted by Salt Lake and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-91—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Salt Lake and All PMHPs

Provider Information	Salt Lake			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	79	100.0%	0.0%	364	97.3%	2.7%
Provider Middle Name	79	82.3%	17.7%	364	85.7%	14.3%
Provider Last Name	79	98.7%	1.3%	364	98.9%	1.1%
Provider Address 1	79	89.9%	10.1%	364	92.9%	7.1%
Provider Address 2	79	91.1%	8.9%	364	93.7%	6.3%
Provider City	79	81.0%	19.0%	364	95.6%	4.4%
Provider State	79	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	79	96.2%	3.8%	364	97.5%	2.5%
Provider County	79	6.3%	93.7%	364	24.5%	75.5%

Table 2-92 displays the number and percent 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.

Table 2-92—Compliance With Time/Distance Standards by Urbanicity—Salt Lake

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Salt Lake	9	3	33.3%	2	22.2%	8	88.9%

Salt Lake—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Geographic network adequacy analysis indicated that Salt Lake met the urban time/distance standard for eight of the nine provider categories.

Opportunities for Improvement and Recommendations

Accurate provider information in Salt Lake's online provider directory is critical for members to have timely access to appropriate health care providers. The CY 2020 PDV indicated that 66.5 percent of the sampled providers could not be found in Salt Lake's online directory and the provider locations could not be found in the online directory for an additional 9 percent of the sampled providers. Salt Lake should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Salt Lake report the last updated date on its online provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Salt Lake should also provide an option for members to request a paper form of the provider directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Salt Lake should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Salt Lake only met the time/distance standards for three of the provider categories in the frontier areas and two in the rural areas. The provider categories that did not meet the standards are listed in Table 2-93. While failure to meet some of the standards might result from lack of providers, Salt Lake should continue to assess areas of inadequacy to identify providers who chose not to contract with Salt Lake and the inability to identify the providers in the data using the standard definitions.

Table 2-93—Provider Categories That Failed to Meet Time/Distance Standards—Salt Lake*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical - Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—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).

Southwest Behavioral Health Center (Southwest)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Southwest submitted its new PIP topic: *Outcome Questionnaire (OQ) Project*. Southwest aims to improve behavior therapy by increasing the number of OQ reviews with members during psychotherapy sessions. According to the PIP documentation, the OQ reviews help in treatment planning by predicting those members who need special attention to prevent treatment failure and maximize treatment effectiveness.

Validation Results

Table 2-94 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-94—CY 2020 Performance Improvement Project Validation Results for Southwest (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Implementation Total	**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100% (16/16)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100% (9/9)**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2020, Southwest reported baseline data. For the baseline measurement period, Southwest reported that 15.1 percent of the psychotherapy sessions included an OQ review with the member at the time of service.

Table 2-95 displays data for Southwest's PIP.

Table 2-95—PIP—*Outcome Questionnaire Project*
Southwest

Study Indicator	Baseline Period 07/01/2018 to 06/30/2019		Sustained Improvement
The percentage of psychotherapy sessions during which the OQ is reviewed with a member who is age 18 or older at the time of service.	N: 990	15.1%	*Not Assessed*
	D: 6,547		

N–Numerator D–Denominator

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

Strengths

Southwest designed a scientifically sound PIP, reported accurate data, and implemented a provider intervention that was related to barriers identified through appropriate QI processes. Southwest's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Southwest's PIP aims to improve member behavior therapy outcomes by increasing the number of OQ reviews with members during psychotherapy sessions.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

- As the PIP progresses, HSAG recommends the following:
- Southwest must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Southwest must develop an evaluation methodology to determine the effectiveness of the implemented intervention and report evaluation results. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-96 presents Southwest's MY 2020 performance measure results

Table 2-96—Southwest MY 2020 *FUH* Results

Indicator	Southwest Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	59.84%	52.33%
Follow-Up Within 30 Days	71.65%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Southwest demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Southwest also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Southwest based on *FUH* rates above the Statewide PMHP Average; however, continued opportunities exist to focus improvement efforts on increasing *FUH* rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Southwest's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Southwest's sample of credentialed providers included several case managers, a nurse, a mobile crisis outreach worker, and two therapists. Southwest submitted a sample of seven grievance records for the period under review. Southwest reported that it did not have any prior authorization denials or appeals for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Southwest submitted and through conducting a virtual, web-based review consisting of interviews with key Southwest staff members.

Strengths

HSAG reviewed the grievance records and found that Southwest had acknowledged and resolved them within the allotted time frame and had included the required information in the resolution letter. HSAG found full compliance with Southwest's grievance submission.

In CY 2019, HSAG found that Southwest stated within its provider directory, "All internal staff at Southwest Behavioral Health are required to complete Cultural Competency trainings. Subcontracted providers do not have a contract requirement to complete training"; however, the provider directory did not delineate which providers are employed and which are contracted. In response to this finding,

Southwest included a column in its provider directory listing which providers are with the group "Southwest Behavioral Health," impacting the quality and access domains.

Opportunities for Improvement and Recommendations

HSAG reviewed a sample of initial credentialing files and found that Southwest had collected an application from four of the 10 providers after the hire date. HSAG also found that Southwest had not checked seven of the 10 providers against federal exclusion databases prior to hire. HSAG found that Southwest had not verified education and licensure for two of the three licensed providers prior to hire. HSAG suggests that Southwest leadership review all credentialing files for completeness and evaluate the processes in place to ensure consistency of credentialing processes.

During the interview, HSAG recommended that Southwest develop a method to more clearly document the acknowledgement that occurs during a verbal grievance.

In CY 2019, HSAG had found that Southwest did not note the languages (including American Sign Language) the providers or providers' offices offered, as required, within its provider directory, but the directory did state that interpreters are available. This finding remained in CY 2020. HSAG suggests that Southwest indicate the languages (including American Sign Language) each provider or provider's office offers in its provider directory.

VALIDATION OF NETWORK ADEQUACY

Table 2-97 displays the match percentage for provider information between the data submitted by Southwest and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-97—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Southwest and All PMHPs

Provider Information	Southwest			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	29	100.0%	0.0%	364	97.3%	2.7%
Provider Middle Name	29	79.3%	20.7%	364	85.7%	14.3%
Provider Last Name	29	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	29	89.7%	10.3%	364	92.9%	7.1%
Provider Address 2	29	96.6%	3.4%	364	93.7%	6.3%
Provider City	29	100.0%	0.0%	364	95.6%	4.4%

Provider Information	Southwest			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider State	29	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	29	89.7%	10.3%	364	97.5%	2.5%
Provider County	29	0.0%	100.0%	364	24.5%	75.5%

Table 2-98 displays the number and percent 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.

Table 2-98—Compliance With Time/Distance Standards by Urbanicity—Southwest

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Southwest	9	4	44.4%	4	44.4%	0	0.0%

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

Strengths

Southwest's online provider directory included a last update date for provider information in the online provider directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Southwest's online provider directory is critical for members to have timely access to appropriate health care providers. Only 22.8 percent of the sampled providers could be found in Southwest's online directory. Southwest should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Southwest include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Southwest should also provide an option for members to request a paper form of the provider directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Southwest should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Southwest only met the time/distance standards for four of the nine provider categories in the frontier and rural areas. The provider categories that did not meet the standards are listed in Table 2-99. While failure to meet some of the standards might result from lack of providers, Southwest should continue to assess areas of inadequacy to identify providers who chose not to contract with Southwest and the inability to identify the providers in the data using the standard definitions.

Table 2-99—Provider Categories That Failed to Meet Time/Distance Standards—Southwest*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Utah County Department of Drug and Alcohol Prevention and Treatment

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Utah County continued its PIP topic: *Suicide Prevention*

Validation Results

Table 2-100 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-100—CY 2018 Performance Improvement Project's Validation Results for Utah County (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**100% (2/2)**	**0% (0/2)**	**0% (0/2)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (19/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (10/10)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Utah County reported Remeasurement 2 results. The baseline rate for the percentage of eligible members who received the C-SSRS screening was 30.0 percent. For Remeasurement 2, the Study Indicator 1 rate of 43.5 percent demonstrated a statistically significant increase ($p = 0.0001$) of 13.5 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 0.0 percent. For Remeasurement 2, the Study Indicator 2 rate of 30.8 percent exceeded the Remeasurement 1 rate by 4.7 percentage points and demonstrated a statistically significant increase ($p = 0.0001$) of 30.8 percentage points over the baseline.

The PIP was not evaluated for sustained improvement because only one study indicator demonstrated statistically significant improvement over the baseline during Remeasurement 1.

Table 2-101 displays data for Utah County's PIP.

Table 2-101—PIP—*Suicide Prevention*
Utah County

Study Indicator	Baseline Period 01/01/2017–12/31/2017		Remeasurement 1 01/01/2018–12/31/2018		Remeasurement 2 01/01/2019–12/31/2019		Sustained Improvement
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 149	30%	N: 172	30%	N: 164	43.5%*	*Not Assessed*
	D: 497		D: 573		D: 377		
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 0	0.0%	N: 12	26.1%*	N: 8	30.8%*	*Not Assessed*
	D: 51		D: 46		D: 26		

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator NA-Not Applicable

Utah County—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Utah County designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Utah County reported and analyzed its Remeasurement 2 data accurately. Utah County conducted appropriate QI processes to identify and prioritize barriers, and implemented interventions that were logically linked to the barriers and had a positive impact on the outcomes. Utah County's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Utah County's PIP aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions based on level of risk.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

CY 2020 was the last year for Utah County's PIP. HSAG recommends that Utah County continue to build on its momentum of improvement and apply any lessons learned and knowledge gained through the QI processes applied during this PIP.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-102 shows Utah County's MY 2020 results for the state-modified *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure. Utah County's rates were materially biased and assessed as Not Reportable by the HSAG auditor.

Table 2-102—Utah County MY 2020 *IET* Results

Indicator	Utah County 2020 Rate
Alcohol Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Initiation of AOD Treatment—Total—Total	**NR**
Alcohol Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Engagement of AOD Treatment—Total—Total	**NR**

NR—Not Reportable

Utah County—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

While Utah County demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy and had appropriate processes to receive and process claims and encounters, HSAG's auditor identified several measure pre-production and reporting errors.

Opportunities for Improvement and Recommendations

HSAG identified several pre-production steps that negatively affected the production of the performance measures. HSAG identified an error in Utah County's source code associated with the length of time used to evaluate continuous enrollment. Utah County subsequently resubmitted data correcting that error, and HSAG approved the source code. Additionally, during the PSV section of the

virtual site visit, HSAG identified three critical errors. The errors included both data validation errors (i.e., discrepancies between Credible and the measure source file) and event categorization errors (i.e., compliance status of selected dates of service and AOD diagnoses categorization). Following the virtual site visit, HSAG identified several follow-up items to address the measure pre-production and reporting errors. Utah County staff members reviewed, modified, and resubmitted performance measure rates and clarification surrounding HSAG's findings. Upon review, HSAG determined that the responses were insufficient to support the accuracy of the revised rates or confidence in the limiting of potential bias in the rates. Additionally, final rate review revealed ongoing data aggregation errors.

HSAG recommended that Utah County review and update both its source code and measure calculation steps. Specifically, source code should be reviewed to ensure that diagnoses are pulled and assigned to members accurately based on the qualifying index event. Additionally, the selection of the index episode start date should be updated to reflect the discharge date if the qualifying index event is an inpatient stay. At the time of the CY 2020 PMV, measure calculation processes relied on the use of pivot tables that may not account for errors contained within the source data. Additional data cleaning and validation may be necessary to ensure appropriate counting of numerator and denominator elements.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

Utah County Department of Drug and Alcohol Prevention and Treatment—Quality, Timeliness, and Access to Care—Compliance Reviews

Effective April 2020, Utah County discontinued activities as a PAHP directly contracted with UDOH. Utah County is now a subcontractor providing services under Wasatch Behavioral Health, which was already operating as a PMHP in the area. As such, HSAG's compliance monitoring activities for Utah County for CY 2020 consisted of a review of Utah County's CY 2019 CAP. HSAG did not review any additional administrative credentialing, denial, grievance, or appeals records.

Strengths

Based on HSAG findings in the CY 2018 and CY 2019 compliance reviews, in CY 2020 Utah County developed policies, procedures, and a mechanism to detect over- and underutilization and ensure consistent application of any criteria used to make authorization decisions. Utah County also updated its NABD letter to include appropriate time frames for requesting an appeal if continuing benefits during an appeal or State fair hearing.

In 2020, Utah County also addressed findings that the provider directory was found to be incomplete and posted the updated directory on its website in a machine-readable format.

In its 2020 CAP, Utah County described a new policy and mechanism for sending a letter to members asking if they had received the actual service that is documented on a certain date chosen during peer reviews. Utah County also began developing processes to evaluate the effectiveness of reporting QAPI data.

Opportunities for Improvement and Recommendations

HSAG did not identify any ongoing opportunities for improvement for Utah County.

VALIDATION OF NETWORK ADEQUACY

Utah County's contract with UDOH ended prior to the start of NAV activities; therefore, Utah County was not included in this EQR-related activity in CY 2020.

Valley Behavioral Health (Valley)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Valley submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 2-103 summarizes the validation findings for each stage validated for CY 2020. Overall, 81 percent of all applicable evaluation elements received a score of *Met.*

Table 2-103—CY 2019 Performance Improvement Project Validation Results for Valley (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	67% (2/3)	33% (1/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	67% (4/6)	33% (2/6)	0% (0/6)
	Implementation Total	**67% (6/9)**	**33% (3/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	0% (0/1)	100% (1/1)	0% (0/1)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Outcomes Total	**67% (2/3)**	**33% (1/3)**	**0% (0/3)**
	Percentage Score of Applicable Evaluation Elements *Met*	**81% (17/21)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**83% (10/12)**		
	Validation Status	***Partially Met***		

Indicator Outcomes

For CY 2020, Valley progressed to reporting Remeasurement 3 results.

For Summit County, the baseline rate for the percentage of eligible members who received the C-SSRS screening was 45.5 percent. For Remeasurement 3, the Study Indicator 1 rate of 85.4 percent demonstrated a statistically significant increase ($p < 0.0001$) of 39.9 percentage points over the baseline.

For Summit County, the baseline rate for the percentage of members who required and received a same-day safety plan was 90.5 percent. For Remeasurement 2, the Study Indicator 2 rate of 89.9 percent decreased from the Remeasurement 1 rate of 100 percent and did not represent statistically significant improvement over the revised baseline (CY 2017) results. Note that since the denominator population for this study indicator is very small, the percentage point change in results should be interpreted with caution.

For Tooele County, the baseline rate for the percentage of members who received the C-SSRS screening was 39.8 percent. For Remeasurement 3, the Study Indicator 1 rate of 96.8 percent demonstrated a statistically significant increase ($p < 0.0001$) of 57.0 percentage points over the baseline.

For Tooele County, the baseline rate for the percentage of members who required and received a same-day plan was 63.2 percent. For Remeasurement 3, the Study Indicator 2 rate of 86.9 percent decreased from the Remeasurement 2 rate by 0.9 percentage points; however, this rate demonstrated a statistically significant increase ($p < 0.0001$) of 23.7 percentage points over the baseline.

Valley was able to sustain a statistically significant improvement that was achieved at Remeasurement 1 for the subsequent measurement period for Study Indicator 1 in both counties and for Study Indicator 2 in Tooele County; however, for Study Indicator 2 in Summit County, the health plan was not able to sustain a statistically significant improvement.

Table 2-104 displays data for Valley's PIP.

Table 2-104—PIP—*Suicide Prevention*
Valley

Study Indicator	Baseline Period^ 01/01/2016–12/31/2016		Remeasurement 1 01/01/2017–12/31/2017		Remeasurement 2 01/01/2018–12/31/2018		Remeasurement 3 01/01/2019–12/31/2019		Sustained Improvement
Summit County									
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 80 D: 176	45.5%	N: 183 D: 217	84.3%*	N: 168 D: 200	84.0%*	N: 146 D: 171	85.4%*	*Yes*
Study Indicator	**Baseline Period^ 01/01/2017–12/31/2017**		**Remeasurement 1 01/01/2018–12/31/2018**		**Remeasurement 2 01/01/2019–12/31/2019**				**Sustained Improvement**
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 19 D: 21	90.5%	N: 16 D: 16	100%	N: 8 D: 9	89.9%	N: D:		*No*
Study Indicator	**Baseline Period^ 01/01/2016–12/31/2016**		**Remeasurement 1 01/01/2017–12/31/2017**		**Remeasurement 2 01/01/2018–12/31/2018**		**Remeasurement 3 01/01/2019–12/31/2019**		**Sustained Improvement**
Tooele County									
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 335 D: 841	39.8%	N: 616 D: 980	62.9%*	N: 674 D: 947	71.2%*	N: 1,038 D: 1,072	96.8%*	*Yes*
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 43 D: 68	63.2%	N: 95 D: 107	88.8%*	N: 108 D: 123	87.8%*	N: 139 D: 160	86.9%*	*Yes*

*Indicates statistically significant improvement over the Remeasurement 1 rate. N–Numerator D–Denominator

^Due to concerns regarding a true comparison of study indicator rates with CY 2015 data as the baseline, CY 2016 was reassigned as the new baseline measurement period for Study Indicator 1 for both counties and Study Indicator 2 for Toole County. For Summit County, Study Indicator 2, the health plan reassigned CY 2017 as the new baseline measurement period.

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

Strengths

Valley designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Valley reported accurate data and conducted appropriate QI processes to identify and prioritize barriers. Valley implemented interventions that were logically linked to the barriers and had a positive impact on the outcomes. Valley's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Valley's PIP aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions based on level of risk.

Opportunities for Improvement and Recommendations

The PIP received an overall *Partially Met* validation status, with a *Met* score for 83 percent of critical evaluation elements and 81 percent of overall evaluation elements across all activities completed and validated. There were opportunities for improvement in the narrative interpretation of results and evaluation of interventions for effectiveness.

CY 2020 was the last year for Valley's PIP. HSAG recommends that Valley continue to build on its momentum of improvement and apply any lessons learned and knowledge gained through the QI processes applied during this PIP.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-105 presents Valley's MY 2020 performance measure results.

Table 2-105—Valley MY 2020 *FUH* Results

Indicator	Valley Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	64.71%	52.33%
Follow-Up Within 30 Days	82.35%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Valley demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data

completeness and accuracy. Valley also had appropriate processes to receive and process claims and encounters.

Opportunities for Improvement and Recommendations

Although Valley established and demonstrated robust data systems for collecting, extracting, and validating performance measure data, HSAG identified some pre-production steps that initially affected the production of performance measure rates. During the virtual site visit, HSAG conducted PSV on a random sample of members and identified critical errors in several of the records. The errors included data validation errors affecting the inclusion and exclusion of members from both the denominator and numerator, thereby impacting overall rates.

Following the virtual site visit, HSAG provided guidance and follow-up requests to Valley for review. Analytic staff members reviewed the list of items, assessed the code, and implemented appropriate fixes to correct the identification of the eligible population and numerator compliance. In addition to addressing unintended restrictions, code was updated to incorporate claims and encounter data. HSAG reviewed both the updated code and measure source file and confirmed correction of all outstanding data issues.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Effective October 2020, Valley suspended activities as a PMHP in Utah. As such, HSAG's compliance monitoring activities for CY 2020 consisted of a review of Valley's CY 2019 CAP.

Strengths

Valley indicated in its CY 2020 CAP that it will implement a mechanism to ensure that the information included in the paper provider directory is updated at least monthly and that electronic provider directories are updated no later than 30 calendar days after Valley receives updated provider information.

During the CY 2018 review, HSAG reviewed Valley's Client Complaint System policy (dated February 2016), which described Valley's client grievance processes, and the Client Appeal System (dated September 2013), which addressed the appeals and State fair hearing processes. During the on-site interview, HSAG noted that the processes described by staff members were inconsistent with written policies. Staff members commented that the policies were old and outdated. For the CY 2019 review, Valley noted that the policy was being revised and was not yet available. For CY 2020, Valley indicated in its CAP that the policies and procedures governing its grievance and appeal systems had been updated. Valley also indicated that training on the revised policies was to occur in January 2020.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG evaluated the accessibility of Valley's website and the PDFs on its website and identified 48 accessibility and 96 contrast errors. For the CY 2019 follow-up review, HSAG again evaluated Valley's website using the WAVE Web Accessibility Evaluation Tool and identified 47 accessibility and 72 contrast errors. For the CY 2019 review, Valley stated that it had not yet taken measures to address this issue and intended to overhaul the website in November 2019. For the CY 2020 CAP, Valley did not provide sufficient evidence that it would evaluate the website and make corrections to ensure that the format and content are readily accessible. Additionally, Valley did not indicate that it would provide language on the website informing members that the information on the website is available in paper form without charge upon request, and that the information would be provided within five business days.

In CY 2018, HSAG found that Valley did not have a provider directory in written or electronic form for members. For the CY 2019 review, Valley provided HSAG with Community Partners Lists for Tooele County and Summit County as evidence of compliance. These lists included community resources and stakeholders, but not providers. For its CY 2020 CAP, Valley indicated that is does not contract with physicians. HSAG noted that Valley's provider directory should include the required demographic details of both employed and contracted providers and be made available in a format that is readily accessible.

VALIDATION OF NETWORK ADEQUACY

None of the providers sampled during the PDV were located in the health plan's online directory.

Table 2-106 displays the number and percent of provider categories wherein Valley met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-106—Compliance With Time/Distance Standards by Urbanicity—Valley

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Valley	9	2	22.2%	0	0.0%	0	0.0%

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

Strengths

In 2020 PDV, HSAG identified that Valley had an option for members to request a paper form of the provider directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Valley's online provider directory is critical for members to have timely access to appropriate health care providers. In the CY 2020 PDV, none of the providers in the submitted data were found in Valley's online provider directory. In CY 2019 compliance reviews, HSAG had identified that Valley's provider directory lacked much of the required information about Valley's providers and was not updated as frequently as required. Valley should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Valley include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Valley should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Valley only met the time/distance standards for two of the provider categories in frontier areas and none in rural or urban areas. The provider categories that did not meet the standards are listed in Table 2-107. While failure to meet some of the standards might result from lack of providers, Valley should continue to assess areas of inadequacy to identify providers who chose not to contract with Valley and the inability to identify the providers in the data using the standard definitions.

Table 2-107—Provider Categories That Failed to Meet Time/Distance Standards—Valley*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Wasatch Behavioral Health (Wasatch)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Wasatch submitted its PIP topic: *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ [Youth Outcomes Questionnaire] Outcome Measures*. Wasatch aims to improve behavioral therapy by increasing the administration of the Clinical Support Tool (CST) in conjunction with Y/OQ instruments during outpatient individual psychotherapy. According to the PIP documentation, the appropriate use of CSTs will improve treatment outcomes and decrease the frequency of deterioration for the most at-risk members.

