State of Utah

Division of Medicaid and Health Financing

Bureau of Managed Health Care

Annual External Quality Review Report of Results

April 2020

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary 1-1
Introduction 1-1
Purpose of the Report 1-1
Quality 1-2
Timeliness 1-2
Access 1-3
The Utah Managed Care Delivery System 1-3
Overview of EQR Activities 1-5
Compliance Reviews 1-5
Performance Measure Validation 1-5
Validation of Performance Improvement Projects 1-7
Validation of Network Adequacy 1-7
Summary of Health Plan Performance, Conclusions, and Recommendations Related to EQR Activities 1-7
Compliance Monitoring 1-7
Validation of Performance Measures 1-9
Validation of Performance Improvement Projects 1-13
Validation of Network Adequacy 1-13
The State of Utah Managed Care Quality Strategy 1-14
2. Objectives and Methodology for External Quality Review by EQR Activity 2-1
Assessment of Compliance With Medicaid Managed Care Regulations 2-1
Objectives 2-1
Technical Methods of Data Collection and Analysis 2-1
How Conclusions Were Drawn 2-2
Validation of Performance Measures 2-3
Objectives—Physical Health 2-3
Objectives—Behavioral Health 2-3
Technical Methods of Data Collection and Analysis 2-3
How Conclusions Were Drawn 2-4
Validation of Performance Improvement Projects 2-7
Objectives 2-7
Technical Methods of Data Collection and Analysis 2-7
How Conclusions Were Drawn 2-9
Validation of Network Adequacy 2-11
Objectives 2-11
Technical Methods of Data Collection and Analysis 2-11
How Conclusions Were Drawn 2-12
3. Evaluation of Utah Medicaid and CHIP Health Plans 3-1

A. Description of Data Obtained 3-1
Assessment of Compliance With Medicaid Managed Care Regulations 3-1
Validation of Performance Measures 3-1
Validation of Performance Improvement Projects 3-2
Validation of Network Adequacy 3-2
B. Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement 3-3
ACOs Operating Under the Choice of Health Care Delivery 1915(b) Waiver 3-3
MCO Providing Both Physical Health and Mental Health Services for Individuals With Developmental Disabilities and a Mental Illness 3-42
PMHPs Providing Mental Health Services Under Medicaid 3-49
PAHP Providing Substance Use Disorder Services 3-117
CHIP MCOs Providing Both Physical Health and Mental Health Services 3-125
PAHPs Providing Medicaid Dental Services 3-143
PAHP Providing CHIP Dental Services 3-155

4. Statewide Comparative Results, Assessment, Conclusions, and Recommendations 4-1

Assessment of Compliance With Medicaid Managed Care Regulations 4-1
Statewide Results 4-1
Statewide Conclusions and Recommendations—Compliance With Medicaid Managed Care Regulations 4-6
Validation of Performance Measures 4-7
Statewide Results 4-7
Statewide Conclusions and Recommendations—Performance Measures 4-12
Validation of Performance Improvement Projects 4-15
Statewide Results 4-15
Statewide Conclusions and Recommendations—Performance Improvement Projects 4-16
Network Adequacy 4-18
Statewide Results 4-18
Statewide Conclusions and Recommendations—Network Adequacy 4-20

5. Assessment of Health Plan Follow-up on Prior Year's Recommendations 5-1

Medicaid ACOs Providing Physical Health Services 5-1
Steward Health Choice Utah 5-1
Healthy U 5-3
Molina Healthcare of Utah 5-5
SelectHealth Community Care 5-8
MCO Providing Both Physical and Mental Health Services for Individuals With Developmental Disabilities and a Mental Illness 5-10
Healthy Outcomes Medical Excellence (HOME) 5-10
PMHPs Providing Mental Health Services 5-11
Bear River Mental Health Services 5-11
Central Utah Counseling Center 5-12
Davis Behavioral Health 5-13