Validation Results

Table 2-108 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-108—CY 2020 Performance Improvement Project Validation Results for Wasatch (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Implementation Total	**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**100% (16/16)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100% (8/8)**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2020, Wasatch reported baseline data.

The baseline rate for the percentage of Y/OQ signal cases wherein the CST was administered within the four-month window (including two calendar months before the signal month, the signal month, and one calendar month after the signal month) was 6.2 percent.

Table 2-109 displays data for Wasatch's PIP.

Table 2-109—PIP—*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*
Wasatch

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2019–12/31/2019)**		**Sustained Improvement**
The percentage of Y/OQ signal cases wherein CST was administered during a four-month window surrounding the signal event.	N: 292 D: 4,700	6.2%	*Not Assessed*

N–Numerator D–Denominator

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

Strengths

Wasatch designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes. Wasatch reported baseline data accurately, used appropriate QI processes, and implemented interventions that have the potential to drive improvement toward the desired outcomes. Additionally, Wasatch's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Wasatch must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Wasatch must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-110 presents Wasatch's MY 2020 performance measure results.

Table 2-110—Wasatch MY 2020 *FUH* Results

Indicator	Wasatch Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	61.37%	52.33%
Follow-Up Within 30 Days	78.97%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Wasatch demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Wasatch also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Wasatch based on *FUH* measure rates exceeding the Statewide PMHP Average; however, opportunities continue to exist for Wasatch to increase *FUH* rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Wasatch's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Wasatch's sample of credentialed providers included social workers, case managers, therapists, human service workers, a peer support specialist, and a clinical mental health counselor. HSAG reviewed a full sample of 10 prior authorization denial records and a full sample of 10 grievance records. Wasatch submitted a sample of nine appeal records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Wasatch submitted and through conducting a virtual, web-based review consisting of interviews with key Wasatch staff members.

Strengths

HSAG reviewed the initial credentialing files and found that Wasatch had verified licensure and education, as well as potential exclusions from federal health care programs, prior to hire. HSAG found full compliance with Wasatch's initial credentialing records reviewed.

HSAG reviewed the grievance records and found that Wasatch had documented all required information and resolved the grievances in a timely manner. HSAG found full compliance with the grievance records reviewed.

During the review conducted in CY 2018, HSAG found that Wasatch's provider directory did not contain all required information. In CY 2019, HSAG found that Wasatch's provider directory still lacked some required information. For the CY 2020 review, HSAG found that Wasatch had updated its provider directory to include the missing provider demographics.

In CY 2018, HSAG had found that Wasatch did not have provisions for a method to routinely verify, by sampling or other methods, whether members received services that network providers represented to have been delivered. During the interview conducted in CY 2019, Wasatch staff members discussed methods used to detect potential fraud; however, none of the methods in place involved determining whether members had received services that had been represented as provided. For the CY 2020 review, Wasatch reported that it had developed a method to routinely verify, by sampling or other methods, whether members received services that network providers represented to have been delivered. Wasatch reported that it was surveying 10 to 20 randomly selected members per month.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement as a result of the CY 2020 follow-up compliance review.

VALIDATION OF NETWORK ADEQUACY

None of the providers sampled during the PDV were located in the health plan's online directory.

Table 2-111 displays the number and percent 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.

Table 2-111—Compliance With Time/Distance Standards by Urbanicity—Wasatch

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Wasatch	9	0	0.0%	0	0.0%	0	0.0%

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

Strengths

Wasatch's online provider directory allowed users to search by provider name, specialty, language spoken, completion of cultural competency training, and department.

Opportunities for Improvement and Recommendations

Accurate provider information in Wasatch's online provider directory is critical for members to have timely access to appropriate health care providers. In the CY 2020 PDV, none of the providers in the submitted data were found in Wasatch's online provider directory. Wasatch should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Wasatch also include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website and an option to request a paper form of the provider directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Wasatch should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Wasatch did not meet any of the time/distance standards for any of the provider categories in any of the geographic areas. The health plan's submitted data did not include providers in any category other than Behavioral Therapists (adult and pediatric). The provider categories that did not meet the standards are listed in Table 2-112. While failure to meet some of the standards might result from lack of providers, Wasatch should continue to assess areas of inadequacy to identify providers who chose not to contract with Wasatch and the inability to identify the providers in the data using the standard definitions.

Table 2-112—Provider Categories That Failed to Meet Time/Distance Standards—Wasatch*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Weber Human Services (Weber)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Weber submitted its clinical PIP topic: *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder (OUD)*. Weber aims to improve processes and outcomes of members' behavioral health care by increasing member engagement and retention in OUD treatment. The table below lists the two study indicators for this PIP.

Validation Results

Table 2-113 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-113—CY 2020 Performance Improvement Project Validation Results for Weber (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	*Not Assessed*		
	Implementation Total	**100% (3/3)**	**0% (0/3)**	**0% (03)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (11/11)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (6/6)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Weber progressed to reporting baseline results. The baseline rate for the percentage of members who received at least six case management or peer support services per year was 33.3 percent. The baseline rate for the percentage of members who were discharged and successfully completed the treatment was 21.1 percent.

Table 2-114 displays data for Weber's PIP.

Table 2-114—PIP—*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder Prevention*
Weber

Study Indicator	Baseline Period 01/01/2019–12/31/2019		Sustained Improvement
1. The percentage of members diagnosed with opioid use disorder, who received at least 6 case management or peer support services per year.	N: 33	33.3%	*Not Assessed*
	D: 99		
2. The percentage of members diagnosed with opioid use disorder that were discharged from treatment and who successfully completed the treatment.	N: 4	21.1%	*Not Assessed*
	D: 19		

N–Numerator D–Denominator

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

Strengths

Weber designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Weber's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Weber must conduct a causal/barrier analysis, identifying and prioritizing barriers, and develop appropriate evidence-based interventions.
- Weber must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-115 presents Weber's MY 2020 performance measure results.

Table 2-115—Weber MY 2020 *FUH* Results

Indicator	Weber Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	**49.01%**	52.33%
Follow-Up Within 30 Days	68.38%	67.11%

Rates in **red** font indicate the rate fell below the statewide PMHP average.
*Statewide Average excludes HOME which falls into the MCO section above.

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

Strengths

Weber demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Weber also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Weber's rates for members hospitalized for mental illness who received a follow-up visit within seven days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Weber focus on improvement efforts designed to ensure that members receive a Weber-furnished service within seven days following discharge from a hospitalization.

HSAG did not identify any recommendations as a result of the PMV process.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Weber's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Weber's sample of credentialed providers included several human service workers, a peer support specialist, a nurse, a retired nurse advocate, and two case managers. HSAG reviewed full samples of 10 prior authorization denials, appeals, and grievance records.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Weber submitted and through conducting a virtual, web-based review consisting of interviews with key Weber staff members.

Strengths

HSAG found that, for all licensed providers reviewed, Weber searched the Utah Division of Occupational and Professional Licensing (DOPL) prior to hire. HSAG also found very detailed grievance records and full compliance with the files reviewed pertaining to quality, access, and timeliness.

In CY 2018 and 2019, HSAG had reviewed Weber's website and found that it did not contain language to notify members that the information on the website is available in paper form without charge upon

request, and that the information would be provided within five business days. In CY 2020, HSAG found that Weber had added a statement to its website notifying members that the information on the website is available in paper form without charge upon request, and that the information would be provided within five business days.

In CY 2018 and 2019, HSAG had found that within its provider directory, Weber did not note the "languages (including American Sign Language) offered by the provider or provider's office" as required, but the directory did state that interpreters are available. For CY 2020, Weber met this requirement by making an overall statement about cultural competency in the directory and added a column indicating the foreign languages available for each provider.

Opportunities for Improvement and Recommendations

For the credentialing review, HSAG found that Weber did not collect an application from one provider and collected the application for another provider after the hire date.

For the prior authorization denial records, HSAG found that for expedited denial requests (continued inpatient care), while Weber did inform the provider of the denial verbally, Weber was not sending the member a NABD letter within 72 hours.

HSAG reviewed the appeal records and noted that most denials were related to denied requests for additional inpatient days after the initial approved days were complete. HSAG noted that two of the 10 files reviewed did not include an acknowledgement letter to the member, and that four of the files did not include a resolution letter to the member. For appeal resolution letters to the member, HSAG suggests that Weber add language informing members that they are not liable for payment (as applicable) to ensure that members are aware of their rights pertaining to balance billing.

VALIDATION OF NETWORK ADEQUACY

Table 2-116 displays the match percentage for provider information between the data submitted by Weber and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-116—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Weber and All PMHPs

Provider Information	Weber			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	76	98.7%	1.3%	364	97.3%	2.7%
Provider Middle Name	76	89.5%	10.5%	364	85.7%	14.3%

Provider Information	Weber			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider Last Name	76	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	76	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	76	100.0%	0.0%	364	93.7%	6.3%
Provider City	76	100.0%	0.0%	364	95.6%	4.4%
Provider State	76	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	76	100.0%	0.0%	364	97.5%	2.5%
Provider County	76	30.3%	69.7%	364	24.5%	75.5%

Table 2-117 displays the number and percent 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.

Table 2-117—Compliance With Time/Distance Standards by Urbanicity—Weber

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	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 (%)
Weber	9	0	0.0%	6	66.7%	6	66.7%

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

Strengths

Weber's PDV indicated that 88.4 percent of the sampled providers were found in the online directory. Additionally, Weber's match rate for all provider fields except Provider First Name, Provider Middle Name, and Provider County information was 100 percent between the submitted data and the online provider directory. The health plan's website also clearly displayed an option to request a paper form of the provider directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Weber's online provider directory is critical for members to have timely access to appropriate health care providers. Weber should ensure that the online provider directory is frequently updated with required, accurate provider information. HSAG recommends that

Weber include the latest update date for provider information on its website and an option for members to report errors in provider information using an email address or toll-free number.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Weber should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Geographic network adequacy results indicate that Weber met six of the nine standards (66.7 percent) in both rural and urban areas. Weber's submitted data for network adequacy did not include any General Hospitals with a Psychiatric Unit or Substance Abuse Facilities. The provider categories that did not meet the standards are listed in Table 2-118. While failure to meet some of the standards might result from lack of providers, Weber should continue to assess areas of inadequacy to identify providers who chose not to contract with Weber and the inability to identify the providers in the data using the standard definitions.

Table 2-118—Provider Categories That Failed to Meet Time/Distance Standards—Weber*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	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).

Medicaid PAHPs Providing Dental Services

Premier Access

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Premier submitted its PIP topic: *Improving Dental Sealant Rates in Members Ages 6–9.*

Validation Results

Table 2-119 summarizes the validation findings for each stage validated for CY 2020. Overall, 84 percent of all applicable evaluation elements received a score of *Met*.

Table 2-119—CY 2020 Performance Improvement Project Validation Results for Premier Access (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	67% (4/6)	17% (1/6)	17% (1/6)
	Implementation Total	**78% (7/9)**	**11% (1/9)**	**11% (1/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	50% (1/2)	0% (0/2)	50% (1/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		50% (1/2)	0% (0/2)	50% (1/2)
Percentage Score of Applicable Evaluation Elements *Met*		**84% (16/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**80% (8/10)**		
Validation Status		***Not Met***		

Indicator Outcomes

For CY 2020, Premier progressed to reporting Remeasurement 1 results. The baseline rate for members 6 to 9 years of age who received a dental sealant during the baseline measurement was 23.0 percent, which decreased to 21.0 percent during Remeasurement 1.

Table 2-120 displays baseline data for Premier's *Improving Dental Sealant Rates in Members Ages 6–9* PIP.

Table 2-120—PIP—*Improving Dental Sealant Rates in Members Ages 6–9*
Premier

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Remeasurement 1 01/01/2019–12/31/2019		Sustained Improvement
The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	N: 5,665	23.0%	N: 4,899	21.0%	*Not Assessed*
	D: 24,586		D: 23,333		

N–Numerator D–Denominator

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

Strengths

Premier documented a sound PIP design, reported accurate data, and implemented member- and provider-level interventions that were related to barriers identified through QI processes. Premier's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Premier's PIP aims to improve dental sealant rates in children 6 to 9 years old. By increasing the dental sealant rates, Premier intends to prevent the occurrence of dental caries in permanent molars.

Opportunities for Improvement and Recommendations

The PIP received an overall *Not Met* validation status, with a *Met* score for 80 percent of critical evaluation elements and 84 percent of overall evaluation elements across all activities completed and validated. There were opportunities for improvement in the documentation of the QI processes, evaluation of interventions, and achievement of improvement in the study indicator outcomes.

As the PIP progresses, HSAG recommends the following:

- Premier must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Premier must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Premier must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicator. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should be documented in the PIP Submission Form and should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Premier's HEDIS compliance auditor found Premier's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Premier contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier's FAR revealed that Premier's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations.

Performance Measure Outcomes

Table 2-121 shows Premier's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-121—Premier HEDIS 2020 Results

HEDIS Measure	Premier 2020 Rate	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	54.02%	43.10%
4–6 Years of Age	68.67%	63.85%
7–10 Years of Age	71.21%	67.17%
11–14 Years of Age	65.01%	62.53%
15–18 Years of Age	58.16%	54.16%
19–20 Years of Age	48.53%	38.26%
Total	64.68%	55.46%

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

Strengths

Premier exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit* measure for all performance measure indicator rates.

Opportunities for Improvement and Recommendations

Premier did not have any opportunities for improvement, and HSAG does not have any recommendations for Premier Access.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2020 compliance monitoring activities, HSAG reviewed Premier's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Premier's sample of credentialed providers consisted of a selection of dentists, including general dentists, pediatric dentists, and two oral surgeons. HSAG reviewed a full sample of 10 prior authorization denial records and a full sample of 10 appeal records. Premier submitted a sample of six grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Premier submitted and through conducting a virtual, web-based review consisting of interviews with key Premier staff members.

Strengths

In CY 2018 and CY 2019, HSAG had found that Premier's provider directory did not identify which providers had completed cultural competency training. For CY 2020, HSAG found that Premier had included a field in its online provider directory to identify which providers participated in cultural competency training. At the time of the review, Premier had not updated this field for many providers; however, Premier had a process in place to collect this information and was engaged in ongoing efforts to ensure that it queried providers for participation and included the results of the query in the directory.

In CY 2018, HSAG found that Premier's policies, procedures, and member information stated that members may file an appeal orally or in writing and that oral appeals must be followed with a written, signed appeal within five days of an oral appeal. In the preamble to 42 CFR §438, the requirements specifically address that a time limitation for a written response to an oral appeal is not permitted. In response to the requirement, Premier fully removed its requirement for the member to follow an oral request for an appeal with the request in writing. The federal requirements at 42 CFR §438.402 require that an oral request for appeal is followed by a request in writing without time limitation. In CY 2020, HSAG reviewed Premier's revised policy and found that it required members to follow an oral appeal in writing except in the case of expedited appeals.

HSAG reviewed the credentialing records and found that for all providers, Premier collected an application, verified education and licensure, and checked the providers' names against federal exclusions databases prior to hire.

HSAG reviewed Premier's appeal records and found that Premier sent the appeal acknowledgements and resolutions in a timely manner.

HSAG reviewed the grievance records and found that Premier acknowledged and resolved each grievance quickly and within the allotted time frame. HSAG found that the resolution letter to the member was transparent, detailed, and specific to the member's case. Premier included all required information.

Opportunities for Improvement and Recommendations

HSAG reviewed the credentialing records and found that for one provider the credentialing approval date was listed as March 11, 2020, on the credentialing cover sheet; however, Premier depicted two different dates on two different approval letters to the provider. One letter depicted the approval date as January 29, 2020, and the other letter was dated February 24, 2020. Premier conducted the validations and exclusion checks for this provider on February 25, 2020.

HSAG found Premier's NABD letters to be confusing and difficult to follow. The letter template stated in bold font across the top, "This is not a bill. This is a response to your dentist's request for dental treatment for you." A text box in large letters stated, "Notice of Authorization." The letter contained a list of informational bullets; the first bullet listed the authorization dates that the letter is "good for" (even though some or all services listed in the specific letters reviewed may have had a denied status). The letter also contained a table of procedure codes (one line for each procedure for each tooth) and dollar amounts for amount submitted, covered expense, deductible, primary paid, copay, plan payment, patient payment, then status and reason (in code). Following the table, the letter explained the meaning of the procedure codes and reason codes. The status column in the table was the only place in the letter noting that Premier was denying the service. HSAG strongly suggests that Premier work to streamline and simplify its NABD letters and grievance/appeal forms and consider testing them with a member focus group to ensure readability and ease of understanding.

Premier used a hybrid Grievance/Appeal form, sent with the NABDs, for members to request a grievance or appeal. The form stated that "Appeals filed orally must be followed with a written appeal within five business days. The appeal will not be processed if Premier does not receive a written appeal within five business days." In accordance with federal regulations, the member must follow an oral appeal with a written appeal; however, Premier cannot put a time limit on the member to file the appeal in writing. Further clarification on this topic is located in the preamble to the Medicaid managed care regulations (Federal Register, Volume 81, Number 88, published May 6, 2016, page 27,511, third column). When faced with an oral appeal and requesting that the member follow up in writing, HSAG suggests that Premier consider 42 CFR §438.406(a) which requires that Premier provide a member with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. Further, the continuation of benefits language in the Grievance/Appeal form stated that for continuation of benefits, an appeal must be filed in 10 days, which is incorrect. A request for continuation must be filed in 10 days; however, the member still retains a 60-day filing time frame in which to file an appeal. HSAG also noted that for one appeal, the same provider that made the denial decision also made the decision to uphold the denial upon appeal.

In the appeal resolution letters, HSAG noted unclear language that the member would not easily understand and situations where appeals and grievances were confused. At the beginning of the Appeal Rights information section, Premier stated, "You have 60 days from the date of a 'Notice of Adverse Benefit Determination letter' to file an Appeal." This language sounds like Premier is referring to a separate letter, as this letter is titled "Notice of Authorization." The letter also stated:

> If you are currently getting treatment and want to continue getting treatment you must ask for an appeal within 10 days from the date this letter was postmarked or delivered to you; OR before the date your dental plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

For dental services, this is confusing given that treatment is usually intermittent and continuation is very rare. Therefore, "getting treatment" is confusing language. Neither the letters nor the Appeals Rights insert included the member's right to free access to all documents or records relevant to the

appeal. In addition, many of the reason code explanations refer to a Salzmann score number, which members may not understand without additional, clarifying information.

For all grievance responses to members, Premier included a blank Grievance/Appeal form with the acknowledgment letter to the member, which is confusing as the grievance had already been filed. For the grievance resolution, Premier included language stating that "If you are not happy with our decision, you can ask for a State Fair Hearing. The attached Your Right to a State Fair Hearing form has information about how to ask for a fair hearing." However, a member does not have any State fair hearing rights following a grievance. HSAG suggested that Premier reference the federal regulations to clearly distinguish grievance processes from appeal processes.

VALIDATION OF NETWORK ADEQUACY

Table 2-122 displays the match percentage for provider information between the data submitted by Premier and all dental PAHPs and the online provider directory. Table 2-123 reflects the percentage of providers who have the service listed as available on Premier's online directory as compared to all dental PAHPs.

Table 2-122—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Premier and All Dental PAHPs

Provider Information	Premier			All Dental PAHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	172	100.0%	0.0%	380	100.0%	0.0%
Provider Middle Name	172	2.3%	97.7%	380	4.5%	95.5%
Provider Last Name	172	100.0%	0.0%	380	100.0%	0.0%
Provider Address 1	172	98.8%	1.2%	380	98.7%	1.3%
Provider Address 2	172	52.9%	47.1%	380	76.8%	23.2%
Provider City	172	100.0%	0.0%	380	100.0%	0.0%
Provider State	172	100.0%	0.0%	380	100.0%	0.0%
Provider Zip Code	172	98.8%	1.2%	380	99.2%	0.8%
Provider County	172	0.6%	99.4%	380	55.0%	45.0%
Provider Specialty*	172	98.3%	1.7%	380	99.2%	0.8%
Provider Accepting New Patients	172	97.1%	2.9%	380	96.6%	3.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-123—Percentage of Provider Service Information Available in Online Directory for Premier and All Dental PAHPs

Available Services Information	Premier			All Dental PAHPs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	172	100.0%	0.0%	380	59.7%	40.3%
Non-English Language Speaking Provider	172	91.9%	8.1%	380	96.3%	3.7%
Provider Accommodates Physical Disabilities	172	99.4%	0.6%	380	86.8%	13.2%
Provider Completed Cultural Competency Training	172	0.0%	100.0%	380	0.3%	99.7%
Provider URL	172	0.0%	100.0%	380	31.6%	68.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-124 displays the number and percent of provider categories wherein Premier met the time/distance standards at the statewide level.

Table 2-124—Compliance With Time/Distance Standards by Provider Domain—Premier

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
General Dental	2	2	100.0%
Specialist Dental	1	1	100.0%

*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).

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

Strengths

Premier's online and paper directory are updated every 24 hours according to the health plan's website. The provider directory is available in paper form upon request, and the website also conspicuously displayed an email address or toll-free number to use to report errors in the information presented in the provider directory.

Geographic network distribution analysis indicated that Premier met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

Opportunities for Improvement and Recommendations

Accurate provider information in Premier's online provider directory is critical for members to have timely access to appropriate health care providers. Only 73.5 percent of the sampled providers were found online, and Provider Middle Name, Provider Address 2, and Provider County were missing for a significant number of sampled providers found in the directory. Additionally, the provider directory did not include information on cultural competency training or provider URL for any of the sampled providers. Since the provider directory is updated every 24 hours, Premier should compare the submitted data and online provider directory to identify areas of discrepancy.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Premier should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results.

MCNA

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, MCNA submitted its PIP topic: *Annual Dental Visits.*

Validation Results

Table 2-125 summarizes the validation findings for the Design stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-125—CY 2020 Performance Improvement Project Validation Results for MCNA (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
	Implementation Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (9/9)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, MCNA reported baseline data. 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, and the baseline rate for members ages 21 and over accessing a dentist at least once during the measurement year was 27.4 percent.

Table 2-126 displays the data for MCNA's PIP.

Table 2-126—PIP—*Annual Dental Visits*
MCNA

Study Indicator	Baseline Period (01/01/2019–12/31/2019)		Sustained Improvement
1. The percentage of members ages 1–20 who had at least one dental visit during the measurement year.	N: 30,020 D: 57,218	52.5%	*Not Assessed*
2. The percentage of members ages 21 and older who had at least one dental visit during the measurement year.	N: 5,756 D: 20,980	27.4%	*Not Assessed*

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

Strengths

MCNA documented a sound PIP design, reported accurate data, and implemented member- and provider-level interventions that were related to barriers identified through QI processes. The PIP

study indicators are based on the nationally recognized CMS 416 measure. MCNA's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of, and access to care and services. MCNA's PIP aims to improve annual dental visit rates for its members. The dental PAHP documented that an annual dental visit can help identify dental health problems early when treatment is likely to be simpler and more affordable. It also helps to prevent many problems from developing by reducing the risk of tooth decay, gum disease, tooth loss, and oropharyngeal cancers.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- MCNA must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- MCNA must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that MNCA'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 2020. 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.

Performance Measure Outcomes

Table 2-127 shows MCNA's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-127—MCNA HEDIS 2020 Results

HEDIS Measure	MCNA 2020 Rate	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	54.52%	43.10%

HEDIS Measure	MCNA 2020 Rate	2020 NCQA Quality Compass Average
4–6 Years of Age	69.75%	63.85%
7–10 Years of Age	72.40%	67.17%
11–14 Years of Age	66.80%	62.53%
15–18 Years of Age	59.41%	54.16%
19–20 Years of Age	44.95%	38.26%
Total	65.74%	55.46%

Strengths

MCNA exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit* measure for all performance measure indicator rates.

Opportunities for Improvement and Recommendations

MCNA did not have any opportunities for improvement, and HSAG does not have any recommendations for MCNA.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review for MCNA. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations. As such, for the CY 2020 review, HSAG did not conduct a review of federal regulations or State contract requirements.

HSAG did, however, request a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. MCNA's sample of credentialed providers included several general dentists, a pediatric dentist, and an orthodontist. HSAG reviewed a full sample of 10 prior authorization denial records and 10 appeal records. MCNA reported that eight grievances were filed during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records MCNA submitted and through conducting a virtual, web-based review consisting of interviews with key MCNA staff members.

Strengths

HSAG reviewed the initial credentialing sample and found that MCNA had obtained an application, verification of licensure and education, and checked the applicants' names against federal exclusion databases prior to hire. HSAG found full compliance with the credentialing records.

HSAG reviewed the sample of prior authorization denials and found that MCNA sent all other denial decisions in the sample to the member in a timely manner. In addition, HSAG found that the NABD letters included all required information and were well written with an intention to provide ease of understanding.

HSAG reviewed the appeal records and found that MCNA sent acknowledgement and resolution letters in a timely manner. For some files, HSAG found that the members requested an expedited decision and MCNA denied the request, as the member's condition was not life threatening. MCNA sent a letter to the member acknowledging the appeal request but denying the expedition. This letter included the member's right to grieve about the denied expedition request, as required. Within the resolution letters, MCNA provided the member with ample information to clearly explain the reason for not resolving an appeal in the member's favor.

MCNA reported that eight grievances were filed during the period under review. However, MCNA only included seven grievances in the sample it provided to HSAG. HSAG reviewed the records and found that MCNA acknowledged and resolved all seven grievances in a timely manner. HSAG found that the resolution letters included all required information and were well written, detailing the member's grievance, MCNA's actions or investigations, and the resolution.

Opportunities for Improvement and Recommendations

HSAG reviewed the sample of prior authorization denials and found that MCNA sent one denial decision 15 days after the prior authorization request instead of within 14 days, as required.

HSAG reviewed the appeal records and found that most resolution letters contained medical terminology that was more advanced than a sixth-grade reading level, without including an easy-to-understand explanation.

HSAG observed notes for the grievances in several member records in the electronic documentation system that stated, "referred from verbal complaint because the verbal complaint was not able to be resolved on the same day." HSAG noted that none of the grievances MCNA reported were resolved on the same day, meaning that any complaints received and resolved on the same day may not have been included in MCNA's full tally of grievances. HSAG also noted that eight grievances over a five-month period is a relatively small number of grievances. HSAG suggests that MCNA identify and track all grievances, even those resolved in one day, for trending and QI.

VALIDATION OF NETWORK ADEQUACY

Table 2-128 displays the match percentage for provider information between the data submitted by MCNA and all dental PAHPs and the online provider directory. Table 2-129 reflects the percentage of providers who have the service listed as available on MCNA's online directory as compared to all dental PAHPs.

Table 2-128—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for MCNA and All Dental PAHPs

Provider Information	MCNA			All Dental PAHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	208	100.0%	0.0%	380	100.0%	0.0%
Provider Middle Name	208	6.3%	93.8%	380	4.5%	95.5%
Provider Last Name	208	100.0%	0.0%	380	100.0%	0.0%
Provider Address 1	208	98.6%	1.4%	380	98.7%	1.3%
Provider Address 2	208	96.6%	3.4%	380	76.8%	23.2%
Provider City	208	100.0%	0.0%	380	100.0%	0.0%
Provider State	208	100.0%	0.0%	380	100.0%	0.0%
Provider Zip Code	208	99.5%	0.5%	380	99.2%	0.8%
Provider County	208	100.0%	0.0%	380	55.0%	45.0%
Provider Specialty*	208	100.0%	0.0%	380	99.2%	0.8%
Provider Accepting New Patients	208	96.2%	3.8%	380	96.6%	3.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-129—Percentage of Provider Service Information Available in Online Directory for MCNA and All Dental PAHPs

Available Services Information	Premier			All Dental PAHPs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	208	26.4%	73.6%	380	59.7%	40.3%
Non-English Language Speaking Provider	208	100.0%	0.0%	380	96.3%	3.7%
Provider Accommodates Physical Disabilities	208	76.4%	23.6%	380	86.8%	13.2%

Available Services Information	Premier			All Dental PAHPs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Provider Completed Cultural Competency Training	208	0.5%	99.5%	380	0.3%	99.7%
Provider URL	208	57.7%	42.3%	380	31.6%	68.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-130 displays the number and percent of provider categories wherein MCNA met the time/distance standards at the statewide level.

Table 2-130—Compliance With Time/Distance Standards by Provider Domain—MCNA

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
General Dental	2	2	100.0%
Specialist Dental	1	1	100.0%

*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).

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

Strengths

MCNA's PDV indicated that 93.3 percent of the sampled providers were found in the online provider directory. Additionally, MCNA's match rates between submitted data and the online provider directory for all fields except Provider Middle name exceeded 96 percent. MCNA's website conspicuously displays an email address or toll-free number to use to report errors in the information presented in the provider directory.

Geographic network distribution analysis indicated that MCNA met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

Opportunities for Improvement and Recommendations

Accurate provider information in MCNA's online provider directory is critical for members to have timely access to appropriate health care providers. Only 4 percent of the sampled providers were not found online, and the location was not found in the directory for an additional 2.7 percent of the sampled providers. HSAG recommends that MCNA update its provider directory to include service information such as practice limitations, cultural competency training, physical disability accommodation, and provider URL for all providers.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. MCNA should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results.

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

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Molina CHIP submitted a new clinical PIP topic: *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*.

Validation Results

Table 2-131 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-131—CY 2020 Performance Improvement Project's Validation Results for Molina CHIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI. Review the Data Collection Procedures	100% (4/4)	0% (0/4)	0% (04)
	Design Total	**100% (16/16)**	**0% (0/16)**	**0% (0/16)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (25/25)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Molina CHIP reported baseline data. For the baseline measurement period, Molina reported that 64.5 percent of children 3 to 17 years of age had evidence of BMI percentile documentation during the measurement year.

Table 2-132 displays data for Molina CHIP's PIP.

Table 2-132—PIP—*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*
Molina CHIP

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2018–12/31/2018)**		**Sustained Improvement**
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN	N: 265 D: 411	64.5%	*Not Assessed*

Study Indicator Results			
Study Indicator	Baseline Period (01/01/2018–12/31/2018)		Sustained Improvement
and who had evidence of BMI percentile documentation during the measurement year.			

N–Numerator D–Denominator

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

Strengths

Molina CHIP designed a scientifically sound PIP, conducted appropriate QI processes to identify and prioritize barriers, and implemented interventions that appeared to be logically linked to the barriers. Additionally, Molina CHIP's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. The PIP aims to increase annual BMI screening among its members to increase the likelihood of desired health outcomes through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Molina must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Molina must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with all applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. 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.

Performance Measure Outcomes

Table 2-133 shows Molina's CHIP HEDIS 2020 results as compared to the 2020 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. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-133—Molina CHIP HEDIS 2020 Results

HEDIS Measure	Molina CHIP 2020Rate	2020 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	92.37%	90.72%
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)	84.92%	70.28%
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 by their 13th birthday. (Combination 1)	90.74%	80.40%
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)	81.51%	76.92%
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. (Six or More Well-Child Visits)	79.82%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**70.07%**	74.08%

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

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

Strengths

Molina CHIP exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Child Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement and Recommendations

Molina CHIP fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Molina CHIP exceeded the 2020 NCQA Quality Compass average for five of the six applicable measure rates (83.33 percent), indicating an opportunity for improvement. Molina CHIP should require well-child visits for young children.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

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

Molina is one of Utah's Medicaid ACOs. Molina also holds a contract with UDOH to provide managed health care services under CHIP. HSAG's compliance monitoring tools were developed using federal health care regulations at 42 CFR §438, as well as the State CHIP contract requirements. Molina used the same organizational processes and resources used to administer its Medicaid program to carry out processes required by the CHIP program; therefore, findings between Molina's Medicaid and CHIP lines of business were relatively comparable.

For the CY 2020 compliance monitoring activities, HSAG reviewed requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of initial provider credentialing records, member grievances, service authorization denials, and appeals for alignment with the quality, timeliness, and access domains. Molina's sample of initial CHIP credentialing records included a behavioral analyst, an audiologist, a psychiatrist, social worker, surgeon, a gerontologist, an optometrist, a surgeon, a family physician, and a physician assistant. HSAG reviewed a full sample of 10 grievances, 10 prior authorization denials, and 10 appeals for the time period under review.

HSAG determined findings for the CHIP line of business based on a desk review of the documents Molina submitted and through a virtual, web-based review consisting of interviews with key Molina staff members.

Strengths

Overall findings for Molina indicated improvement from CY 2019 to CY 2020, specifically pertaining to access to care. Concerning member information, HSAG found that Molina began using an accessibility product, User1st's uRemediate, which has an application on its website to invert the colors on a page or change to grayscale to help with color contrast. There is also an option to better support the viewer's screen reader.

In CY 2018, HSAG had found that Molina did not have a process in place to verify whether members received services that network providers represented as having been delivered. In CY 2019, HSAG found that new policies regarding this process applied only to the Medicaid line of business and that Molina did not have procedures for its CHIP line of business. For CY 2020, HSAG found that Molina had updated its policy and procedures to ensure the process for sampling members to detect fraudulent billing practices applied to both Medicaid and CHIP.

In CY 2019, at the time of the review, the drug formulary posted on the website in the CHIP dropdown menu did not include drug tiers. For the CY 2020 review, HSAG reviewed the CHIP drug formulary on Molina's website and noted the formulary included a listing of the tier for each medication.

In CY 2020, HSAG found that Molina included within each applicant's credentialing file a signed application, evidence of verification of licensure and education, and evidence that it searched providers against federal exclusion databases prior to appointment. HSAG also found that Molina resolved grievances and sent notice within the required time frames for all grievances reviewed, potentiality positively impacting the timeliness of services.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had reviewed Molina's provider directory content and found that Molina did not include the following information in the provider directory located on its website: website URLs for providers; information concerning whether the provider completed cultural competency training; or whether the provider's office had accommodations for people with physical disabilities, including offices, exam rooms, and equipment. HSAG reviewed Molina's provider directory again in CY 2019 and concluded the same findings. In CY 2020, HSAG found that Molina's online provider directory did not include website URLs for providers or information concerning whether the provider completed cultural competency training, negatively impacting the quality and access domains. HSAG suggested that Molina develop a strategy to ensure its provider directory is complete.

In CY 2018, HSAG found that Molina's appeal process included provisions that the member must complete a written appeal request within five days of the oral request or the member would lose the

right to appeal. For CY 2019, Molina revised its policy to remove the statement that members "lose their right to appeal" but did not remove the artificial time frame of five days: "The written, signed Appeal must be received within five working days from the date of the oral Appeal. If the Aggrieved Person does not follow up with a written, signed Appeal, the Contractor has no further obligation to take action on the Aggrieved Person's Appeal." The Preamble to the Medicaid managed care regulations clarifies this topic wherein CMS states that a time limit cannot be imposed on the member's written response to an oral appeal request. HSAG recommended that Molina's policy stress that Molina will work with the member to provide any assistance needed in filing a written appeal following an oral appeal, to comply with 42 CFR §438.406(a). HSAG suggests that Molina review 42 CFR §438 Subpart F and revise sections of the Appeals Policy, such as Section I. Right to Appeal a Grievance.

HSAG found some confusion within Molina's documents regarding the definitions of "NABD," "notice of action," "grievance," and "appeal." HSAG suggested that Molina remove the outdated term "notice of action" and ensure that the definition for "NABD" aligns with the federal definition. HSAG found that in Molina's CHIP Appeals Procedure stated that members have 30 days to file a State fair hearing, instead of 120 days. Within its policies, Molina stated that there is an option, sometimes, for a member to appeal a grievance, which is inaccurate. HSAG suggested that senior leadership who oversee appeals and grievances thoroughly review policies and procedures to ensure consistency with the federal and State requirements.

In Molina's CHIP prior authorization denial records, HSAG found that the records did not meet the requirements of §438.10, impacting the access, quality, and timeliness domains of care. For example, the attachment, Guidelines for Appealing a Medical Denial, was written using a font smaller than the required 12-point font and included the following incorrect information:

Required members to follow an oral request for an appeal with a written request within five days.

Stated that Molina would process expedited appeals within three business days, instead of 72 hours.

Included outdated language regarding continuation of services.

HSAG noted that Molina referred to all denial letters as "notices of action," which is an obsolete term for CMS. NABD is the current term CMS uses for denials related to 42 CFR §438.

HSAG also found that the NABD letters and appeal resolution letters were often confusing, unclear, or written in language that was above a sixth-grade reading level. HSAG suggests that Molina's leadership review the appeal procedures to ensure compliance with all requirements and incorporate a monitoring system to initiate supervisor review of letters for content and ease of understanding prior to mailing.

HSAG found that internal documentation of grievances lacked some important details, including evidence of a resolution. In addition, HSAG found conflicting acknowledgement/resolution dates between the letter dates and various dates in the electronic documentation system. HSAG suggested that Molina work toward more complete and accurate documentation in its system notes.

VALIDATION OF NETWORK ADEQUACY

Table 2-134 displays the match percentage for provider information between the data submitted by Molina CHIP and all CHIP MCOs and the online provider directory. Table 2-135 reflects the percentage of providers who have the service listed as available in Molina CHIP's online directory as compared to all CHIP MCOs.

Table 2-134—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Molina CHIP and All CHIP MCOs

Provider Information	Molina CHIP			All CHIP MCOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	282	98.9%	1.1%	473	99.4%	0.6%
Provider Middle Name	282	97.2%	2.8%	473	96.2%	3.8%
Provider Last Name	282	100.0%	0.0%	473	99.6%	0.4%
Provider Address 1	282	94.3%	5.7%	473	86.7%	13.3%
Provider Address 2	282	91.5%	8.5%	473	89.0%	11.0%
Provider City	282	97.5%	2.5%	473	93.4%	6.6%
Provider State	282	100.0%	0.0%	473	100.0%	0.0%
Provider Zip Code	282	95.0%	5.0%	473	91.8%	8.2%
Provider County	282	0.7%	99.3%	473	0.6%	99.4%
Provider Specialty*	282	100.0%	0.0%	473	96.4%	3.6%
Provider Accepting New Patients	282	86.2%	13.8%	473	58.6%	41.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-135—Percentage of Provider Service Information Available in Online Directory for Molina CHIP and All CHIP MCOs

Available Services Information	Molina CHIP			All CHIP MCOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	282	87.2%	12.8%	473	84.4%	15.6%
Non-English Language Speaking Provider	282	100.0%	0.0%	473	93.0%	7.0%
Provider Accommodates Physical Disabilities	282	46.8%	53.2%	473	60.9%	39.1%

Available Services Information	Molina CHIP			All CHIP MCOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Provider Completed Cultural Competency Training	282	0.0%	100.0%	473	33.6%	66.4%
Provider URL	282	1.1%	98.9%	473	11.6%	88.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-136 displays the number and percent of provider categories wherein Molina CHIP met the time/distance standards at the statewide level.

Table 2-136—Compliance With Time/Distance Standards by Provider Domain—Molina CHIP

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	1	50.0%
Specialists—Pediatric	17	2	11.8%
Additional Physical Health—Providers	6	5	83.3%
Additional Physical Health—Facilities	5	2	40.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	1	0	0.0%
Behavioral Health—Pediatric	2	1	50.0%
Behavioral Health—Facilities	3	0	0.0%

*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).

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

Strengths

Molina CHIP's PDV indicated that 77.5 percent of the sampled providers were found in the health plan's online provider directory. Molina CHIP's match rates between submitted data and the online directory for all provider fields except Provider County and Accepting New Patients exceeded 90 percent. Additionally, the information on the Molina CHIP website noted that the most recent update to the website and paper directory was October 24, 2020, when HSAG reviewed the websites on October 26, 2020.

Geographic network distribution analysis indicated that Molina CHIP met 30 of 41 (73.2 percent) of time/distance standards in the urban counties (74.1 percent) and 100 percent of the standards statewide for the Hospitals provider domain.

Opportunities for Improvement and Recommendations

Accurate provider information in Molina CHIP's online provider directory is critical for members to have timely access to appropriate health care providers. HSAG recommends that Molina CHIP frequently update its online provider directory with the required, accurate provider information and have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website. HSAG also recommends that Molina include provider information on cultural competency training and the provider URL since less than 2 percent of sampled providers included information on these services. Additionally, information on physical disability accommodation was present only in 46.8 percent of the sampled providers found in the online directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Molina CHIP should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Molina CHIP met the time/distance standards for 14 of the 41 (34.1 percent) provider categories and struggled to meet standards in rural and frontier counties. Neither of the CHIP MCOs met any standards at the statewide level for Behavioral Health—Adult and Behavioral Health—Facilities provider domains. The provider categories that did not meet the standards are listed in Table 2-137. Additionally, HSAG did not identify any pediatric psychologists in the data for either CHIP MCO. Molina CHIP did not include any pediatric providers for Dermatology or Ophthalmology or any Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Molina CHIP should continue to assess areas of inadequacy to identify providers who chose not to contract with Molina CHIP and the inability to identify the providers in the data using the standard definitions.

Table 2-137—Provider Categories That Failed to Meet Time/Distance Standards—Molina CHIP*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy; Skilled Nursing Facility; Surgical Services (Outpatient or ASC)
Additional Physical Health—Providers	Diagnostic Radiology
Ancillary—Facilities	Pharmacy
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit

Provider Domain	Provider Category
Behavioral Health—Pediatric	Behavioral Medical—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
PNC/Women's Health Providers	OBGYN—Midlevel
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; Otolaryngology, 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).

SelectHealth CHIP

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, SelectHealth CHIP submitted its PIP topic: *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday.*

Validation Results

Table 2-138 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-138—CY 2020 Performance Improvement Project Validation Results for SelectHealth CHIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
	Outcomes Total	**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, SelectHealth CHIP progressed to reporting Remeasurement 3 results. For Remeasurement 3, the study indicator rate of 40.2 percent was 3.1 percentage points higher than the Remeasurement 2 rate and maintained a statistically significant increase ($p = 0.0015$) of 16.8 percentage points over the baseline. SelectHealth CHIP was able to sustain statistically significant improvement over the baseline for two remeasurement periods.

It should be noted that there was a change in HEDIS 2018 *IMA* measure numerator specifications (i.e., a two-dose HPV vaccination series was added instead of a three-dose series). This change may impact the comparability between baseline and Remeasurement 2 data, as well as subsequent remeasurements.

Table 2-139 displays data for SelectHealth CHIP's PIP.

Table 2-139—PIP—*HPV Vaccine Prior to 13th Birthday for Female CHIP Members*
SelectHealth CHIP

Study Indicator	Baseline Period 01/01/2015–12/31/2015		Remeasurement 1 01/01/2016–12/31/2016		Remeasurement 2 01/01/2017–12/31/2017		Remeasurement 3 01/01/2018–12/31/2018		Sustained Improvement
The percentage of 13-year-old female CHIP members who had 2 doses of human papillomavirus (HPV) vaccine prior to their 13th birthday	N: 36	23.4%	N: 52	31.9%	N: 65	37.1%*	N: 72	40.2%*	*Achieved*
	D: 154		D: 163		D: 175		D: 179		

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

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

Strengths

SelectHealth CHIP designed a scientifically sound project and reported and analyzed its Remeasurement 3 data accurately. SelectHealth CHIP conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and was successful in achievement of a statistically significant, sustained improvement in the study indicator rate over the baseline. The PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. SelectHealth CHIP aims to improve HPV vaccination rates in its female adolescent Medicaid population. By increasing the percentage of 13-year-old female Medicaid members who had two doses of HPV vaccine prior to their 13th birthday, the health plan increases the likelihood of desired health outcomes of its members through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

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 activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Since SelectHealth CHIP has demonstrated sustained improvement in this PIP, the health plan should consult with UDOH on next steps.
- Considering the changes to the HEDIS specifications, if SelectHealth CHIP decides to continue with the current PIP topic, it should redetermine the baseline measurement period to allow for comparability of remeasurement data to the baseline.
- SelectHealth must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that SelectHealth's HEDIS compliance auditor found SelectHealth's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. SelectHealth contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of SelectHealth's FAR revealed that SelectHealth's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-140 shows SelectHealth CHIP's HEDIS 2020 results as compared to the 2020 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. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-140—SelectHealth CHIP HEDIS 2020Results

HEDIS Measure	SelectHealth CHIP 2020 Rate	2020 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	93.07%	90.72%
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)	81.33%	70.28%
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 by their 13th birthday. (Combination 1)	91.24%	80.40%
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)	92.55%	76.92%
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. (Six or More Well-Child Visits)	78.72%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**70.37%**	74.08%

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

SelectHealth CHIP—Assessment With Respect to Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth CHIP exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Child Immunization Status- Combination 3*
- *Immunizations for Adolescents-Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement and Recommendations

SelectHealth CHIP fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

SelectHealth CHIP exceeded the 2020 NCQA Quality Compass average for five of the six applicable measure rates (83.33 percent), indicating an opportunity for improvement. SelectHealth CHIP should focus improvement efforts on ensuring well-child visits for young children.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

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

SelectHealth is one of Utah's Medicaid ACOs. SelectHealth also holds a contract with UDOH to provide managed health care services under CHIP. HSAG's compliance monitoring tools were developed using federal health care regulations at 42 CFR §438, as well as the State CHIP contract requirements. SelectHealth used the same organizational processes and resources used to administer its Medicaid program to carry out processes required by the CHIP program; therefore, findings between SelectHealth's Medicaid and CHIP lines of business were relatively comparable.

For the CY 2020 compliance follow-up review, HSAG reviewed requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of initial provider credentialing records, member grievances, prior authorization denials, and appeals for alignment with quality, timeliness, and access requirements. The SelectHealth CHIP initial credentialing sample included a marriage and family therapist, nurse practitioners, a counselor, a social worker, a physical therapist, a psychologist, an obstetrician, and a physician assistant. SelectHealth reported having four service authorization denials, one service authorization appeal, and three grievances for its CHIP line of business during the period under review.