Four Corners Community Behavioral Health 5-14
Northeastern Counseling Center 5-16
Salt Lake County Division of Mental Health 5-17
Southwest Behavioral Health Center 5-19
Valley Behavioral Health 5-20
Wasatch Mental Health 5-21
Weber Human Services 5-22
PAHP Providing Substance Use Disorder Services 5-23
Utah County Department of Drug and Alcohol Prevention and Treatment 5-23
CHIP MCOs Providing Both Physical and Mental Health Services 5-24
Molina Healthcare of Utah 5-24
SelectHealth CHIP 5-25
PAHP Providing Medicaid Dental Services 5-27
Premier Access 5-27
MCNA 5-27
PAHP Providing CHIP Dental Services 5-28
Premier Access—CHIP 5-28
Appendix A. Summary of PIP Interventions by Plan Type and PIP Topic A-1

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required 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 Children's Health Insurance Program (CHIP). UDOH has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare this report. This is the fifth year HSAG has produced the EQR annual technical report of results for UDOH under the current EQRO contract.

In calendar year (CY) 2019, Utah's Medicaid managed care organizations (MCOs) included four accountable care organizations (ACOs) and Healthy Outcomes Medical Excellence (HOME). The 11 Medicaid prepaid mental health plans (PMHPs) consist of 10 prepaid inpatient health plans (PIHPs) and one substance use disorder (SUD) prepaid ambulatory health plan (PAHP). In CY 2019, there were also two CHIP MCOs and two dental 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.

Purpose of the Report

This report provides the results of the four mandatory EQR activities completed in CY 2019. UDOH contracted with HSAG to conduct an assessment of compliance with Medicaid managed care regulations (EQR Protocol 1)[1-1] (i.e., compliance review), validation of performance measures (EQR

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Feb 25, 2019.

Protocol 2),[1-2] validation of performance improvement projects (PIPs) (EQR Protocol 3),[1-3] 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 health plan-specific and statewide recommendations.

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 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.[1-4]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows:

> The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.[1-5]

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

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Feb 25, 2019.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Feb 25, 2019.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

[1-5] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

response by the MCO or PIHP, such as processing grievances and appeals, and providing timely follow-up care.

Access

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

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care 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).[1-6]

The Utah Managed Care Delivery System

Table 1-1—Summary of Health Plans in CY 2019 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 (HOME)	1915(a) contracting authority
Eleven PMHPs; 10 PIHPs and one SUD 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, SUD, hemophilia, and transplant immunosuppressant drugs. In 2015, UDOH expanded mandatory ACO enrollment to include nine rural counties. During CY 2019, UDOH contracted with the following ACOs:

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

Steward 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.

Eleven 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. This report represents EQR activities conducted with the following 11 PMHPs during CY 2019.

Bear River Mental Health (Bear River)

Central Utah Counseling Center (Central)

Davis Behavioral Health (Davis)

Four Corners Community Behavioral Health (Four Corners)

Northeastern Counseling Center (Northeastern)

Salt Lake County Division of Behavioral Health (Salt Lake)

Southwest Behavioral Health Center (Southwest)

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

Valley Behavioral Health (Valley)

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

One CHIP Dental PAHP Operating Under Title XXI Authority

Premier Access

Overview of EQR Activities

UDOH's goals for the health plans are to:

- Improve quality of care.
- Improve health outcomes for Medicaid and CHIP members.
- Coordinate care among health plans.
- Control costs.

Compliance Reviews

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. This report includes the findings from the compliance review activities HSAG conducted during CY 2019.

Performance Measure Validation

Medicaid ACOs and CHIP MCOs

The ACOs and CHIP MCOs were required to collect Healthcare Effectiveness Data and Information Set (HEDIS®)[1-7] measures following the HEDIS 2019 Technical Specifications, undergo an NCQA HEDIS Compliance Audit™[,1-8] performed by an NCQA-certified auditor, and report the results of their HEDIS audit to UDOH. The ACOs and CHIP MCOs 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

[1-7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-8] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance.

UDOH and evaluated the FARs to assess ACO and CHIP MCO compliance with the NCQA HEDIS Compliance Audit standards.

PMHPs and HOME

Ten 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 performance measure validation (PMV) activities for the 10 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 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),* Version 2.0, September 2012 (cited earlier in this report). These activities included reviewing these health plans' submitted documentation, reviewing their performance measure rates, conducting site visits, compiling and analyzing findings, and reporting results to UDOH.