HSAG determined findings based on a desk review of the documents SelectHealth submitted and through a virtual, web-based review consisting of interviews with key SelectHealth staff members.

Strengths

Overall findings for SelectHealth indicated improvement from CY 2019 to CY 2020, specifically pertaining to the access domain. Concerning member information, HSAG found that SelectHealth's searchable online provider directory included all required information. HSAG noted that the searchable online directory contained the cultural competency and physical accessibility information which had not been included in the past.

HSAG reviewed SelectHealth's submission for CY 2019 and found that the CHIP handbook included a 90-day time frame instead of a 60-day time frame for filing an appeal. For CY 2020, HSAG reviewed SelectHealth's CHIP member handbook posted on its website and found that the handbook included the correct time frame for member appeals.

Based on a review of provider agreements in CY 2018 and CY 2019, HSAG found that provider agreements lacked provisions that the provider agrees to make available for audit, evaluation, or inspection—by the State, CMS, the HHS inspector general, and the comptroller general (or designees)—its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to Medicaid members and pertaining to any aspect of services and activities performed or amounts payable under the Contractor's contract with the State. For the CY 2020 review, SelectHealth submitted evidence that its provider agreements included the required regulatory language as defined in 42 CFR §438.230(c).

HSAG reviewed initial credentialing files and found that SelectHealth obtained an application, verification of licensure and education, and had searched all providers in the sample against federal exclusion databases prior to appointment. For the CHIP service authorization appeals, HSAG found full compliance with the quality, access, and timeliness requirements.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had found that SelectHealth's provider directories (print and electronic) did not include the provider's website URL and did not indicate whether the provider had completed cultural competency training or if the office has accommodations for people with physical disabilities. In CY 2020 HSAG found that the searchable directory continued to lack provider URLs and the PDF directory lacked cultural competency information about providers as well as URLs. HSAG suggested that SelectHealth develop a procedure to resolve this ongoing issue.

In the service authorization denial records, HSAG found that SelectHealth sent the same extension letter to both the member and the provider, which requested additional information and did not clarify medical terminology. In addition, the member was not informed of the right to grieve the extension.

HSAG suggested that SelectHealth establish a process to review letters that are sent to members to ensure clarity and compliance with the requirements.

In the appeals review, HSAG found that for two records, SelectHealth did not send the acknowledgement letters in a timely manner. Also, the language in two of the member letters was not written at or below a sixth-grade reading level. In addition, one appeal resolution was not sent within the required time frame of 30 calendar days. HSAG suggested that SelectHealth examine its appeal response procedures to improve the timeliness and quality of experience for its members.

In grievance records and system notes, HSAGs found that members who called in a grievance were offered an opportunity to file a "formal" grievance. If they chose not to, then SelectHealth did not perform a follow-up investigation and closed the case. The federal regulations state that the Medicaid managed care plan must accept grievances orally or in writing, according to 42 CFR §438.402(c)(3)(i). SelectHealth must accept a grievance regardless of how the member submits it and may not put an additional burden on the member to follow up in writing. HSAG discussed during the review that SelectHealth may have confused the process for filing a grievance orally with the process for filing an appeal orally. HSAG noted that it was likely that SelectHealth missed many grievances and consequently did not investigate potential associated quality of service issues during the period under review. Within the files reviewed, HSAG found evidence of further confusion between grievances and appeals, as some members were offered the opportunity to file an appeal following the review of a quality-of-care grievance. In addition, HSAG removed one appeal file from the review that SelectHealth had misidentified as a grievance. HSAG strongly recommends that SelectHealth management review 42 CFR §438 Subpart F–Grievance and Appeal System and retrain staff on grievance and appeal identification and processing.

HSAG also noted that three grievances over a five-month period is an unusually small amount. HSAG suggests that SelectHealth review its grievance collection policies and procedures to ensure that SelectHealth is accounting for all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-141 displays the match percentage for provider information between the data submitted by SelectHealth CHIP and all CHIP MCOs and the online provider directory. Table 2-142 reflects the percentage of providers who have the service listed as available on SelectHealth CHIP's online directory as compared to all CHIP MCOs.

Table 2-141—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for SelectHealth CHIP and All CHIP MCOs

Provider Information	SelectHealth CHIP			All CHIP MCOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	191	100.0%	0.0%	473	99.4%	0.6%
Provider Middle Name	191	94.8%	5.2%	473	96.2%	3.8%
Provider Last Name	191	99.0%	1.0%	473	99.6%	0.4%
Provider Address 1	191	75.4%	24.6%	473	86.7%	13.3%
Provider Address 2	191	85.3%	14.7%	473	89.0%	11.0%
Provider City	191	87.4%	12.6%	473	93.4%	6.6%
Provider State	191	100.0%	0.0%	473	100.0%	0.0%
Provider Zip Code	191	86.9%	13.1%	473	91.8%	8.2%
Provider County	191	0.5%	99.5%	473	0.6%	99.4%
Provider Specialty*	191	91.1%	8.9%	473	96.4%	3.6%
Provider Accepting New Patients	191	17.8%	82.2%	473	58.6%	41.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-142—Percentage of Provider Service Information Available in Online Directory for SelectHealth CHIP and All CHIP MCOs

Available Services Information	SelectHealth CHIP			All CHIP MCOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	191	80.1%	19.9%	473	84.4%	15.6%
Non-English Language Speaking Provider	191	82.7%	17.3%	473	93.0%	7.0%
Provider Accommodates Physical Disabilities	191	81.7%	18.3%	473	60.9%	39.1%
Provider Completed Cultural Competency Training	191	83.2%	16.8%	473	33.6%	66.4%
Provider URL	191	27.2%	72.8%	473	11.6%	88.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-143 displays the number and percent of provider categories wherein SelectHealth CHIP met the time/distance standards at the statewide level.

Table 2-143—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CHIP

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	1	50.0%
Specialists—Pediatric	17	0	0.0%
Additional Physical Health—Providers	6	3	50.0%
Additional Physical Health—Facilities	5	1	20.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	1	0	0.0%
Behavioral Health—Pediatric	2	1	50.0%
Behavioral Health—Facilities	3	0	0.0%

*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).

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

Strengths

While SelectHealth CHIP's PDV indicated that only 54 percent of the sampled providers were found in the health plan's online provider directory, the provider specialty information matched with the submitted data for 91.1 percent of the providers found online. Additionally, over 80 percent of the sampled providers found in the online directory included service information on cultural competency, physical disability accommodation, practice limitations, and whether the provider speaks non-English languages.

Geographic network distribution analysis indicated that SelectHealth CHIP met 100 percent of the standards statewide for Hospitals and Ancillary—Facilities provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in SelectHealth CHIP's online provider directory is critical for members to have timely access to appropriate health care providers. 39.8 percent of the sampled providers were not found in SelectHealth CHIP's online provider directory. Additionally, 6.2 percent of the provider locations were not found in the directory. SelectHealth CHIP had a lower match rate for Provider Address 1 (75.4 percent), Provider Address 2 (85.3 percent), and Provider Accepting New Patients (17.8

percent) among providers found online. HSAG recommends that SelectHealth CHIP frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that SelectHealth CHIP have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. SelectHealth CHIP should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, SelectHealth CHIP met the time/distance standards for 10 of the 41 (24.4 percent) provider categories and struggled to meet standards in rural and frontier counties. While neither CHIP MCO met any standards at the statewide level for Behavioral Health—Adult and Behavioral Health—Facilities provider domains, SelectHealth CHIP also did not meet any of the Specialists—Pediatric standards at the statewide level. The provider categories that did not meet the standards are listed in Table 2-144. Additionally, HSAG did not identify any pediatric psychologists in the data for either CHIP MCO. SelectHealth CHIP did not include any providers in any county for Pediatric Physical Medicine, Diagnostic Radiology, Behavioral Therapy Agency/Clinic, or General Hospitals with a Psychiatric Unit provider categories. While failure to meet some of the standards might result from lack of providers, SelectHealth CHIP should continue to assess areas of inadequacy to identify providers who chose not to contract with SelectHealth CHIP and the inability to identify the providers in the data using the standard definitions.

Table 2-144—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CHIP*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Laboratory; Outpatient Dialysis; Outpatient Infusion/Chemotherapy; Surgical Services (Outpatient or ASC)
Additional Physical Health—Providers	Audiologist; Diagnostic Radiology; Speech Therapist
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit
Behavioral Health—Pediatric	Behavioral Medical—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
PNC/Women's Health Providers	OBGYN—Midlevel
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).

CHIP PAHP Providing Dental Services

Premier Access—CHIP

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Premier CHIP submitted its PIP topic: *Improving Dental Sealant Rates in CHIP Members Ages 6–9.*

Validation Results

Table 2-145 summarizes the validation findings for each stage validated for CY 2020. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 2-145—CY 2020 Performance Improvement Project Validation Results for Premier CHIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
Implementation Total		**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		100% (2/2)	0% (0/2)	0% (0/2)
Percentage Score of Applicable Evaluation Elements *Met*		**95% (18/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**90% (9/10)**		
Validation Status		***Partially Met***		

Indicator Outcomes

For CY 2020, Premier CHIP progressed to reporting Remeasurement 1 results.

For Remeasurement 1, the study indicator rate demonstrated a statistically significant increase ($p < 0.0001$) of 6.0 percentage points over the baseline, to 21.5 percent. Premier CHIP will be assessed for sustained improvement in the next validation year.

Table 2-146 displays baseline data for Premier CHIP's *Improving Dental Sealant Rates in CHIP Members Ages 6–9* PIP.

Table 2-146—PIP—*Improving Dental Sealant Rates in Members Ages 6–9*
Premier CHIP

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Remeasurement 1 01/01/2019–12/31/2019		Sustained Improvement
The percentage of CHIP members 6–9 years of age who received a dental sealant during the measurement year.	N: 697	15.5%	N: 913	21.5%*	*Not Assessed*
	D: 4,492		D: 4,243		

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

Premier CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Premier CHIP documented a sound PIP design, reported accurate data, and achieved a statistically significant increase in outcomes. Premier's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Premier's PIP aims to improve dental sealant rates in children 6 to 9 years old. By increasing the dental sealant rates, Premier intends to prevent the occurrence of dental caries in permanent molars.

Opportunities for Improvement and Recommendations

The PIP received an overall *Partially Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. There were opportunities for improvement in the documentation of the QI processes and evaluation of interventions.

As the PIP progresses HSAG recommends the following:

- Premier CHIP must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Premier CHIP must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Premier CHIP must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicator. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should be documented in the PIP Submission Form and should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Premier's HEDIS compliance auditor found Premier's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Premier contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier's FAR revealed that Premier's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-147 shows Premier CHIP's HEDIS 2020 results as compared to the 2020 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 MCO measure rates to these averages should be interpreted with caution. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-147—Premier CHIP HEDIS 2020 Results

HEDIS Measure	Premier CHIP 2020 Rate	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	47.69%	43.10%
4–6 Years of Age	**54.44%**	63.85%
7–10 Years of Age	**58.54%**	67.17%
11–14 Years of Age	**57.20%**	62.53%
15–18 Years of Age	**50.77%**	54.16%
19–20 Years of Age	**35.29%**	38.26%
Total	**54.86%**	55.46%

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

Premier CHIP—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Premier CHIP exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit—2–3 Years of Age* measure indicator rate.

Opportunities for Improvement and Recommendations

Premier CHIP fell below the 2020 NCQA Quality Compass average for measure indicator rates *4–6, 7–10, 11–14, 15–18, and 19–20 Years of Age* and *the Total* measure indicator rate.

Premier CHIP fell below the 2020 NCQA Quality Compass average for six of the seven (85.71 percent) measure indicator rates. Premier CHIP should focus efforts on providing education about the importance of dental health to the school-age population.

ASSESSMENT OF COMPLIANCE WITH CHIP MANAGED CARE REGULATIONS

Premier CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Premier's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially*

Met or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Premier's sample of credentialed providers consisted of a selection of dentists, including general dentists, pediatric dentists, and two oral surgeons. HSAG reviewed a full sample of 10 prior authorization denial records. Premier submitted a sample of two CHIP appeals for the period under review and did not report any grievances.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Premier submitted and through conducting a virtual, web-based review consisting of interviews with key Premier staff members.

Strengths

In CY 2018, HSAG found that Premier's NABD letter inaccurately stated that members had 30 days to file an appeal (instead of 60 days) and that Premier would make expedited decisions within three business days (instead of 72 hours). The letters were missing the member's right to be provided upon request (and free of charge) reasonable access to all documents and records relevant to the adverse benefit determination (medical necessity criteria and information or processes used in setting coverage limits), and the letters did not include information about State fair hearings. Following the CY 2018 review, Premier updated its templates; however, Premier updated the CHIP template to include 90 days instead of 60 days, which was accurate under the previous rule (prior to July 1, 2017). In CY 2020, HSAG reviewed a revised CHIP NABD template letter as part of the desk review and found that Premier had updated this template to indicate that members had 60 days to file an appeal.

In CY 2018 and CY 2019, HSAG found that Premier's provider directory did not identify which providers had completed cultural competency training. For CY 2020, HSAG found that Premier had included a field in its online provider directory to identify which providers participated in cultural competency training. At the time of the review, Premier had not updated this field for many providers; however, Premier had a process in place to collect this information and was engaged in ongoing efforts to ensure that it queried providers for participation and included the results of the query in the directory.

In CY 2018, HSAG found that Premier's policies, procedures, and member information stated that members may file an appeal orally or in writing and that oral appeals must be followed with a written, signed appeal within five days of an oral appeal. In the preamble to 42 CFR §438, the requirements specifically address that a time limitation for a written response to an oral appeal is not permitted. In response to the requirement, Premier fully removed its requirement for the member to follow an oral request for an appeal with the request in writing. The federal requirements at 42 CFR §438.402 require that an oral request for appeal is followed by a request in writing without time limitation. In CY 2020, HSAG reviewed Premier's revised policy and found that it required members to follow an oral appeal in writing except in the case of expedited appeals.

HSAG reviewed the credentialing records and found that for all providers, Premier collected an application, verified education and licensure, and checked the providers' names against federal exclusions lists prior to hire.

HSAG reviewed Premier's appeal records and found that Premier sent the appeal acknowledgements and resolutions in a timely manner. HSAG reviewed the grievance records and found that Premier acknowledged and resolved each grievance quickly and within the allotted time frame. HSAG found that the resolution letter to the member was transparent, detailed, and specific to the member's case. Premier included all required information.

Opportunities for Improvement and Recommendations

HSAG found Premier's NABD letters to be confusing and difficult to follow. The letter template stated in bold font across the top, "This is not a bill. This is a response to your dentist's request for dental treatment for you." A text box in large letters stated, "Notice of Authorization." The letter contained a list of informational bullets; the first bullet listed the authorization dates that the letter is "good for" (even though some or all services listed in the specific letters reviewed may have had a denied status). The letter also contained a table of procedure codes (one line for each procedure for each tooth) and dollar amounts for amount submitted, covered expense, deductible, primary paid, copay, plan payment, patient payment, then status and reason (in code). Following the table, the letter explained the meaning of the procedure codes and reason codes. The status column in the table was the only place in the letter noting that Premier was denying the service. HSAG strongly suggests that Premier work to streamline and simplify its NABD letters and grievance/appeal forms and consider testing them with a member focus group to ensure readability and ease of understanding.

Premier used a hybrid Grievance/Appeal form, sent with the NABDs, for members to request a grievance or appeal. The form stated that "Appeals filed orally must be followed with a written appeal within five business days. The appeal will not be processed if Premier does not receive a written appeal within five business days." In accordance with federal regulations, the member must follow an oral appeal with a written appeal; however, Premier cannot put a time limit on the member to file the appeal in writing. Further clarification on this topic is located in the preamble to the Medicaid managed care regulations (Federal Register, Volume 81, Number 88, published May 6, 2016, page 27,511, third column). When faced with an oral appeal and requesting that the member follow up in writing, HSAG suggests that Premier consider 42 CFR §438.406(a) which requires that Premier provide a member with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. Further, the continuation of benefits language in the Grievance/Appeal form stated that for continuation of benefits, an appeal must be filed in 10 days, which is incorrect. A request for continuation must be filed in 10 days; however, the member still retains a 60-day filing time frame in which to file an appeal. HSAG also noted that for one appeal, the same provider that made the denial decision also made the decision to uphold the denial upon appeal.

In the appeal resolution letters, HSAG noted unclear language that the member would not easily understand and situations where appeals and grievances were confused. At the beginning of the

Appeal Rights information section, Premier stated, "You have 60 days from the date of a 'Notice of Adverse Benefit Determination letter' to file an Appeal." This language sounds like Premier is referring to a separate letter, as this letter is titled "Notice of Authorization." The letter also stated:

> If you are currently getting treatment and want to continue getting treatment you must ask for an appeal within 10 days from the date this letter was postmarked or delivered to you; OR before the date your dental plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

For dental services, this is confusing given that treatment is usually intermittent and continuation is very rare. Therefore, "getting treatment" is confusing language. Neither the letters nor the Appeals Rights insert included the member's right to free access to all documents or records relevant to the appeal. In addition, many of the reason code explanations refer to a Salzmann score number, which members may not understand without additional, clarifying information.

Premier stated that it did not have any grievances for its CHIP line of business during the period under review. This is an unusual finding for a five-month time frame. HSAG suggests that Premier review its processes for identifying and collecting grievances to ensure that it identifies and captures any expressions of dissatisfaction that are resolved quickly as grievances.

VALIDATION OF NETWORK ADEQUACY

Table 2-148 displays the match percentage for provider information between the data submitted by Premier CHIP and the online provider directory. Table 2-149 reflects the percentage of providers who have the service listed as available on Premier CHIP's online directory.

Table 2-148—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Premier CHIP

Provider Information	Total	Match Percentage	Unmatched Percentage
Provider First Name	202	100.0%	0.0%
Provider Middle Name	202	5.0%	95.0%
Provider Last Name	202	100.0%	0.0%
Provider Address 1	202	99.5%	0.5%
Provider Address 2	202	50.0%	50.0%
Provider City	202	99.5%	0.5%
Provider State	202	100.0%	0.0%
Provider Zip Code	202	89.6%	10.4%
Provider County	202	6.4%	93.6%
Provider Specialty*	202	99.0%	1.0%
Provider Accepting New Patients	202	99.0%	1.0%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-149—Percentage of Provider Service Information Available in Online Directory for Premier CHIP

Available Services Information	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	202	81.7%	18.3%
Non-English Language Speaking Provider	202	95.5%	4.5%
Provider Accommodates Physical Disabilities	202	93.1%	6.9%
Provider Completed Cultural Competency Training	202	0.0%	100.0%
Provider URL	202	5.9%	94.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-150 displays the number and percent of provider categories wherein Premier CHIP met the time/distance standards at the statewide level.

Table 2-150—Compliance With Time/Distance Standards by Provider Domain—Premier CHIP

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
General Dental	2	2	100.0%
Specialist Dental	1	1	100.0%

*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).

Premier CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Premier CHIP's online and paper directories are updated every 24 hours according to the health plan's website. The website also conspicuously displays an email address or toll-free number to use to report errors in the information presented in the provider directory.

Geographic network distribution analysis indicated that Premier CHIP met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

Opportunities for Improvement and Recommendations

Accurate provider information in Premier CHIP's online provider directory is critical for members to have timely access to appropriate health care providers. Only 78.6 percent of the sampled providers were found online, and the Provider Middle Name, Provider Address 2, and Provider County were missing for a significant number of sampled providers found in the directory. Additionally, the provider directory did not include service information on cultural competency training for any provider or URL information for most of the sampled providers. Since the provider directory is updated every 24 hours, Premier CHIP should compare the submitted data and online provider directory to identify areas of

discrepancy. HSAG also recommends that Premier CHIP provide an option for members to request a paper form of the provider directory on its website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Premier CHIP should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix A. Objectives and Methodology for External Quality Review by EQR Activity

Objectives of EQR-Related Activities

Validation of Performance Improvement Projects

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 UDOH 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.

Performance Measure Validation

The primary objectives of PMV are 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.

Compliance Reviews

Private accreditation organizations, state licensing agencies, Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and

effective health care. Making sure that the standards are followed is the second step. 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 UDOH 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.

Validation of Network Adequacy

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.

The goal of the PDV activity was to determine if the information in the health plans' online provider directories found on the respective health plans' websites aligned with the data in the provider file submitted by the health plans. This analysis assessed the accuracy of the provider directories in order to ensure members have adequate and accurate provider demographic and contact information.

Description of Data Obtained

Validation of Performance Improvement Projects

UDOH required each health plan to conduct one PIP during CY 2020. Each health plan chose its own PIP topic. HSAG obtained the data needed to conduct the PIP validations from each health plans' CY 2020 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 2020 validation cycle.

Each section of the PIP submission form includes one of the protocol activities or steps to be undertaken when conducting PIPs. The form presents instructions for documenting information related to each of the protocol activities. 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 measurement year and submitted it to HSAG for validation.

Validation of Performance Measures

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 2020 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 UDOH. These health plans were also required to provide the HEDIS data, final audit reports (FARs), and a copy of the auditor's certification to UDOH. HSAG obtained the HEDIS FARs from UDOH and evaluated the FARs to assess the health plans' compliance with the NCQA HEDIS Compliance Audit standards.

PMHPs and HOME

The 12 PMHPs and HOME were required to calculate and report one measure, *Follow-Up After Hospitalization for Mental Illness (FUH)*, which was a modified version of NCQA's HEDIS 2019 *FUH* measure. The measure was based on claims/encounter data and data from the organization's care management tracking systems. UDOH 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 12 PIHP 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 site audits and reviewed these health plans' submitted documentation and performance measure rates.

Substance Use Disorder (SUD) PAHP

The only SUD PAHP, Utah County, was required to calculate and report a state-modified version of the HEDIS 2020 measure, *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)*. UDOH identified the measurement period for the *IET* measure as CY 2019 (January 1, 2019, through December 31, 2019). Utah County extracted all data for calculation of the *IET* performance measure from Credible, its electronic health record (EHR).

HSAG conducted PMV activities for Utah County to assess the accuracy of performance measure rates reported and to determine the extent to which the calculated performance measures follow measure specifications and reporting requirements. HSAG conducted a virtual site visit and reviewed Utah County's submitted documentation and performance measure rates.

[A-1] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Assessment of Compliance With Medicaid Managed Care Regulations

During CY 2018, HSAG conducted an assessment of the health plans' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2019, HSAG conducted follow-up compliance reviews that included an evaluation of the health plans' corrective action plans (CAPs) to determine the health plans' progress toward achieving full compliance with federal managed care regulations. In CY 2020, HSAG conducted additional follow-up compliance reviews. Also, in CY 2020, HSAG reviewed the health plans' administrative records related to credentialing providers, as requested by UDOH. For the UMIC plans, HSAG conducted a full review of all standards, which included a review of administrative records related to adverse benefit determinations, grievances, appeals, and credentialing.

Documents reviewed during each of the three-year compliance review cycle consisted of the following:

- The monitoring tool with a portion completed by the health plan
- Policies and procedures
- Staff training materials
- Key committee meeting minutes
- Provider and member informational materials
- Sample administrative records related to credentialing

In addition, HSAG obtained data for assessing compliance with regulations through telephonic interviews with key health plan staff members during virtual site reviews.

Validation of Network Adequacy

The CY 2020 NAV analyses and PDV included all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., health care facilities) contracted to provide care as of June 1, 2020, 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 UDOH. 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, 2020. Upon receiving the member data files from UDOH, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. HSAG collaborated with UDOH 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, 2020. 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 primary care provider (PCP) indicator.

Methodology and Technical Methods of Data Collection and Analysis

Validation of Performance Improvement Projects

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (cited earlier in this report).[A-2]

HSAG evaluates the following components of the quality improvement (QI) process:

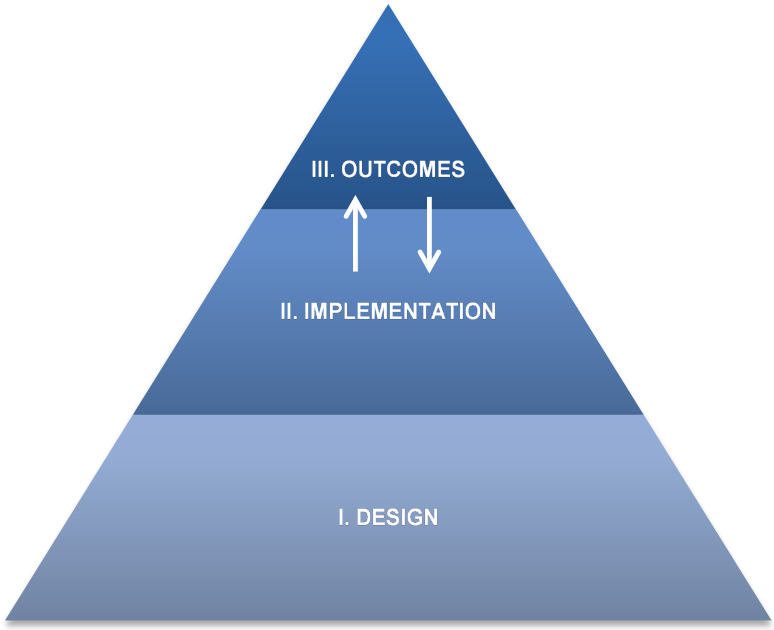
1. Technical structure of the PIP. This step ensures that the MCOs, ACOs, UMIC plans, PMHPs, and PAHPs designed, conducted, and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs. HSAG's validation determines whether the PIP design is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. 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 MCOs, ACOs, UMIC plans, PMHPs, and PAHPS improved rates through implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions).

Figure A-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the study

[A-2] New CMS EQR Protocols were released October 2019 and posted to the CMS website in January 2020. PIP validation activities were already underway at this time; therefore, HSAG used the *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012, for conducting PIP validation activities in CY 2020.

topic, question, population, indicators, sampling techniques, and data collection. To implement successful improvement strategies, a methodologically sound study design is necessary.

Figure A-1—PIP Stages



Once the health plan establishes its study design, the PIP process progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, the health plan evaluates and analyzes its data, identifies barriers to performance, and develops active interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. The Outcomes stage is the final stage, which involves the evaluation of real and sustained improvement based on reported results.

Sustained improvement is achieved when outcomes exhibit significant improvement over the baseline and the improvement is sustained with a subsequent measurement period. This stage is the culmination of the previous two stages. If the outcomes do not improve, the health plan investigates the data collected to ensure that the health plan has correctly identified the barriers and implemented appropriate and effective interventions. If it has not, the health plan should revise its interventions and collect additional data to remeasure and evaluate outcomes for improvement. This process becomes cyclical until sustained improvement is achieved.

HSAG evaluated each PP submitted in CY 2020 using the PIP submission form. In addition, HSAG continued to provide training and technical assistance to the health plans who chose new PIP topics as they began the process of selecting a PIP topic and framing the study design. These health plans submitted the PIP study design for validation in the CY 2020 validation cycle.

Validation of Performance Measures

At the end of the NCQA HEDIS Compliance Audit season, these health plans submitted their FARs and final auditor-locked Interactive Data Submission System (IDSS) rate submissions to UDOH. HSAG obtained the data and FARs from UDOH and reviewed and evaluated the FARs to assess health plan compliance with the NCQA HEDIS Compliance Audit standards. The information system (IS) standards are:[A-3]

- 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—Training, 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.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation for Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, October 2019 (CMS PMV protocol) cited earlier in this report. The CMS protocol activities for validation of performance measures includes three protocol activities. To conduct validation of performance measures for the PMHPs and HOME, HSAG:

1. Conducted pre-on-site activities including collecting and reviewing relevant documentation and rate review.
   - HSAG obtained a list of the indicators selected for validation as well as the indicator definitions from UDOH for the validation team to review.
   - HSAG prepared a documentation request for the PMHPs, HOME, and the SUD PAHP, 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-on-site phase.
   - HSAG prepared an agenda describing all audit activities, including the type of staff needed for each session. HSAG forwarded the agendas to the respective organizations prior to the virtual

[A-3] HEDIS Compliance Audits did not include IS 6.0 beginning with HEDIS 2017; therefore, IS 6.0 was not included in the scope of the health plans' audits for HEDIS 2019.

site visit. When requested, HSAG conducted pre-audit conference calls with each organization to discuss any outstanding ISCAT questions and audit activities.

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, primary source verification, 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 UDOH.

Assessment of Compliance With Medicaid Managed Care Regulations

To accomplish the stated objectives for the site reviews, for assessing each health plan's compliance with Medicaid and CHIP managed care regulations HSAG collaborated with UDOH on the development of follow-up compliance reporting tools and methods, document review and telephonic assessment processes, schedules, agendas, and scoring methodology. HSAG completed follow-up document review and telephonic interviews to assess any requirement scored *Partially Met* or *Not Met* in CY 2019. Upon completion of each review, for each health plan, HSAG assigned a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Scored* to each individual requirement reviewed and indicated where continued required actions existed, if appropriate. In addition, HSAG reviewed each health plans' administrative records related to credentialing providers. For the UMIC plans, HSAG conducted a full review of all standards, which included a review of administrative records related to adverse benefit determinations, grievances, appeals, and credentialing. HSAG organized the Medicaid managed care regulations into eight standards as follows:

Table A-1—Compliance Standards

Standard Number and Title	Regulations Included
Standard I—Coverage and Authorization of Services	438.114 438.210
Standard II—Access and Availability	438.206 438.207
Standard III—Coordination and Continuity of Care	438.208
Standard IV—Member Rights and Information	438.100 438.224 438.10
Standard V—Grievance and Appeal System	438.400 438.402 438.404 438.406 438.408 438.410

Standard Number and Title	Regulations Included
	438.414 438.416 438.420 438.424
Standard VI—Provider Participation and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610
Standard VII—Delegation Subcontracts	438.230
Standard VIII—Quality Assessment and Performance Improvement	438.236 438.330 438.242

HSAG conducted compliance review activities consistent with CMS' *EQR Protocol 3: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, October 2019 (cited earlier in this report). The CMS protocol activities for assessing health plan compliance with regulations includes five protocol activities. To conduct compliance review activities, HSAG:

1. Collaborated with UDOH on the development of both the follow-up compliance reporting tools and tools used for a full assessment of the UMIC plans.
   - Collaborated with UDOH to determine review and scoring methods and thresholds
   - Collaborated with the health plans and UDOH 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 site visit 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 UDOH with a second draft to the health plans for review.
   - Submitted the final health plan-specific reports to the health plans and UDOH.

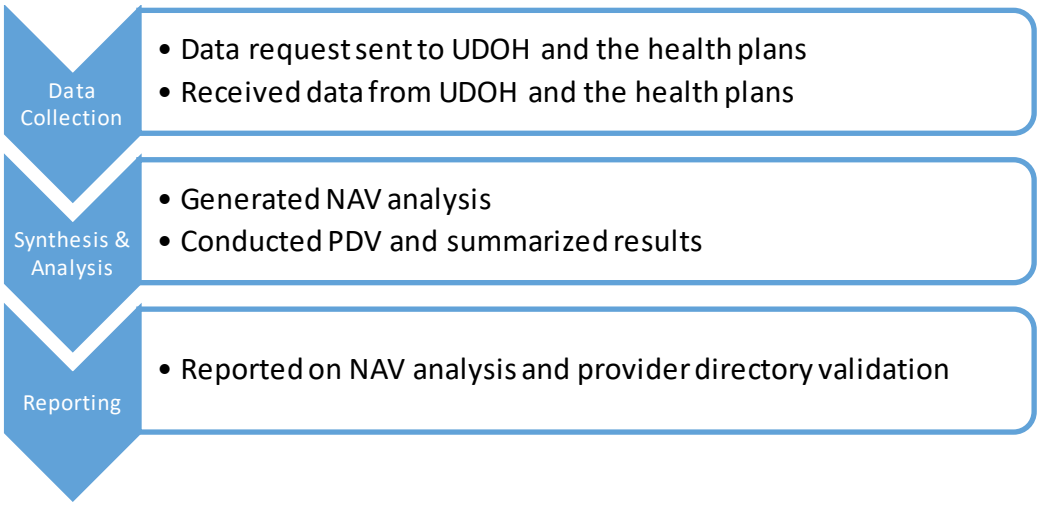
Validation of Network Adequacy

According to the Medicaid and CHIP managed care regulations released in May 2016, the activity related to 42 CFR §438.358(b)(1)(iv), validation of network adequacy, shall commence no later than

one year from the issuance of the associated EQR protocol.[A-4] In preparation of the release of the protocol, HSAG collaborated with UDOH and the health plans to develop a provider crosswalk in CY 2019. In CY 2020, HSAG conducted a NAV analysis which included network capacity and geographic distribution analyses conducted on provider network data submitted by the health plans after the health plans applied the provider crosswalk developed in CY 2019. Additionally, HSAG performed a PDV to ensure members have access to accurate provider demographic and office information.

Figure A-2 describes HSAG's three main phases for the CY 2020 network adequacy tasks. The remainder of this section provides methodologic details for each phase.

Figure A-2—Summary of CY 2020 Network Adequacy Tasks



Network Adequacy Validation (NAV) Analysis

HSAG used the provider data submitted by the health plans to conduct a NAV analysis. The NAV analysis evaluated three dimensions of access and availability:

- **Network Capacity Analysis:** To assess the capacity of a given provider network, HSAG compared the number of providers associated with the health plan's provider network relative to the number of enrolled members. This provider-to-member ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a health plan's provider network to deliver services to Medicaid/CHIP members.
- **Geographic Network Distribution Analysis:** To assess the second dimension of this activity, HSAG evaluated the geographic distribution of the providers relative to member populations. For each health plan, HSAG calculated the average time and distance to the nearest three providers.

[A-4] Government Publishing Office. Electronic Code of Federal Regulations. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7a43ffaad13c1c1450dc0b4101fd92a9&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1358. Accessed on: Mar 3, 2021.

- **Provider Directory Validation (PDV):** The third dimension of this activity assessed the accuracy of the provider directories in order to ensure members have adequate and accurate provider demographic and contact information.

NETWORK CAPACITY ANALYSIS

HSAG calculated the provider ratio for each provider category 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. [A-5] Please note, provider counts for this analysis are based on unique providers, not provider locations.

GEOGRAPHIC NETWORK DISTRIBUTION ANALYSIS

The second dimension of this analysis 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 plan's Medicaid 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-6]: A higher percentage of members meeting access standards indicates better geographic distribution of a health plan's providers in relation to its Medicaid/CHIP members. This metric was calculated for any provider categories for which UDOH has identified a time/distance access standard prior to initiation of the analysis.

Average travel distance (in miles) and travel time [A-7] (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.

[A-5] The availability based on provider ratio does not account for key practice characteristics—i.e., panel status, acceptance of new patients, practice restrictions. Instead, the provider ratio analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of members.

[A-6] The percentage of members within predefined standards were only calculated for provider categories with predefined access standards.

[A-7] 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 members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times are estimated by Quest Analytics software based on the following drive speeds: urban areas are estimated at a drive speed of 30 miles per hour, suburban areas are estimated at a drive speed of 45 miles per hour, rural areas are estimated at a drive speed of 55 miles per hour.

HSAG used Quest Analytics 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.

PROVIDER DIRECTORY VALIDATION (PDV)

The eligible population consisted of a sample of active providers for each health plan as of June 1, 2020. Given the wide range of providers across the health plan types and to ensure meaningful results across the provider types, HSAG limited the number of provider types assessed per health plan to the provider types shown in Table A-2.

Table A-2—Provider Categories Included in the PDV by Health Plan Type

Provider Category	ACO	UMIC	MCO	CHIP MCO	PMHP	Medicaid Dental PAHP	CHIP Dental PAHP
PNC/Women's Health Providers							
OB/GYN	✓	✓	✓	✓			
Primary Care Providers							
PCP—Adult	✓	✓	✓				
PCP—Pediatric	✓		✓	✓			
BH Providers							
Behavioral Mental Health (Medical)—Adult		✓			✓		
Behavioral Mental Health (Medical)—Pediatric					✓		
Behavioral Substance Use Disorder—Adult		✓			✓		
Behavioral Substance Use Disorder—Pediatric					✓		
Behavioral Therapist—Adult		✓			✓		
Behavioral Therapist—Pediatric					✓		
Dental Providers							
All Dental Providers						✓	✓
General Dentists						✓	✓

Based on the eligible provider population, HSAG generated a random sample of providers for each health plan that maintains a contract with UDOH. For each health plan, the results generated from the sample are within ± 5 percent of the population results, at a 95 percent confidence level.

The tasks below show the steps HSAG followed to complete the validation. Task 1 shows the fields that HSAG verified when validating the health plans' online provider directories for each of the sampled providers against the submitted provider data, as applicable. Task 2 shows those items that were

validated for inclusion in the health plans' online directories at the plan level (i.e., overall review of the health plan website).

- Task 1—Provider Data Accuracy: HSAG sampled providers from each health plan and compared them to the health plan's online directory to ensure that the information was accurate, complete, and updated in a timely manner. Below is a list of indicators showing which fields HSAG used for this comparison, as applicable, per health plan type.
  - The following indicators were validated against the health plan's submitted provider file:
    - Provider's First/Middle/Last Name, Street Address, City, State, Zip Code, County, and Acceptance of New Patients
  - The following indicators were assessed as present or not present in the online directory:
    - Website URL, Provider Type/Specialty, Non-English Languages Spoken, Completed Cultural Competency Training, Accommodation for Physical Disabilities, and Any Practice Limitations
- Task 2—Health Plan Provider Directory Validation: HSAG confirmed each health plan's website has the following items:
  - Search fields for members to easily find providers by location or provider type, if applicable
  - Information on how a member can request a paper directory
  - Information on when the data were last updated

Since the PMHPs function in a slightly different manner than some of the other health plans, the PDV parameters were adjusted to best suit the nature of the services provided by the PMHPs. If a PMHP had less than 100 unique providers, the entire eligible population was sampled.

- Providers sampled for a specific PMHP were considered validated if the provider's name appeared on the provider list for the PMHP.
- The sampled provider's address and telephone number were considered validated if the address listed for the PMHP's sampled provider data matched the information listed on the PMHP's website as a location for that PMHP or if the provider was listed at that address.
- For each PMHP, the following items were noted per provider or for the entire PMHP:
  - Provider's Name, Street Address, Office or Clinic Affiliation, Website URL, Provider Type/Specialty, Acceptance of New Patients, Non-English Languages Spoken, Completed Cultural Competency Training, and Accommodation for Physical Disabilities

How Conclusions Were Drawn

Validation of Performance Improvement Projects

Each required protocol activity 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 to care domains, depending upon 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

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Report* or *Not Reported*, (see Table A-3) 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. Meaning, it was possible that a single error could result in a designation of *Not Reported* 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 *Report*.

After completing the validation process, HSAG prepared a report of the PMV findings and recommendations for each PMHP, HOME, and the SUD PAHP. HSAG forwarded these reports to UDOH and the appropriate health plan. Section 2 contains information about the health plan-specific performance measure rates and validation status.

Table A-3—Designation Categories for Performance Indicators

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

To draw conclusions about the quality and timeliness of, and access to care provided by the Utah's Medicaid and CHIP health plans, HSAG determined that each of the performance measures reported were associated to one or more of the three domains of care (quality, timeliness of, and access to services). Each measure may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance based on measure rates and on those associations and the potential impact on member outcomes related to the domains of care.

Assessment of Compliance With Medicaid Managed Care Regulations

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 quality and timeliness of, and access to services (domains of care) provided by each health plan, HSAG determined the requirements within each standard that were associated with each of the domains of care (quality, timeliness of, and access to services). 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

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. Provider data submitted by health plans were also used to assess the accuracy of the online provider directory available to members.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Validation of Performance Improvement Projects

Statewide Comparative Results

For CY 2020, HSAG validated one PIP for each of the four Medicaid ACOs, five Medicaid MCOs, four UMIC health plans, 12 PMHPs, and two CHIP MCOs.

Table B-1 lists the PIP topics and validation scores for each health plan.

Table B-1—CY 2020 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	*Breast Cancer Screening*	84%	90%	*Not Met*
Health Choice UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*Met*
Healthy U	*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*	100%	100%	*Met*
Healthy U UMIC	*Improving Adults' Access to Preventive/Ambulatory Services*	100%	100%	*Met*
Molina	*Medicaid Comprehensive Diabetic Care—Eye Exams*	100%	100%	*Met*
Molina UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*Met*
SelectHealth	*Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*	100%	100%	*Met*
SelectHealth UMIC	*7-day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members*	100%	100%	*Met*
HOME	*Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus*	100%	100%	*Met*

Table B-2—CY 2020 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	*Suicide Prevention*	95%	100%	*Met*
Central	*Inpatient Readmission Rates*	100%	100%	*Met*
Davis	*Access to Care*	100%	100%	*Met*
Four Corners	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	100%	100%	*Met*
Healthy U	*Improving Follow-up After Hospitalization for Mental Illness*	100%	100%	*Met*
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	100%	100%	*Met*
Salt Lake	*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*	87%	75%	*Partially Met*
Southwest	*Outcome Questionnaire Project*	100%	100%	*Met*
Utah County	*Suicide Prevention*	100%	100%	*Met*
Valley	*Suicide Prevention*	81%	83%	*Partially Met*
Wasatch	*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*	100%	100%	*Met*
Weber	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	100%	100%	*Met*

Table B-3—CY 2020 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*	100%	100%	*Met*
SelectHealth CHIP	*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*	100%	100%	*Met*

Dental PAHPs

For CY 2020, HSAG validated one PIP for each of the two dental Medicaid PAHPs and the dental CHIP PAHP.

Table B-4 lists the PIP topics and validation scores for each dental PAHP.

Table B-4—CY 2020 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 Visits*	100%	100%	*Met*
Premier	*Improving Dental Sealant Rates in Medicaid Members Ages 6–9*	84%	80%	*Not Met*
Premier CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*	95%	90%	*Partially Met*

Statewide Opportunities for Improvement and Recommendations—Performance Improvement Projects

For CY 2020, 16 of the 26 PIPs received were new PIP topics. This includes new PIPs initiated by nine PMHPs, four UMIC plans, two ACOs (Healthy U and Molina), and one CHIP (Molina) health plan. The remaining health plans continued with the PIP topic from previous year.

The PIPs were in varying stages. Seven health plans reported PIP study design only; nine health plans and one dental plan (MCNA) reported baseline results; one health plan (Health Choice) and two dental plans (Premier and Premier CHIP) reported Remeasurement 1 results; two health plans (HOME and Utah County) submitted Remeasurement 2 results; three health plans (SelectHealth, SelectHealth CHIP, and Valley) reported Remeasurement 3 results; and one health plan (Bear River) reported Remeasurement 4 results. The health plans submitting remeasurement data were evaluated for achievement of statistically significant and sustained outcomes.

Of the 26 PIPs received, 21 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles and use of appropriate QI activities to support improvement of PIP outcomes. Three PIPs received an overall *Partially Met* validation status, and the remaining two PIPs received a *Not Met* validation status. The opportunities for improvement existed primarily in accurate analysis and interpretation of data, implementation of appropriate improvement strategies with evaluation of effectiveness of each intervention, and achievement of statistically significant outcomes across all study indicators. More specific information about the PIP validation results for CY 2020 for each health plan is included in Section 2 of this report.

In the next annual PIP submissions, HSAG recommends the following:

- The health plans must ensure that all documentation in the PIP Submission Form is documented correctly and completely to address each applicable evaluation element.
- The health plans must ensure that the data collection methodology is in accordance with the approved study design and is comparable to the baseline.
- The health plans must ensure that the narrative interpretation of results is accurate and includes all the required components in accordance with the PIP Completion Instructions.
- The health plans must continue to revisit the causal/barrier analysis at least annually determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plans' PIP submission forms must provide a comprehensive description of the causal/barrier analysis process. The health plans must document the process/steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis during each measurement period.
- The health plans must ensure that in addition to improving data collection, the PIP interventions address barriers toward improving member care.
- The health plans must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
- The health plans must ensure that the interventions are implemented in a timely manner to allow for impact to the remeasurement period reported.
- The health plans seek technical assistance from HSAG, if needed.

Validation of Performance Measures

Statewide Comparative Results

Table B-5 shows the ACOs' HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table B-5—ACOs' HEDIS 2020 Results

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2020 NCQA Quality Compass Average
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)	**NA**	**50.73%**	**NA**	**50.88%**	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)					
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	93.17%	94.12%	93.26%	94.84%	90.72%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**34.73%**	**49.39%**	**40.00%**	**50.02%**	58.35%
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**44.04%**	**48.18%**	**54.99%**	**57.66%**	60.13%
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)	78.35%	75.43%	72.02%	73.41%	70.28%
Chlamydia Screening in Women					
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**32.16%**	**48.28%**	**41.14%**	**38.01%**	58.04%
Comprehensive Diabetes Care					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	88.32%	88.56%	**88.08%**	91.67%	88.22%
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)	**56.93%**	58.64%	**52.07%**	65.36%	57.11%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2020 NCQA Quality Compass Average
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.	61.19%	80.98%	**60.58%**	76.12%	60.75%
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 by their 13th birthday. (Combination 1)	83.80%	90.51%	84.43%	86.93%	80.40%
Prenatal and Postpartum Care					
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**65.93%**	76.89%	**74.70%**	79.56%	75.22%
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.	77.50%	**71.76%**	**73.21%**	74.76%	74.62%
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)	**56.93%**	84.67%	79.32%	90.46%	76.92%
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. (Six or More Well-Child Visits)	**59.12%**	**56.69%**	68.86%	**65.36%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**60.10%**	**67.97%**	**66.18%**	**67.00%**	74.08%

*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.*

Table B-6 presents the findings reported by HOME for the *Follow-Up After Hospitalization for Mental Illness* (*FUH*) measure.