Substance Use Disorder (SUD) PAHP

The only SUD PAHP, Utah County, was required to calculate and report a state-modified version of the HEDIS 2019 measure, *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)*. UDOH identified the measurement period for the *IET* measure as CY 2018 (January 1, 2018 through December 31, 2018). 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 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)*, Version 2.0, September 2012 (cited earlier in this report). These activities included reviewing Utah County's documentation, reviewing performance measure rates, conducting site visits, compiling and analyzing findings, and reporting results to UDOH.

Medicaid and CHIP Dental PAHPs

One dental PAHP (Premier) that contracted with UDOH in CY 2019 was required to calculate and report the HEDIS 2019 measure *Annual Dental Visit* for both its Medicaid and CHIP populations. The measurement year was CY 2018. Premier was also required to undergo an NCQA HEDIS Compliance Audit performed by an NCQA-certified auditor and report the results of its HEDIS audit to UDOH. Additionally, the PAHP was 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 PAHP's compliance with the NCQA HEDIS Compliance Audit standards. The other contracted dental PAHP (MCNA) began providing services in Utah in September 2018; therefore, no HEDIS data are available for MCNA.

Validation of Performance Improvement Projects

UDOH required each health plan to conduct one PIP during CY 2019. Each ACO, HOME, CHIP MCO, and PAHP chose its own PIP topic. UDOH and the PMHPs jointly decided to conduct a PIP on suicide prevention.

HSAG continued to provide training and technical assistance to the CHIP and Medicaid dental PAHPs as they began the process of selecting a PIP topic and framing the study design. The dental PAHPs submitted the PIP study design for validation in the CY 2019 validation cycle.

Validation of Network Adequacy

UDOH requested that HSAG prepare a provider crosswalk and conduct a baseline network adequacy validation (NAV) analysis of the health plan provider networks for CY 2019. The focus for developing the provider crosswalk was to generate standardized definitions consisting of provider types, specialties, credentials, and/or taxonomy codes to be used in identifying managed care providers classified into the categories UDOH selected. The goal of the NAV analysis was to apply the proposed provider crosswalk to the health plans' provider networks to assess network capacity and geographic distribution.

Summary of Health Plan Performance, Conclusions, and Recommendations Related to EQR Activities

Compliance Monitoring

For CY 2019 compliance reviews, HSAG conducted a review of the health plans' required actions, as identified in the CAPs following the full review conducted in CY 2018. HSAG found that the most significant improvement overall appeared in the health plans' policies and procedures. The health plans worked diligently to revise, rewrite, and clarify processes and procedures to successfully come into compliance with federal and State requirements, primarily in the Member Information and Grievance and Appeals standards.

While HSAG identified significant improvement among all health plans, HSAG still required corrective actions for most of the plans. Across all types of managed care health plans (Medicaid and CHIP MCOs,

PMHPs, and PAHPS), HSAG found that several plans were still not compliant with having a process to query members to ensure that the plan had a method to regularly verify, by sampling or other methods, whether members had received services that had been delivered by network providers, based on the plans' claims data. HSAG recommended that the management teams for these plans devise a system via mail, telephone, or other method to ensure that members are regularly surveyed to add an additional layer of fraud protection, as required.

Medicaid ACOs and CHIP MCOs

In CY 2019, at UDOH's request, HSAG reviewed a sample of initial credentialing records for new providers recently credentialed with each health plan. HSAG found that Medicaid ACOs and CHIP MCOs performed well on these reviews based on whether all required documentation was collected and reviewed prior to granting the provider clinical privileges.

Based on CY 2019 compliance follow-up reviews, HSAG found that almost all ACOs and MCOs continued to struggle with the revised federal health care regulations that electronic information for members must be readily accessible based on Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. HSAG recommended that the ACOs and MCOs continue their efforts to monitor and address accessibility issues in Web content as well as in documents posted to their website, including the member handbook, drug formulary, provider directory, and other applicable publications.

PMHPs

PMHPs provided evidence of improvement in the accuracy and completeness of member informational materials and publications (electronic and paper) by including revisions in compliance with federal regulations and State contract requirements. HSAG reviewed revised letter templates, forms, handbooks, and information posted on PMHP websites and found improved compliance in the alignment with information provided to members, most notably regarding timelines related to the grievance and appeal requirements.