Table B-6—HOME RY 2020 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	50.00%
Follow-Up Within 30 Days	97.37%

Table B-7 presents the findings reported by the PMHPs for the *Follow-Up After Hospitalization for Mental Illness* (*FUH*) measure.

Table B-7—PMHPs RY 2020 *FUH* Results

PMHP	Follow-Up Within 7 Days	Follow-Up Within 30 Days
Statewide PMHP Average	**52.33%**	**67.11%**
Bear River	60.16%	69.92%
Central	**42.00%**	78.00%
Davis	70.15%	82.84%
Four Corners	**37.50%**	**50.00%**
Healthy U	-	-
Northeastern	63.33%	73.33%
Salt Lake	**41.23%**	**59.58%**
Southwest	59.84%	71.65%
Valley	64.71%	82.35%
Wasatch	61.37%	78.97%
Weber	**49.01%**	68.38%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*
Healthy U did not submit performance measures since its contract with UDOH began September 2020.

Table B-8 presents the findings reported by Utah County for the *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure.

Table B-8—Utah County RY 2020 *IET* Results

Indicator	Utah County 2020 Rate
Alcohol Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**

Indicator	Utah County 2020 Rate
Initiation of AOD Treatment—Total—Total	**NR**
Alcohol Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Engagement of AOD Treatment—Total—Total	**NR**

NR—Not Reportable

Table B-9 shows CHIP MCOs' HEDIS 2020 results as compared to the 2020 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. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table B-9—CHIP MCO HEDIS 2020 Results

HEDIS Measure	Molina CHIP	SelectHealth CHIP	2020 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection (URI)			
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	92.37%	93.07%	90.72%
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)	84.92%	81.33%	70.28%
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 by their 13th birthday. (Combination 1)	90.74%	91.24%	80.40%
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)	81.51%	92.55%	76.92%

HEDIS Measure	Molina CHIP	SelectHealth CHIP	2020 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. (Six or More Well-Child Visits)	79.82%	78.72%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**70.07%**	**70.73%**	74.08%

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

Table B-10 shows the HEDIS 2020 results for the dental PAHPs serving the Medicaid population as compared to the 2020 NCQA Quality Compass average rates.

Table B-10—Medicaid Dental PAHPs HEDIS 2020 Results

HEDIS Measure	MCNA	Premier	2020 NCQA Quality Compass Average
Annual Dental Visit			
2–3 Years of Age	54.52%	54.02%	43.10%
4–6 Years of Age	69.75%	68.67%	63.85%
7–10 Years of Age	72.40%	71.21%	67.17%
11–14 Years of Age	66.80%	65.01%	62.53%
15–18 Years of Age	59.41%	58.16%	54.16%
19–20 Years of Age	44.95%	48.53%	38.26%
Total	65.74%	64.68%	55.46%

Table B-11 shows the HEDIS 2020 results for the dental PAHP serving the CHIP populations compared to the 2020 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. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table B-11—CHIP Dental PAHP HEDIS 2020 Results

HEDIS Measure	Premier CHIP	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	47.69%	43.10%
4–6 Years of Age	**54.44%**	63.85%

HEDIS Measure	Premier CHIP	2020 NCQA Quality Compass Average
7–10 Years of Age	**58.54%**	67.17%
11–14 Years of Age	**57.20%**	62.53%
15–18 Years of Age	**50.77%**	54.16%
19–20 Years of Age	**35.29%**	38.26%
Total	**54.86%**	55.46%

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

Statewide Opportunities for Improvement and Recommendations—Performance Measures

Medicaid ACOs

All ACOs except one exceeded the 2020 NCQA Quality Compass average for each of the following measure rates, representing areas of strength.

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbAc1 Testing*
- *Controlling High Blood Pressure*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Immunizations for Adolescents—Combination 1*

All ACOs fell below the 2020 NCQA Quality Compass average for the following measure rates, representing opportunities for improvement.

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

With performance in these measures consistently falling below the 2020 NCQA Quality Compass average for the ACOs, improvement efforts could be focused on increasing breast cancer, cervical cancer, and chlamydia screenings for women and required well-child visits for infants and young children.

HOME

For RY 2020, HOME calculated and reported results for the state-modified *Follow-Up After Hospitalization for Mental Illness (FUH)* measure. Since 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. In addition, with HOME being a unique health plan type, results for the *FUH* measure also could not be compared to the PMHP *FUH* measure results.

PMHPs

For RY 2020, six PMHPs (Bear River, Davis, Northeastern, Southwest, Valley, and Wasatch) exceeded the statewide PMHP average for both state-modified *Follow-Up After Hospitalization for Mental Illness (FUH)* indicators, and two PMHP (Salt Lake and Four Corners) fell below the statewide average for both indicators. Healthy U did not submit performance measures since its contract with UDOH began September 2019. With performance in these measures falling below the 2020 NCQA Quality Compass average for the PMHPs, improvement efforts could be focused on increasing follow-up after hospitalization for mental illness appointments for both the 7-day and 30-day indicators.

SUD PAHP

For RY 2020, Utah County calculated and reported results for the state-modified *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure. Since Utah County used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. In addition, because Utah County was the only health plan that reported *IET* measure rates, HSAG could not compare the results to other health plans. Utah County had errors with its source code, errors with data validation and event categorization, and was not able to provide sufficient explanation or accurate revised rates to HSAG; therefore, it received a *DNR* rating. Improvement efforts for this SUD PAHP could be focused on correcting and updating its source code and measure calculation steps to ensure that all members were appropriately included in the numerator and the denominator.

CHIP MCOs

Both CHIP MCOs exceeded the 2020 NCQA Quality Compass average on all but one measure rate, representing strength for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Both CHIP MCOs fell below the 2020 NCQA Quality Compass average for the following measure rate, representing opportunities for improvement:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

With performance falling below the 2020 NCQA Quality Compass average for both CHIP MCOs, improvement efforts could be focused on increasing required well-child visits for young children.

Dental PAHPs

Both MCNA's and Premier's performance for the Medicaid population exceeded the 2020 NCQA Quality Compass Average for all *Annual Dental Visit* measure rates*: 2–3 Years of Age, 4–6 Years of Age*, *7–10 Years of Age*, *11–14 Years of Age*, *15–18 Years of Age*, and *19–20 Years of Age* and *Total* measure rates.

Premier's performance for the CHIP population exceeded the 2020 NCQA Quality Compass average for one of the seven *Annual Dental Visit* measure rates, indicating needed improvement for the CHIP PAHP. With these rates falling below the 2020 NCQA Quality Compass average, improvement efforts could be focused on increasing the annual dental visits for members ages 4 to 20 years and improving the *Total* indicator rate.

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Comparative Results

ACOs and HOME

Table B-12 provides the number of required corrective actions by Medicaid MCO across the three-year compliance review cycle.

Table B-12—Number of Required Actions by Medicaid MCO

MCO	CY 2018	CY 2019	CY 2020
Health Choice	22	3	1
Healthy U	31	11	1
HOME	19	1	0
Molina	21	7	3
SelectHealth	40	2	1

Entering CY 2020, all five MCOs (four ACOs and HOME) had completed CAPs following the CY 2018 and CY 2019 compliance review activities. Only two of the MCOs were required to complete a CAP for only one standard area by Year 3 of the three-year compliance review cycle (Health Choice and HOME). All MCOs were required to complete corrective actions in the Member Rights and Information standard in CY 2020. Following the CY 2020 follow-up review, only one MCO (HOME) was found to have full compliance with the standards. Two MCOs (Health Choice and SelectHealth) continued to struggle with achieving compliance with Section 508 of Section 504 of the Rehabilitation Act to ensure member electronic materials and the MCOs' websites are readily accessible as defined in §438.10. Molina's provider directory still did not contain all required information about providers, and Molina continued to struggle with revising grievance and appeal policies procedures and member communications to reflect changes in federal regulations that were released in May 2016 and effective July 2017. Healthy U still did not have a process to verify (through sampling or other processes) that services presented to have been provided to members were in fact provided. The four ACOs completed CAPs as a result of CY 2020 follow-up compliance reviews.

Based on record reviews, HSAG found that all five MCOs were in full compliance with credentialing standards reviewed. For the prior authorization denials record review, one MCO (Health Choice) was in full compliance with denials processing and record-keeping requirements; one MCO (HOME) did not send an NABD to the member in one case, and for the remaining three MCOs, some NABD letters did not meet the readability requirements of 42 CFR §438.10. For the appeals record review, two MCOs (Health Choice and Molina) did not send one of 10 acknowledgement letters in a timely manner, two MCOs (Healthy U and SelectHealth) did not send one resolution letter in a timely manner, and one MCO (Molina) had several resolution letters that did not meet the readability requirements of §438.10. For the grievance record reviews, two MCOs (Health Choice and HOME) reported only one grievance for the review period. Healthy U's resolution letters included incorrect information. Molina's grievance documentation system contained incomplete grievance details and SelectHealth had three of 10 resolutions fall outside the required time frame and demonstrated general confusion between when to process a member contact as an appeal or a grievance.

Utah Medicaid Integrated Care (UMIC) Plans

The four UMIC plans initiated operations in January 2020. As such, HSAG conducted a full compliance review inclusive of all standards. While findings were identified in most standards, overall, the plans scored well in the Coordination and Continuity of Care, Subcontracts and Delegations, and Quality Assessment and Performance Improvement standards.

Table B-13 provides the number of required corrective actions assigned in CY 2020 by UMIC plan.

Table B-13—Number of Required Actions by UMIC Plan

UMIC Plan	CY 2020
Health Choice	24
Healthy U	27

UMIC Plan	CY 2020
Molina	18
SelectHealth	24

The most common required corrective actions were related to:

- NABDs or member-specific grievance and appeal communications not being clear or not at an easy-to-understand reading level (all four UMIC plans).
- Not accurately depicting timely access standards in policies and procedures and/or member informational materials (all four UMIC plans).
- Member communications not including taglines that contained the required information (all four UMIC plans).
- Not meeting requirements related to Section 508 of Section 504 of the Rehabilitation Act for electronic member materials and/or the health plan's website (three of four UMIC plans).
- Policies and procedures or member-specific communication inaccurately depicting various time frames and requirements related to the Grievance and Appeal System standard.

PMHPs

Table B-14—Number of Required Actions by PMHP

MCO	CY 2018	CY 2019	CY 2020
Bear River	24	3	0
Central	17	0	0
Davis	13	1	0
Four Corners	22	3	0
Northeastern	11	0	0
Healthy U*	NA	NA	27
Salt Lake	11	0	0
Southwest	20	1	1
Utah County**	33	7	0
Valley**	35	4	0
Wasatch	22	2	0
Weber	24	2	0

*Healthy U PMHP began operations in September 2020.

**Utah County and Valley contracts with UDOH ended in June 2020; therefore, HSAG did not conduct record reviews for these PMHPs or assign ongoing required corrective actions.

In CY 2020 HSAG conducted compliance monitoring activities for 12 PMHPs. Healthy U was operating as a new PMHP as of September 2020; therefore, HSAG conducted a full review of all requirements for Healthy U and follow-up reviews for the remaining PMHPs.

Healthy U's PMHP full compliance review in CY 2020 resulted in 27 required corrective actions for Healthy U across six of the eight standards. Healthy U was found to be in full compliance with the Coordination and Continuity of Care and Quality Assessment and Performance Improvement standards.

Entering CY 2020, three of the 11 PMHPs that had follow-up compliance review activities in CY 2019 (Central, Northeast, and Salt Lake) did not have any continued required corrective actions. The required corrective actions among the remaining eight PMHPs were primarily related to ensuring that members received provider directories in the required format and/or that contained all the required information (seven PMHPs). Five PMHPs had required actions related to ensuring that members receive correct information about the grievance and appeal system in a readily accessible format and implementing the required time frames for processing grievances and appeals. Three PMHPs did not yet have a process to ensure (through sampling or other methods) that members received the services that were represented to have been furnished.

Following CY 2020 follow-up compliance reviews, only one PMHP had a continued required corrective action. Southwest's provider directory did not yet inform members of non-English languages spoken by its providers.

HSAG conducted record reviews for nine applicable PMHPs. Six PMHPs demonstrated full compliance with credentialing requirements. Three PMHPs (Davis, Southwest, and Weber) conducted elements of primary source verification (education, licensure, or exclusion searches) following the date of hire. Only two PMHPs (Salt Lake and Weber) did not report any denials or appeals. While Salt Lake demonstrated full compliance with denial and appeal records reviewed, Weber had a few issues with timeliness of member-specific acknowledgement and resolution letters.

HSAG found that six PMHPs reported less than 10 grievances for the review period, a particularly small number, and recommended that these organizations verify definitions and grievance tracking and documentation processes to ensure all Medicaid member grievances are captured. Six PMHPs were found to be in full compliance with grievance processing, and three (Four Corners, Northeastern, and Southwest) received a recommendation to enhance documentation of grievance acknowledgement.

CHIP MCOs

Table B-15 provides the number of required corrective actions by CHIP MCO across the three-year compliance review cycle.

Table B-15—Number of Required Actions by CHIP MCO

MCO	CY 2018	CY 2019	CY 2020
Molina	21	7	3
SelectHealth	40	3	1

Entering CY 2020, HSAG found that Molina and SelectHealth had ongoing findings in the Member Rights and Information, Grievance and Appeal System, and Provider Participation and Program Integrity standards. Following the CY 2020 reviews, Molina continued to struggle with the required content of the provider directory and accurately informing members of the time frames related to appeal processing. SelectHealth continued to struggle with ensuring that provider directories include all the required information.

Based on CY 2020 record reviews, HSAG found that both CHIP MCOs were in full compliance with credentialing requirements. Molina depicted outdated appeal time frames in its denial letters (i.e., NABDs), and SelectHealth did not report any denials during the review period. Molina did not report any appeals while SelectHealth reported one appeal, which was found to be in full compliance with the requirements. HSAG reviewed a full sample of grievances for Molina and found that grievance acknowledgements were not well documented. SelectHealth reported only three grievances during the review period, which HSAG found to be in full compliance with the requirements. HSAG also found, however, that SelectHealth closed grievances without processing them if members did not follow verbal grievances with a written "formal" grievance, which HSAG found to be noncompliant with managed care regulations.

Dental PAHPs—Medicaid and CHIP

Table B-16—Number of Required Actions by Dental PAHP

MCO	CY 2018	CY 2019	CY 2020
MCNA	12	0	0
Premier (Medicaid and CHIP)	33	3	0

In CY 2019, MCNA achieved full compliance; therefore, in CY 2020 HSAG only conducted a review of denial, appeal, grievance, and credentialing records for this PAHP.

Following the 2019 review, Premier and Premier CHIP had ongoing required actions to resolve pertaining to the Member Rights and Information, and Grievances and Appeals standards. In particular, HSAG found that both lines of business were missing demographic information in the provider directory and that the requirement for a member to follow an oral appeal with a written appeal was missing from their policies. Premier CHIP had additional findings in CY 2019 in the Coverage and Authorization of Services standard, specifically that the CHIP NABD letter included an incorrect time

frame for a member to file an appeal. In CY 2020, HSAG found that Premier and Premier CHIP had corrected these items. HSAG did not identify any ongoing required actions in CY 2020 for the dental PAHPs.

For record reviews, MCNA's credentialing files and denials records were in full compliance with the requirements. MCNA's appeals records were found to be in compliance with all requirements except the requirement for resolution letters to be easy for members to understand. HSAG also found that MCNA's grievance records were in compliance with all requirements; however, HSAG found that MCNA did not document "verbal complaints" as grievances and did not keep any records of this category of grievances.

One Premier credentialing file contained conflicting dates. HSAG found Premier's denials documentation to be unclear, and that member NABD communications did not meet the requirements of §438.10. HSAG found that Premier's appeal communications to members depicted inaccurate appeals processing and State fair hearing time frames and that Premier closed appeals when members did not submit written follow-up to oral appeals after five days of the oral appeal. Premier submitted a full Medicaid grievance sample of 10 records, which HSAG found to be in full compliance with the requirements, while Premier did not report any grievances for it CHIP line of business.

Statewide Opportunities for Improvement and Recommendations—Compliance With Medicaid Managed Care Regulations

As a result of the CY 2020 reviews, HSAG found that Utah's managed care entities performed very well pertaining to requirements associated with the Coordination and Continuity of Care and Quality Assessment and Performance Improvement standards. The plans that underwent a follow-up compliance monitoring review of the CY 2019 CAP made great strides in correcting deficiencies and coming into compliance with federal regulations and State contract requirements across all standards.

Among the health plans, HSAG identified areas with ongoing issues primarily related to record reviews. Pertaining to the Coverage and Authorization of Services standard, HSAG found a lack of clarity in the NABD letters sent to members, the use of complex or confusing language or medical jargon that was not explained, inaccurate State fair hearing timelines, unclear or inaccurate processes or timelines for members to request the continuation of benefits in informational appeal attachments, and the use of inappropriate timeline processes for NABD extensions and expedition requests. For these issues, HSAG recommends that UM supervisors examine NABD letters to identify opportunities to enhance clarity and accuracy, examine processes for expedition requests and extensions, and develop a process where all NABD letters are scrutinized for ease of understanding before they are mailed to the member. HSAG also found that some plans used a peer-to-peer or provider consultation process to reconsider or review a denial decision, rather than processing these requests as appeals. HSAG recommends that these processes are reviewed to confirm that they function within the parameters of the denial and appeal processes, ensuring that members are granted appeal rights, including notifications.

The most common ongoing opportunities for improvement HSAG identified within the Access and Availability standard related to the managed care entities not complying with the network adequacy or timely access standards provided in the State contract as their benchmark for determining the adequacy of the provider, hospital, and pharmacy network. HSAG recommends that health plans review their State contract to determine how to assess the adequacy and accessibility of their network for their member population. Additionally, while many managed care entities improved their cultural competency training, some plans still demonstrated deficiencies in this area. HSAG recommends that these plans look to national organizations, such as CMS, the American Hospital Association, and other organizations or associations, for ideas on how to establish and support a meaningful program.

Pertaining to the Member Rights and Information standard, the most common ongoing opportunities for improvement HSAG identified were related to enhancing the content of health plan websites and searchable provider directory accessibility (Section 508 compliance); improving the font size of documents to meet guidelines; and including large print where indicated (i.e., taglines) to comply with requirements of §438.10. HSAG recommends that MCOs still experiencing challenges with Web accessibility consider contracting with a third-party technology firm to assist with ideas and innovations for simplifying the website or enhancing the accessibility technology. Pertaining to the provider directory, many Utah health plans have struggled with including all required demographics in their provider directory (provider URL, whether a provider had completed cultural competency training, non-English languages spoken by individual providers, etc.). In CY 2020 HSAG found that many health plans were able to remedy these findings; however, for a few plans the findings remained. HSAG recommends that these plans expand their strategies to collect this information and make it available to members in the provider directory.

HSAG found that the most consistent and critical areas needing improvement across health plan types fell under the Grievance and Appeal System standard. Many health plans could benefit from strengthening working definitions for "medical necessity," "grievances," and "appeals"; aligning appeal resolution processes, including the proper use of expeditions and extensions when needed; removing limitations to member appeals by eliminating artificial barriers to members filing appeals; notifying members of their right to grieve an extension; collecting and counting all grievances, including those that are resolved promptly; and treating oral inquiries from members seeking to file an appeal as an actual appeal to establish the earliest possible filing date. HSAG recommends that health plans that are struggling in these areas consult the regulations at 42 CFR §438 Subpart F Grievance and Appeal Systems and the State contract language regarding grievances, appeals, and State fair hearings to reconcile policies and procedures to align with the regulations.

Pertaining to the Provider Participation and Program Integrity standard, HSAG found that some health plans needed to enhance provider agreements, expand the credentialing policy to include provisions for provider retention, and ensure that providers receive comprehensive information about the appeal and grievance process.

Pertaining to the Delegation Subcontracts standard, HSAG found that some health plans had yet to revise or append delegation agreements to include all required language.

Network Adequacy

Statewide Comparative Results

Table B-17 shows the percentage of sampled providers found and not found in the provider directory for each health plan.

Table B-17—Percentage of Sampled Providers Found in the Provider Directory by Health Plan*

Health Plan	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	Percentage	Count	Percentage	Count	Percentage
ACOs							
Health Choice	350	220	62.9%	114	32.6%	16	4.6%
Healthy U	364	271	74.5%	91	25.0%	2	0.5%
Molina	364	277	76.1%	69	19.0%	18	4.9%
SelectHealth	354	190	53.7%	146	41.2%	18	5.1%
UMICs and HOME MCO							
Health Choice	360	152	42.2%	195	54.2%	13	3.6%
Healthy U	375	200	53.3%	168	44.8%	7	1.9%
HOME	364	62	17.0%	291	79.9%	11	3.0%
Molina	375	259	69.1%	102	27.2%	14	3.7%
SelectHealth	363	198	54.5%	146	40.2%	19	5.2%
CHIP MCOs							
Molina	364	282	77.5%	72	19.8%	10	2.7%
SelectHealth	354	191	54.0%	141	39.8%	22	6.2%
PMHPs							
Bear River	32	32	100.0%	0	0.0%	0	0.0%
Central	28	19	67.9%	7	25.0%	2	7.1%
Davis	99	83	83.8%	13	13.1%	3	3.0%

Health Plan	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	Percentage	Count	Percentage	Count	Percentage
Four Corners	25	22	88.0%	3	12.0%	0	0.0%
Healthy U	59	4	6.8%	54	91.5%	1	1.7%
Northeastern	39	20	51.3%	19	48.7%	0	0.0%
Salt Lake	322	79	24.5%	214	66.5%	29	9.0%
Southwest	127	29	22.8%	95	74.8%	3	2.4%
Valley	18	0	0.0%	18	100.0%	0	0.0%
Wasatch	11	0	0.0%	11	100.0%	0	0.0%
Weber	86	76	88.4%	10	11.6%	0	0.0%
Dental PAHPs							
MCNA	223	208	93.3%	9	4.0%	6	2.7%
Premier	234	172	73.5%	57	24.4%	5	2.1%
CHIP Dental PAHPs							
Premier CHIP	257	202	78.6%	29	11.3%	26	10.1%

* Percentage totals may not equal 100 percent due to rounding

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. UMICs operate only in urban areas. Since most PMHPs are inherently regional, statewide results are not presented.

Table B-18—Compliance With Time/Distance Standards by Health Plan Statewide and Urbanicity

Health Plan	Number of Provider Categories	Statewide*		Frontier		Rural		Urban	
		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	Percent Within Time Distance Standard (%)
ACOs									
Health Choice	58	37	63.8%	55	94.8%	41	70.7%	38	65.5%

Health Plan	Number of Provider Categories	Statewide*		Frontier		Rural		Urban	
		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	Percent Within Time Distance Standard (%)
Healthy U	58	42	72.4%	53	91.4%	42	72.4%	50	86.2%
Molina	58	38	65.5%	39	67.2%	43	74.1%	45	77.6%
SelectHealth	58	39	67.2%	56	96.6%	41	70.7%	45	77.6%
UMICs and HOME MCO									
Health Choice	44	38	86.4%	NA	NA	NA	NA	38	86.4%
Healthy U	44	40	90.9%	NA	NA	NA	NA	40	90.9%
HOME	65	36	55.4%	56	86.2%	36	55.4%	55	84.6%
Molina	44	39	88.6%	NA	NA	NA	NA	39	88.6%
SelectHealth	44	37	84.1%	NA	NA	NA	NA	37	84.1%
CHIP MCOs									
Molina	41	14	34.1%	14	34.1%	23	56.1%	30	73.2%
SelectHealth	41	10	24.4%	10	24.4%	20	48.8%	26	63.4%
PMHPs									
Bear River	9	NA	NA	2	22.2%	2	22.2%	0	0.0%
Central	9	NA	NA	2	22.2%	2	22.2%	0	0.0%
Davis	9	NA	NA	6	66.7%	0	0.0%	3	33.3%
Four Corners	9	NA	NA	3	33.3%	3	33.3%	0	0.0%
Healthy U Summit	9	NA	NA	3	33.3%	4	44.4%	0	0.0%
Northeastern	9	NA	NA	2	22.2%	0	0.0%	0	0.0%
Salt Lake	9	NA	NA	3	33.3%	2	22.2%	8	88.9%
Southwest	9	NA	NA	4	44.4%	4	44.4%	0	0.0%
Valley	9	NA	NA	2	22.2%	0	0.0%	0	0.0%
Wasatch	9	NA	NA	0	0.0%	0	0.0%	0	0.0%

Health Plan	Number of Provider Categories	Statewide*		Frontier		Rural		Urban	
		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	Percent Within Time Distance Standard (%)
Weber	9	NA	NA	0	0.0%	6	66.7%	6	66.7%
Dental PAHPs									
MCNA	3	3	100.0%	3	100.0%	3	100.0%	3	100.0%
Premier	3	3	100.0%	3	100.0%	3	100.0%	3	100.0%
CHIP Dental PAHP									
Premier CHIP	3	3	100.0%	3	100.0%	3	100.0%	3	100.0%

Overall network adequacy results are summarized below:

- The results of the PDV analysis show that the percentages of providers found in the health plan directory and match percentages between the plan-submitted provider data and the online provider directory varied greatly by health plan and study indicator.
- The ACOs, MCOs, and CHIP MCOs generally had high match percentages on the provider information (except Provider County, for which these health plans had a match percentage of less than 2 percent) for the providers that could be found in the health plan online provider directory.
- The PMHPs also had high match percentages for the providers found in the provider directories, although HSAG found less than 10 percent of the sampled providers for a few health plans (i.e., Healthy U, Valley, and Wasatch) in the respective provider directories.
- Geographic network distribution analysis results indicate that the ACOs generally maintained a geographically accessible network, with members across the State having access to providers within the time/distance standards in at least 37 of 58 provider categories for all ACOs.
- In general, the ACOs met the time/distance standards for the largest number of provider categories in frontier counties, which may be more indicative of the longer time/distance standards in these counties.
- The PMHPs operate regionally and have demonstrated a wide range in the percentage of members with access to providers. Based on the provider network reported by Wasatch, the health plan did not meet the time/distance standard for any of the provider categories in any urbanicity. Conversely, Salt Lake met the urban time/distance standards for eight of the nine provider categories, indicating a high level of access for its members.

- The Medicaid dental PAHPs and CHIP PAHP met the time/distance standard in all provider categories in frontier, rural, and urban areas, indicating that members have access to dental providers within the time/distance standards.

Statewide Opportunities for Improvement and Recommendations—Network Adequacy

HSAG recommends the following for UDOH and the health plans to strengthen the Medicaid and CHIP managed care provider networks and ensure members' timely access to health care providers:

- Accurate provider information is essential to ensure that Medicaid and CHIP members have access to timely health care and appropriate providers. The PDV results show a varying level of agreement between the provider data submitted by the health plans and the plan-specific online provider directories. UDOH should collaborate with health plans with low match percentages to conduct a root cause analysis to determine the reason for the low match percentage rates for some indicators.
- This PDV focused on whether the information in the submitted provider data and the online provider directory aligned. This PDV analysis cannot confirm whether the information is accurate and up to date for the providers. As a follow-up to this study, HSAG recommends conducting telephone surveys to validate the information in the provider demographic data and online directories. These surveys can be performed concurrently with appointment availability surveys.
- 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, UDOH should use 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.
- UDOH should conduct an in-depth review of provider categories for which each health plan did not meet either the time/distance contract standards, with the goal of determining whether or not the failure of the health plan to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area. Future analyses should evaluate the extent to which the health plans have requested exemptions from UDOH for provider categories in which providers may not be available or willing to contract with the health plan.
- In addition to assessing the number, distribution, and availability of providers, UDOH should review patient satisfaction survey results and grievance and appeals data to evaluate the degree to which members are satisfied with the care they have received.

HSAG HEALTH SERVICES ADVISORY GROUP

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 *Breast Cancer Screening* PIP received a *Met* score for 91 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement in the narrative interpretation of results. In the 2020 PIP submission, the health plan continued to have deficiencies in the narrative interpretation of the data.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Health Choice has responded that it engaged in the following QI initiatives:

- For the measures related to increasing screenings for women (breast cancer, cervical cancer), Health Choice reported that performance improvement coordinators (PICs):
- Provided education for members on *BCS* and *CCS* and why these screenings are important.
- Worked with the Outreach Department to create new informational brochures and pamphlets to help women understand the importance of early detection as well as fundamentally educate women on these cancers and what an appointment for this would look like.
- Called all members with breast cancer and cervical cancer gaps and offered assistance to schedule an appointment for a mammogram/Pap.
- Educated providers on the importance of recommending cancer screenings.
- Delivered gap lists including *BCS* and *CCS* lists to all participating providers every month.
- Set up a process with the HCU Clinical Services team in which PICs are notified when a member delivers a baby; the PIC then calls the member's OB to confirm that a postpartum visit has been scheduled and reminds the provider to perform a Pap during that visit if the member is due.
- For the measures related to required well-child visits for infants and young children, PICs:
- Called the parents or guardians of all members with well-care visits [due] and offered assistance to schedule an appointment for a well-care visit.
- Educated providers on the importance of recommending well-care visits and encouraged them to conduct well-care visits anytime the child is in the office (if the child's condition permits).

- Delivered gap lists including infant and child well-care visit gaps to all participating providers every month.
- For the measures related to documentation of the BMI percentile for children ages 3 to 17:
- PICs educated providers on the importance of measuring, calculating, and addressing BMI at every visit.
- PICs confirmed that for EMRs [electronic medical records] that automatically calculate BMI percentile, the BMI is documented in a compliant format (as a percentile, not as a value or a range).
- For the very few practices with noncompliant documentation, the PIC recommended a change to the EMR and provided the practice with information on compliant documentation.
- Related to the appropriate management of diabetes, Health Choice reported:
- Due to staffing and unexpected growth in membership, disease management programs were put on hold during 2020. We do have a diabetes management program completed and are working to implement it with members who are currently in case management.
- We continue to refer members to reliable community resources for disease management.
- Our pharmacy team actively works with members receiving diabetes and cardiovascular medications to ensure they complete their fills and are compliant with their medication regimen.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements, as well as a review of administrative records related to credentialing of providers. Health Choice scored well in many standard areas. Following the review, Health Choice completed a CAP for requirements found to be out of compliance in the standard area of member rights and information. In CY 2020, HSAG conducted a virtual follow-up review of Health Choice's CAP during which Health Choice demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review in CY 2020, HSAG identified one ongoing required action related to member information, which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Health Choice's provider networks. In response to HSAG's recommendations, Health Choice reported that it continues to streamline data entry in MedMC (data system) to be as uniform as possible. Health Choice has standardized and corrected the addresses, provider titles, and abbreviations in the database. The health plan also reported that quarterly geo-access reports are generated to assess adequacy improvement opportunities. Due to the rural nature of many counties and the centralized nature of others (i.e., the majority of Utah County's provider specialties are located in Provo, leaving communities on the county borders outside the time/distance standards), most instances of inadequacy result from a lack of providers within the

time/distance area. However, as providers are located or as inadequacies due to other reasons are found, Health Choice places recruiting efforts on bringing those provider specialties in network.

While Health Choice reported that classifications of specialty and title are not uniform due to its database design, HSAG's provider crosswalk can help standardize provider classification within and across health plans. In CY 2020, Health Choice submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

Healthy U

Validation of Performance Improvement Projects

In CY 2020, Healthy U submitted a new PIP, *Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds.* Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Healthy U has responded that it engaged in the following QI initiatives:

- For the measures related to increasing screenings for women (breast cancer, cervical cancer, and chlamydia), Healthy U reported:
- Continuing to conduct outreach to members and providers to increase compliance rates with the women's health measures.
- Using HEDIS prospective data, identifying women ages 21 through 74 years who are due for cervical cancer and/or breast cancer screening to send reminder letters.
- PCPs receive a list of their patients who were overdue for these exams and are encouraged to contact these members to schedule appointments.
- Starting to make member phone outreach calls to help members with scheduling appointments or finding a provider.
- For the care for women following delivery, Healthy U:
- Makes outreach calls to all high-risk pregnant members for referral into our U Baby Care Management program.
- Follow women identified for the program throughout the pregnancy and postpartum period. Once a woman delivers, a care manager reaches out to complete a postpartum questionnaire which assesses birth control, completion of a postpartum visit, and screens for postpartum depression.
- Sends 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.

- For the measures related to the required well-child visits for infants and young children, Healthy U reported:
- Continues to offer parents/guardians of children turning 3, 4, 5, or 6 years of age a $25 gift card for receiving a well-child visit during 2020.
- Sends postcards to members informing them of this initiative and encouraging them to schedule the exam.
- Providers receive a list of their patients who are due for a well visit to schedule appointments.
- In addition, Healthy U emailed members immunization reminders and faxed providers lists of members who were overdue for age-appropriate immunizations.
- Healthy U is planning to begin phone outreach to members in 2021 to remind parents of the importance of well visits and assist with scheduling appointments or finding a provider.
- Related to the appropriate management of diabetes, Healthy U reported:
- Completing outreach to members and providers to increase compliance with diabetic eye exams, using HEDIS prospective run data.
- Information was sent to members explaining the importance of diabetic eye exams and how to schedule an appointment with an eye care provider. The member letter also contained a Diabetic Eye Exam Communication Form that members could take to their eye care provider. The form instructed the member and the eye care provider to send the form to the member's PCP.
- PCPs received a list of patients who were overdue for these exams to encourage follow-up. Healthy U also conducted member phone outreach to educate and encourage members to schedule diabetic eye exam appointments.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Healthy U scored well in many standard areas. Following the review, Healthy U completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, access and availability, member rights and information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Healthy U's CAP during which Healthy U demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG identified one ongoing required action related to provider participation and program integrity, which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Healthy U's provider networks. In response to HSAG's recommendations, Healthy U responded that the network deficiency for pediatric specialists is very

likely based on the Healthy U member's home ZIP Code not being within the mileage standard to Primary Children's or Riverton Hospital. This is attributed to the lack of supply of pediatric specialists throughout Utah and the Intermountain region. Therefore, Healthy U believes this is not a true contracting opportunity. Healthy U also responded that the reported deficiencies for infusion, diagnostic radiology, and lab are very likely a data issue and not a true network deficiency. These services are generally included within hospitals and were not included in the data file and therefore are not showing as member access points for these services. Additionally, the health plan does not include all access points for a lab in its data due to the complexity of maintaining all lab and draw station locations.

Molina Healthcare of Utah

Validation of Performance Improvement Projects

In CY 2020, Molina submitted a new PIP, *Medicaid Comprehensive Diabetic Care—Eye Exams.* Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG recommended that Molina focus improvement efforts on the following:

- Increasing screenings for women (breast cancer, cervical cancer, and chlamydia)
- Care for women following delivery
- Required well-child visits for infants and young children
- Documentation of BMI percentile for children ages 3 to 17
- Appropriate management of conditions for members with diabetes and high blood pressure
- Decreasing the use of clinical imaging for members with low back pain

In 2020, Molina reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Began using telemedicine to complete patient visits.
- Seven high-volume pediatric offices agreed to participate in a bonus program in which they are rewarded for completing preventive services and immunizations for their Molina pediatric patients.
- Utilized incentives to pregnant women to encourage them to continue obtaining prenatal care and postpartum care.
- Utilized incentive programs for patients to ensure they were still completing wellness services.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Molina scored well in many standard areas. Following the review, Molina completed a CAP for requirements found to be out of compliance in the standard areas of member information, grievance and appeal system, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Molina's CAP during which Molina demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG identified ongoing required actions related to member information and the grievance and appeal system which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Molina's provider networks. In response to HSAG's recommendations, Molina responded that the health plan's performance in the rural and frontier counties for pediatric specialties was primarily due to lack of providers and recommended updating network standards to reflect the same. Additionally, Molina responded that it will conduct an analysis of its pediatric specialties to determine opportunities to more accurately reflect traveling physicians and the use of telehealth to improve adequacy based on current time/distance standards. Molina also recognizes a portion of the challenges seen in urban and rural areas are due to data integrity issues. Since the 2018 study and follow-up, the health plan has taken steps to correct data integrity issues through self-auditing provider records to ensure information is accurately reported and reviewing provider communities, competitor networks, and other resources to identify additional providers to include in the network.

Based on CY 2019 recommendations, Molina responded that it has reviewed provider information, corrected spelling errors, and found that the provider specialties accurately reflect the provider's licensed specialty and match the provider's taxonomy codes. Molina reported that it will continue to review how specialties are classified and look for ways to streamline provider specialty representation. In CY 2020, Molina submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

SelectHealth Community Care

Validation of Performance Improvement Projects

SelectHealth's *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*

PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, SelectHealth has reported the following QI initiatives:

- Related to increasing screenings for women (breast cancer, cervical cancer, and chlamydia), SelectHealth:
- Created a Women's Health brochure. The brochure addresses cervical cancer screening, colon cancer screenings, vaccinations, chlamydia testing, breast cancer screening, wellness, and depression screenings.
- Specifically, for cervical cancer screening, SelectHealth also improved the process and look of the Women's Preventive Health Report. This is sent to providers and encourages them to set up appointments with their patients for the necessary screenings.
- Included chlamydia screening rates in comparison to the national benchmarks for OB/GYN/CNM [obstetrician/gynecologist/certified nurse-midwife] providers in the publicly reported quality ribbon ratings that were published this year on the SelectHealth provider search page. The hope is that this will draw attention to the measurements for the community (SelectHealth reports having included some patient education with the ribbons online) and also for the providers so that they are encouraged to continue educating the patients.
- Is also considering a program next year for self-swabbing for HPV to improve *CCS* and chlamydia screening. It is just in the discussion process right now and would pilot at a certain clinic that has been interested.
- Organized a breast cancer screening taskforce between SelectHealth Quality Improvement, SelectHealth Medical Home, Castell (SelectHealth's delegate for Practice Transformation and provider support), R1 (SelectHealth's delegate for administrative services), Intermountain Imaging Services, Intermountain Internal Medicine, and Intermountain Women's Services. The purpose was to decrease wait times, improve access, coordinate scheduling workflows, and share data so outreach was not overlapping and potentially abrasive. This group started in 2019 but grew to include appropriate stakeholders in 2020.
- Moved outreach from Symphony RM to Castell. This change has resulted in more members being contacted with the offer to schedule a mammogram directly without the need for transfers or conference calls.
- Mailed out the annual breast cancer screening brochure. It was not significantly changed this year but is planned to undergo a rewrite in 2021.
- For measures related to required well-child visits for young children, SelectHealth:
- Continued the three-part member directed outreach for well-child visits for young children. Part 1 was an appointment reminder outreach that consists of one contact two months before the

anticipated due date of a well exam based on prior year claims. This is a brief touch to parents/guardians with a high propensity to close clinical gaps. Part 2 consisted of a parent education IVR [interactive voice response] call/email with a opt-in for a 30-day reminder call/email/SMS [short message service]. This reaches out to parents of children with no claim for a well-child visit in the prior year. Part 3 was an IVR call that goes out in August and September to members who still have a well-visit gap. During 2020 all of these communications were updated with COVID-19 language informing members that their child still needs a well visit during the pandemic and that provider offices are open.

- Updated the IVR communications to comply with the new NCQA *WCV* measure.
- In 2020, also worked on a *Protect Your Child With Preventive Care* brochure. SelectHealth reported hoping to have this new brochure finalized and available to send during Q1 2021 to members least likely to schedule a well exam based on prior claims.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. SelectHealth scored well in many standard areas. Following the review, SelectHealth completed a CAP for requirements found to be out of compliance in the standard areas of member information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of SelectHealth's CAP during which SelectHealth demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG identified one ongoing required action related to member information, which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of SelectHealth's provider networks. In response to HSAG's recommendation, SelectHealth responded that the SelectHealth Provider Development team will actively work with the Provider Relations team to research whether there are available providers of this specialty type in the identified counties based on the Medicaid Known Provider Look Up tool, reach out to any available providers and explore the possibility of a contract, and make best efforts to fill these deficiencies by offering a contract and proceeding with system setup and enrollment with the new providers. SelectHealth reported that the success of these ongoing efforts is contingent on availability and willingness of providers to join the Medicaid/CHIP network. According to the Medicaid Known Provider Look Up tool, there are deficiencies in all rural and frontier counties for the following provider categories: Behavioral Health, OB/GYN, and Primary Care—Pediatric.

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

Health Choice

Validation of Performance Improvement Projects

In CY 2020, Health Choice submitted a new PIP, *Follow-Up After Hospitalization for Mental Illness*. Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for Health Choice's UMIC line of business; therefore, this section is not applicable for Health Choice.

Validation of Network Adequacy

CY 2020 was the first year of the network adequacy study for Health Choice's UMIC provider network. Therefore, this section is not applicable for Health Choice.

Healthy Outcomes Medical Excellence (HOME)

Validation of Performance Improvement Projects

HOME's *Impact of Clinical and Educational Intervention on Progression of Pre-Diabetes to Type II Diabetes Mellitus* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In CY 2019, HSAG recommended that HOME focus improvement efforts on the following:

- Add a column in its tracking spreadsheet to denote who was or was not counted in the calculation of the performance measure. HSAG recommended that HOME investigate the substantial difference between the rate for members receiving a follow-up service within seven days following a hospitalization and the rate for members receiving a follow-up service within 30 days following a hospitalization.
- Determine if barriers exist that negatively impact members' ability to receive services within seven days following a hospitalization and determine if targeted interventions will improve this rate.

In 2020, HOME reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Refined verification and validation processes of hospitalizations and follow-up appointments.
- HOME case managers began documenting all reported inpatient encounters and follow-up visits that are cross-checked with linked claims.
- Adding another layer to ensure accuracy of data, this information is reconciled with patients' records housed in the EMR system, Epic.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. HOME scored well in many standard areas. Following the review, HOME completed a CAP for one requirement found to be out of compliance in the standard area of member information. In CY 2020, HSAG conducted a virtual follow-up review of HOME's CAP during which HOME demonstrated improvement in that standard area that had been less than fully compliant in the previous review year. During the follow-up review, HSAG determined the requirement to be met and HOME to be fully compliant.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of HOME's provider networks, and HSAG had made the following recommendations:

- Assess available data values in HOME's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met—behavioral health providers, pediatric specialists and additional physical health specialties—to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with HOME, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, HOME submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Healthy U

Validation of Performance Improvement Projects

In CY 2020, Healthy U submitted a new PIP, *Improving Adults' Access to Preventive/Ambulatory Care Services.* Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for Healthy U's UMIC line of business; therefore, this section is not applicable for Healthy U.

Validation of Network Adequacy

CY 2020 was the first year for the network adequacy study of Healthy U's UMIC provider network. Therefore, this section is not applicable.

Molina

Validation of Performance Improvement Projects

In CY 2020, Molina submitted a new PIP, *Follow-Up After Hospitalization for Mental Illness*. Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for Molina's UMIC line of business; therefore, this section is not applicable for Molina.

Validation of Network Adequacy

CY 2020 is the first year for Molina's network adequacy study for the UMIC line of business. Therefore, this section is not applicable.

SelectHealth

Validation of Performance Improvement Projects

In CY 2020, SelectHealth submitted a new PIP, *7–Day Follow–Up After Hospitalization for Mental Illness for Medicaid Integration Members*. Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for SelectHealth's UMIC line of business; therefore, this section is not applicable for SelectHealth.

Validation of Network Adequacy

CY 2020 is the first year for SelectHealth's network adequacy study for the UMIC line of business. Therefore, this section is not applicable.

Medicaid PIHP and PAHP PMHPs Providing Mental Health and/or Substance Use Disorder Services

Bear River Mental Health Services

Validation of Performance Improvement Projects

Bear River's *Suicide Prevention* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement in the narrative interpretation of results. In the 2020 PIP submission, the health plan addressed the deficiencies in the narrative interpretation of the data.

Validation of Performance Measures

In CY 2019, HSAG recommended that Bear River focus improvement efforts on the following:

- Ensuring that members receive a Bear River-furnished service within seven days and within 30 days following discharge from a hospitalization.
- Have processes in place to document and track authorizations for inpatient hospitalization to ensure accurate performance measure calculation.
- Implement quality checks to ensure that State specifications are followed during the measure calculation process.

In 2020, Bear River reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Implemented review of the HEDIS report quarterly at the executive team meeting. This allows supervisors to see how Bear River is doing with its follow-up.
- Implemented regular reviews of the HEDIS report during the quarterly QIP meeting so that QIP members can remind staff of the importance of follow-up with members after hospitalization.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Bear River scored well in many standard areas. Following the review, Bear River completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Bear River's CAP during which Bear River demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG determined the requirements to be met and Bear River to be fully compliant.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Bear River's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Bear River's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Bear River, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Bear River submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Central Utah Counseling Center

Validation of Performance Improvement Projects

In CY 2020, Central submitted a new PIP, *Inpatient Readmission Rates*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Central has responded that is initiated the following activities:

- Added two additional columns (i.e., "Numerator" and "Denominator") to its tracking spreadsheet that include a "Yes" response in the drop-down list to identify cases that are either numerator or denominator compliant and ensure accurate performance measure calculation.
- Updated and improved its spreadsheet used for tracking of all inpatient stays to include vital information for the determination of inclusion/exclusion in the PMV.
- Also began a QI project that will better meet the needs of clients upon discharge from hospitals. This includes having an assigned case manager working with them.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Central demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Central had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Central's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Central's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Central, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Central submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Davis Behavioral Health

Validation of Performance Improvement Projects

In CY 2020, Davis submitted a new PIP, *Access to Care.* Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Davis related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Davis scored well in many standard areas. Following the review, Davis completed a CAP for requirements found to be out of compliance in one standard area of member information. In CY 2020, HSAG conducted a virtual follow-up review and determined that Davis demonstrated full compliance in the standard area that had been less than fully compliant in the previous review year. Therefore, HSAG found that Davis had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Davis's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Davis's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Davis, the inability to identify the providers in the data using the standard definitions, or something else.

To address these recommendations, in CY 2020, Davis reported that it has:

- Actively worked to create and organize an active provider database to better monitor and regulate its provider network.
- Recently purchased rights to utilize Modio OneView, a cloud-based platform that securely manages and stores providers' credentials and licensure in one easily accessible place. This is anticipated to not only allow the agency to more effectively and efficiently perform credentialing efforts for both Medicaid and other payors, but also allow the agency to improve efforts to track training, continuing education, and other certifications that are critical to maintain a strong provider network and meet the needs of the members.

In addition, in CY 2020, Davis successfully submitted data for the network adequacy activity using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

Four Corners Community Behavioral Health

Validation of Performance Improvement Projects

In CY 2020, Four Corners submitted a new PIP, *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG recommended that Four Corners focus improvement efforts on the following:

- Perform a review of the Medicaid Managed Care System (MMCS) to check for enrollment 30 days past the date of hospital discharge to ensure members who were enrolled during this time frame are appropriately included.
- Use its EHR, Credible, as well as claims information when conducting a secondary review to ensure members who meet the performance measure specifications are accurately included, which could result in an improvement in the measure rates.
- Date stamp any paper claims received via mail to ensure inclusion of appropriate members in the rate calculations.

In 2020, Four Corners reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- The accounts payable specialist stamps the paper claims as received via USPS mail.
- The billing specialist doublechecks all hospitalizations and verifies the member's Medicaid eligibility using MMCS.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Four Corners scored well in many standard areas. Following the review, Four Corners completed a CAP for requirements found to be out of compliance in the standard areas of access and availability and member information. In CY 2020, HSAG conducted a virtual follow-up review and identified that Four Corners demonstrated full compliance in the standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Four Corners had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Four Corners' provider networks, and HSAG had made the following recommendations:

- Assess available data values in Four Corners' provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Four Corners, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Four Corners submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Northeastern Counseling Center

Validation of Performance Improvement Projects

In CY 2020, Northeastern submitted a new PIP, *Inpatient Post Discharge Engagement and Suicide Intervention*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Northeastern Counseling Center related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Northeastern demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG determined that Northeastern had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Northeastern's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Northeastern's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Northeastern, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Northeastern submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Salt Lake County Division of Mental Health

Validation of Performance Improvement Projects

In CY 2020, Salt Lake submitted a new PIP, *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Salt Lake County related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Salt Lake demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Salt Lake had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Salt Lake's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Salt Lake's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Salt

Lake, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Salt Lake submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Southwest Behavioral Health Center

Validation of Performance Improvement Projects

In CY 2020, Southwest submitted a new PIP, *Outcome Questionnaire (OQ) Project*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Southwest has responded with the following information:

- Over this past year, Southwest has worked with, and trained, both front-office and back-office staff in using the same protocol and practice when entering and documenting a client's enrollment date. The Center discussed this practice at length with the EQRO team during the site visit and has developed a process anticipated to be the most useful and reasonable way to ensure consistency in recording.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Southwest scored well in many standard areas. Following the review, Southwest completed a CAP for requirements found to be out of compliance in one standard area related to member information. In CY 2020, HSAG conducted a virtual follow-up review of Southwest's CAP during which Southwest demonstrated improvement in the standard area that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified ongoing required actions related to member information which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Southwest's provider networks. In response to HSAG's recommendations, Southwest reported that it worked to clean up the variances in license designations

to maintain a more consistent way of reporting. In CY 2020, Southwest submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. Additionally, Southwest continued to seek to fill vacant positions with qualified and licensed candidates including using intern and practicum slots to entice future candidates. The health plan also reported using a productivity-based incentive plan to aid in retention of qualified staff and expand its subcontractor network to meet the minimum treatment timelines.

Utah County Department of Drug and Alcohol Prevention and Treatment

Validation of Performance Improvement Projects

Utah County's *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement with the PIP achieving real improvement. In the 2020 PIP submission, the health plan addressed the deficiency. Both the study indicators demonstrated statistically significant improvement over baseline.

Validation of Performance Measures

Utah County no longer has a contract directly with the State of Utah and therefore did not provide updates on PMV recommendations from the CY 2019 technical report.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Utah County scored well in many standard areas. Following the CY 2019 review, Utah County completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, provider participation and program integrity, and QAPI. In CY 2020, HSAG reviewed Utah County's CAP and provided feedback. HSAG did not assign continued required actions due to Utah County's contract with UDOH ending in June 2020.

Validation of Network Adequacy

Utah County no longer has a contract directly with the State of Utah, and therefore did not provide updates on network adequacy recommendations from the CY 2019 technical report.

Valley Behavioral Health

Validation of Performance Improvement Projects

Valley's *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified an opportunity for improvement with the improvement strategies. In the 2020 PIP submission, the health plan was again unable to achieve a *Met* score for all applicable evaluation elements, receiving a *Met* score for only 81 percent of all applicable evaluation elements.

Validation of Performance Measures

Valley no longer has a contract directly with the State of Utah and therefore did not provide updates on the PMV recommendations in the CY 2020 technical report.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Valley scored well in many standard areas. Following the CY 2019 review, Valley completed a CAP for requirements found to be out of compliance in the standard areas of member information and grievance and appeals system. In CY 2020, HSAG reviewed Valley's CAP and provided feedback. HSAG did not assign continued required actions due to Valley's contract with UDOH ending In June 2020.

Validation of Network Adequacy

Valley no longer has a contract directly with the State of Utah and therefore did not provide updates on the network adequacy recommendations in the CY 2020 technical report.

Wasatch Behavioral Health

Validation of Performance Improvement Projects

In CY 2020, Wasatch submitted a new PIP, *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ [Youth Outcomes Questionnaire] Outcome Measures*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

Wasatch did not provide any information regarding the recommendations in the CY 2020 technical report.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Wasatch scored well in many standard areas. Following the review, Wasatch completed a CAP for requirements found to be out of compliance in the standard areas of member information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Wasatch's CAP during which Wasatch demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the 2020 follow-up review, HSAG identified ongoing required actions related to member information and provider participation and program integrity which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Wasatch's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Wasatch's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Wasatch, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Wasatch submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Weber Human Services

Validation of Performance Improvement Projects

In CY 2020, Weber submitted a new PIP, *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder (OUD)*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations related to PMV for Weber.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Weber scored well in many standard areas. Following the review, Weber completed a CAP for requirements found to be out of compliance in the standard area related to member information. In CY 2020, HSAG conducted a virtual follow-up review of Weber's CAP during which Weber demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified ongoing required actions related to member information which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Weber's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Weber's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Weber, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Weber submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

CHIP MCOs Providing Both Physical and Mental Health Services

Molina Healthcare of Utah

Validation of Performance Improvement Projects

In CY 2020, Molina submitted a new PIP, *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG recommended that Molina focus improvement efforts on the following:

- Well-child visits for infants and young children
- Documentation of BMI percentile for children ages 3 to 17

In 2020, Molina reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Began using telemedicine to complete patient visits.
- Seven high-volume pediatric offices agreed to participate in a bonus program in which they are rewarded for completing preventive services and immunizations for their Molina pediatric patients.
- Molina also utilized incentive programs for patients to ensure they were still completing wellness services.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Molina scored well in many standard areas. Following the review, Molina completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization, member information, grievance and appeal system, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Molina's CAP during which Molina demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified ongoing required actions related to member information and the grievance and appeal system which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Molina's provider networks. In response to HSAG's recommendations, Molina responded that the plan's performance in the rural and frontier counties for pediatric specialties was primarily due to lack of providers and recommended updating network standards to reflect the same. Additionally, Molina will conduct an analysis of its pediatric specialties to determine opportunities to more accurately reflect traveling physicians and the use of telehealth to improve adequacy based on current time/distance standards. Molina also recognizes that a portion of the challenges seen in urban and rural areas are due to data integrity issues. Since the 2018 audit and follow-up, the health plan has taken steps to correct data integrity issues through self-auditing provider records to ensure information is accurately reported and reviewing provider communities, competitor networks, and other resources to identify additional providers to include in the network.

Based on CY 2019 recommendations, Molina responded that it has reviewed provider information, corrected spelling errors, and found that the provider specialties accurately reflect the provider's licensed specialty and match the provider's taxonomy codes. Molina reported that it will continue to review how specialties are classified and look for ways to streamline provider specialty representation. In CY 2020, Molina submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

SelectHealth CHIP

Validation of Performance Improvement Projects

SelectHealth's *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, SelectHealth has responded with the following information:

- Required well-child visits for young children

  SelectHealth continued the three-part member directed outreach for well-child visits for young children. Part 1 was an appointment reminder outreach that consists of one contact two months before the anticipated due date of a well exam based on prior year claims. This is a brief touch to parents/guardians with a high propensity to close clinical gaps. Part 2 consisted of a parent education IVR call/email with an opt-in for a 30-day reminder call/email/SMS. This reaches out to parents of children with no claim for a well-child visit in the prior year. Part 3 was an IVR call that

goes out in August and September to members who still have a well-visit gap. During 2020 all of these communications were updated with COVID-19 language informing members that their child still needs a well visit during the pandemic and that provider offices are open. The communications were also updated to comply with the new NCQA *WCV* measure. In 2020 we also worked on a *Protect Your Child With Preventive Care* brochure. We hope to have this finalized and available to send during Q1 2021 to members least likely to schedule a well exam based on prior claims.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. SelectHealth scored well in many standard areas. Following the review, SelectHealth completed a CAP for requirements found to be out of compliance in the standard areas of member information, grievance and appeal system, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of SelectHealth's CAP during which SelectHealth demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified one ongoing required action related to member information which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of SelectHealth's provider networks. In response to HSAG's recommendation, SelectHealth responded that SelectHealth Provider Development will actively work with the Provider Relations team to research whether there are available providers of this specialty type in the identified counties based on the Medicaid Known Provider Look Up tool, reach out to any available providers and explore the possibility of a contract, and make best efforts to fill these deficiencies by offering a contract and proceeding with system setup and enrollment with the new providers. SelectHealth reported that the success of these ongoing efforts is contingent on availability and willingness of providers to join the Medicaid/CHIP network. According to the Medicaid Known Provider Look Up tool, there are deficiencies in all rural and frontier counties for the following provider categories—Behavioral Health, OB/GYN, and Primary Care—Pediatric.

PAHPs Providing Medicaid Dental Services

Premier Access

Validation of Performance Improvement Projects

Premier's *Improving Dental Sealant Rates in Members Ages 6–9* PIP received a *Met* score for 56 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement with the study population, indicators, data collection, and interventions. In the 2020 PIP submission, the health plan addressed the recommendations from the 2019 validation.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Premier Access related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Premier scored well in many standard areas. Following the review, Premier completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and grievance and appeal system. In CY 2020, HSAG conducted a virtual follow-up review of Premier's CAP during which Premier demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Premier had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Premier's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Premier's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Premier, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Premier reported that its network adequacy exceeded all requirements and that it did not undertake any improvement activities outside of standard engagement with the Utah provider community.

MCNA

Validation of Performance Improvement Projects

MCNA's *Annual Dental Visits* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for MCNA related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. MCNA demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that MCNA had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of MCNA's provider networks, and HSAG had made the following recommendations:

- Assess available data values in MCNA's provider data systems and standardize available data value options to ensure complete and accurate data.
- Continue to monitor statewide compliance with time/distance standards.

In CY 2020, MCNA submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. MCNA also met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

PAHP Providing CHIP Dental Services

Premier Access—CHIP

Validation of Performance Improvement Projects

Premier's *Improving Dental Sealant Rates in CHIP Members Ages 6–9* PIP received a *Met* score for 50 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement with the study population, indicators, data collection, and interventions. In the 2020 PIP submission, the health plan addressed the recommendations from the 2019 validation.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Premier Access related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Premier scored well in many standard areas. Following the review, Premier completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and grievance and appeal system. In CY 2020, HSAG conducted a virtual follow-up review of Premier's CAP during which Premier demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Premier had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Premier's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Premier's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Premier, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Premier reported that its network adequacy exceeded all requirements and that it did not undertake any improvement activities outside of standard engagement with the Utah provider community.

Appendix D. Summary of PIP Interventions by 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 2020.

Table D-1—Health Plan Interventions by Plan Type and PIP Topic

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Medicaid ACOs Providing Physical Health Services			
Health Choice	*Breast Cancer Screening*	1. The percentage of measure-eligible women 50–74 years of age who had a mammogram to screen for breast cancer during the measurement year.	• The Health Choice performance improvement coordinator (PIC) team used the Utah Health Information Network (UHIN) to obtain better contact information for members. • Implemented the PIC program to perform provider outreach, supply care gap reports, and work with practice quality champions to close gaps in care. • Partnered with a mobile mammography van to provide mammogram screenings to members in southern Utah.
Healthy U	*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*	1. The percentage of children 3–6 years of age who received one or more well-child visits with a primary care provider during the measurement year.	• Parents of Healthy U children in the target age group will receive a $25 gift card incentive for obtaining a well-child visit. • Healthy U will send PCPs a list of attributed members who are overdue for well-child visits. PCPs will be encouraged to call members to schedule appointments. • Healthy U is developing a project with Take Care Utah to provide outreach to non-attributed members. Take Care Utah will assist members with identifying a PCP, making an initial appointment, and ensuring that the member follows through with the appointment.
Molina	*Medicaid Comprehensive Diabetic Care—Eye Exams*	1. The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received a retinal eye exam.	• Partnered with Care Connections, a vendor that completes in-home diabetic exams for members. • Mailed $40 Walmart gift cards as incentives for members upon completion of a retinal eye exam. • Partnered with VSP Vision Care (VSP) to increase diabetic member awareness by sending letters including VSP contact information so

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
			members can call and obtain benefit information and assistance with scheduling eye exams. • Dissemination of a monthly missing services gap list to value-based contracting (VBC) groups so they can encourage and assist members in obtaining an eye exam.
SelectHealth	*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*	1. The percentage of 13-year-old female Medicaid members who had at least 2 doses of Human Papilloma Virus (HPV) vaccine prior to their 13th birthday.	• Scheduled meetings with Utah Statewide Immunization Information System (USIIS) staff to improve the data exchange process, and then standardize the internal process to ensure consistent data availability. • Updated the programming and member communications to reflect changes to the recommended HPV vaccine dosing schedule and HEDIS measure specifications. • Revised the reward program member mailings to clarify what is required to receive the gift cards. These letters are being mailed to members at 11 years, 10 months of age. • Created a reminder program for parents and providers of members who have received the first dose of the HPV vaccine series. The program includes a reminder letter to members, which is mailed at five and seven months after their first dose and informs them of their next dose due date. The program also includes a report to providers that indicates members who are due for the HPV vaccine.
Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services			
Healthy Outcomes Medical	*Impact of Clinical and Educational Interventions on Progression of Pre-*	1. Percentage of HOME enrollees in the identified pre-diabetic study cohort, who had a most recent	• Continued to assign a dedicated nurse case manager to meet with patients and caregivers at the time of clinic visits to explain the importance of regular monitoring, lifestyle modifications, and regular clinic visits. Additionally, the nurse case manager will notify

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Excellence (HOME)	*Diabetes to Type II Diabetes Mellitus*	HbA1c < 5.7 in the measurement period.	providers of PIP participants' upcoming appointments during morning rounds. • Continued to adjust the provider schedule to increase availability of the nutritionist. • At every visit, the providers closely evaluate medication regimes leading to polypharmacy and include metformin as deemed clinically appropriate to the identified cohort. • Educate PCPs to refer patients to a nutritionist whenever clinically indicated. The nurse case manager will add the "need for nutritional counseling" to the notification of upcoming appointments to PCPs.
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	• Health Choice had not progressed to reporting interventions for this project.
Healthy U	*Improving Adults' Access to Preventive/Ambulatory Care Services*	1. The percentage of members 20 year of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	• Healthy U had not progressed to reporting interventions for this project.
Molina Healthcare of Utah	*Follow Up After Hospitalization for Mental Illness*	1. The percentage of discharges for members 6 years of age and older who were hospitalized for	• Molina had not progressed to reporting interventions for this project.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.	
SelectHealth	*7-Day Follow-Up after Hospitalization for Mental Illness for Medicaid Integration Members*	1. 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.	• SelectHealth had not progressed to reporting interventions for this project.
Medicaid PMHPs Providing Mental Health Services			
Bear River	*Suicide Prevention*	1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit. 2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	• Training to address that all members who need a safety plan receive one. This topic is addressed in ongoing training, and staff members are reminded of the requirement to create a safety plan for new admits. • Emphasis on making sure the same-day safety plans are created and recorded.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Central	*Inpatient Readmission Rates*	1. 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 an additional and specific case manager who will make frequent/weekly outreach to individuals discharged from inpatient settings for one year following discharge.
Davis	*Access to Care*	1. Percentage of initial appointments scheduled within 7 calendar days from first contact. 2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	• Intake and evaluating staff have been informed of the seven-calendar-day requirement. • The Substance Treatment Program director is notified when a clinical staff member is unavailable and, if needed, assists in ensuring that the member is seen within 14 days.
Four Corners	*Increasing the Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	1. Percentage of members diagnosed with F11 code, who received 20 or more services within 6 months of admission into OUD treatment.	• Four Corners had not progressed to the Implementation stage and reporting QI activities during this validation cycle.
Healthy U	*Improving Follow-Up After Hospitalization for Mental Illness*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days	• Healthy U had not progressed to reporting interventions for this project.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		2. Follow-Up After Hospitalization for Mental Illness within 30 Days	
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	• Train clinicians, suicide prevention specialists, and support staff (including temporary staff) that the three-business-day follow-up requirement applies to anyone being discharged from an inpatient unit. • 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 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. • 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	Study Indicator Descriptions	Interventions
		"Caring Contact" (i.e., documented "outreach") 31 to 60 days post inpatient discharge.	
Salt Lake	*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*	1. Percentage of members who have been diagnosed with an OUD and who may have received MAT services. 2. Percentage of members who received MAT services and remained in treatment longer than 6 months.	• Provide two-hour MAT training for peer recovery coaches (PRCs) offering services in the Optum Medical network of SUD providers. • Provide training to provider administrative staff (billing) to ensure the diagnoses for OUD are entered correctly. • Requested access to pharmacy data from UDOH.
Southwest	*Outcome Questionnaire Project*	1. The percentage of psychotherapy sessions during which the OQ is reviewed with a member who is age 18 or older at the time of service.	• A monthly OQ administration report is sent to the manager, which is reviewed by the manager with the clinicians and the clinical director.
Utah County Department of Drug and Alcohol Prevention and Treatment	*Suicide Prevention*	1. The percentage of members who received a C-SSRS screening during a face-to-face outpatient visit. 2. The percentage of members who had a C-SSRS screening completed with a score of 2	• Removed the current C-SSRS and Stanley Brown Safety Plan (SBSP) versions from the EHR and replaced them with new versions. • Continued training the clinicians on how to use the SBSP if the C-SSRS result was 2 or higher.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		or higher and received a same-day safety plan.	
Valley	*Suicide Prevention*	1. The percentage of members who received a C-SSRS screening during a face-to-face outpatient visit. 2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	• Provided feedback to staff on the number of C-SSRS screenings and safety plans completed. • Included the C-SSRS as a mandatory document in the assessment tool. • Worked with the EHR vendor to add information to the C-SSRS and safety plan report. • Provided clinicians with an updated report that identified members in need of an assessment. • Provided additional training to subcontractors on completing the C-SSRS and identifying high-risk members who would benefit from a safety plan. • Designated an employee to track the C-SSRS and safety plans received from the subcontractors and input them into the EHR for the subcontractors.
Wasatch	*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*	1. The percentage of Y/OQ signal cases wherein CST was administered during a four-month window surrounding the signal event.	• Reports on CST usage will be provided monthly to program managers. Reports will contain: – The percentage of clinicians who administered CSTs within the last four months, indicated by the Y/OQ instruments. – Information on which clinicians are using the CSTs accurately and which clinicians are not. • Program managers will provide monthly reports to the executive director regarding improvement in the number of CSTs the clinics are collecting.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Weber	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	1. The percentage of members diagnosed with opioid use disorder, who received at least 6 case management or peer support services per year. 2. The percentage of members diagnosed with opioid use disorder that were discharged from treatment and who successfully completed the treatment.	• The health plan had not progressed to identifying barriers and interventions at the time of the PIP submission.
CHIP MCOs Providing Both Physical Health and Mental Health Services			
Molina—CHIP	*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*	1. 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 needing well-child visits. • 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 plan staff to develop mitigation strategies. Educate providers regarding coding issues and resolutions.
SelectHealth—CHIP	*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members*	1. The percentage of 13-year-old female CHIP members who had at least 2 doses of Human Papilloma Virus	• Scheduled meetings with USIIS staff to improve the data exchange process, and then standardize the internal process to ensure consistent data availability.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
	who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday	(HPV) vaccine prior to their 13th birthday.	• Updated the programming and member communications to reflect changes to the recommended HPV vaccine dosing schedule and HEDIS measure specifications. • Revised the reward program member mailings to clarify what is required to receive the gift cards. These letters are being mailed to members at 11 years, 10 months of age. • Created a reminder program for parents and providers of members who have received the first dose of the HPV vaccine series. The program includes a reminder letter to members, which is mailed at five and seven months after their first dose and informs them of their next dose due date. The program also includes a report to providers that indicates members who are due for the HPV vaccine.
PAHPs Providing Medicaid Dental Services			
Premier Access	*Improving Dental Sealant Rates in Members Ages 6–9*	1. The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	• Created and mailed a compelling wafer-sealed member communication which will encourage the member to unseal it. • Outreach to providers as soon as normal business practices are resumed and encourage application of dental sealants through education.
MCNA	*Annual Dental Visits*	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.	• MCNA member service representatives (MSRs) will 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. • Send text messages once a month to members who have no claims history on file. • Provide monthly member rosters to high-volume providers of members who have not had a dental checkup in the current reporting year to a primary care dentist (PCD)/dental home.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		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 plan using like criteria to the nationally recognized CMS 416 specifications for members under age 21.	• Conduct outbound calls to members who have not had a dental checkup within the last six months to encourage them to schedule an appointment.
PAHP Providing CHIP Dental Services			
Premier Access—CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*	The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	• Created and mailed a compelling, wafer-sealed member communication which will encourage the member to unseal it. • Outreach to providers as soon as normal business practices are resumed and encourage application of dental sealants through education.