Based on CY 2019 compliance follow-up reviews, HSAG found that most PMHPs continued to struggle with ensuring their provider directory included all required information, particularly the provider's cultural and linguistic capabilities, including languages (e.g., American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training, as required at 42 CFR §438.10 (h)(1)–(3). HSAG recommended that PMHPs continue to work toward collecting and developing a complete provider directory to support members as they try to access and establish a relationship with a provider that is the best fit for their mental health care needs.

In CY 2019, at UDOHs' request, HSAG reviewed a sample of initial credentialing records for new providers recently credentialed with each health plan. HSAG found that PMHPs generally performed poorly on these reviews based on whether all required documentation was collected prior to granting the provider clinical privileges. These findings were particularly concerning as HSAG found that nine of

the 11 PMHPs had not collected all pertinent information but still approved the provider to see Medicaid members. HSAG strongly recommends that PMHP leadership work to revise noncompliant credentialing processes and perhaps require a higher-level review of all complete provider files prior to engaging the provider in employment or contracting.

Dental PAHPs

The dental PAHPs demonstrated their most significant improvements in the grievances and appeals requirements. Both dental PAHPs improved their processes and policies for defining and identifying grievances and appeals. In addition, the dental PAHPs implemented processes to ensure appropriate staff reviewed or made decisions about grievances and appeals.

Based on CY 2019 compliance follow-up reviews, HSAG found that one dental PAHP continued to struggle with ensuring its provider directory included whether the provider has completed cultural competency training, as required at 42 CFR §438.10 (h) (1)–(3). HSAG recommends that this PAHP continue to work toward collecting and developing a complete provider directory to support members as they try to access and establish a relationship with a provider that is the best fit for each member's dental care.

Further, HSAG found that one dental PAHP removed from its policies and procedures the requirement for a member to follow an oral request for appeal with a written appeal request, rather than only removing the time frame from this provision. Medicaid MCOs, PIHPs, and PAHPs are required to obtain a written appeal request after receiving an oral request; however, they cannot set an artificial time limit on this request.

In CY 2019, at UDOH's request, HSAG reviewed a sample of initial credentialing records for new providers recently credentialed with each dental PAHP. Upon review, HSAG found that one dental PAHP performed poorly on this review based on whether all required documentation was collected prior to granting the provider clinical privileges. HSAG strongly recommends that PAHP leadership work to resolve the noncompliant credentialing processes and perhaps require a more comprehensive review of all completed provider credentialing files prior to contracting with the provider.

Validation of Performance Measures

Medicaid ACOs and CHIP MCOs

VALIDATION FINDINGS

The Medicaid ACOs' and CHIP MCOs' HEDIS compliance auditor determined that the health plans' information systems (IS) and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2019.

PERFORMANCE MEASURE RESULTS

All four ACOs and both CHIP MCOs exceeded the 2019 NCQA Quality Compass[1-9] average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*

In addition, at least three of the four ACOs exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Controlling High Blood Pressure*
- *Use of Imaging Studies for Low Back Pain*

Both CHIP MCOs exceeded the 2019 NCQA Quality Compass average for all but two of the measure rates collected.

The following measure rate demonstrated the most need for improvement, as all four ACOs and both CHIP MCOs fell below the 2019 NCQA Quality Compass average:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

In addition, at least three of the four ACOs fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Based on performance measure outcomes:

- At least three out of four ACOs exceeded the 2019 NCQA Quality Compass average for five of the 15 measure rates collected.
- Both CHIP MCOs exceeded the 2019 NCQA Quality Compass average for four of the six measure rates collected.
- At least three of the four ACOs fell below the 2019 NCQA Quality Compass average for six of the 15 measure rates collected.

[1-9] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Both CHIP MCOs fell below the 2019 NCQA Quality Compass average for one of the six measure rates collected.

PMHPs and HOME

VALIDATION FINDINGS[1-10]

HSAG determined that 10 of the 11 PMHPs' IS and processes were compliant with IS standards and that the measures calculated by the PMHPs had a status of *Reportable* (R) based on the reporting requirements for the PMV for 2019.

HSAG determined that one PMHP's IS and processes were not compliant and had a status of *Not Reportable* (NR) with the reporting requirements for the PMV for 2019.

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.

For the current reporting period, HSAG determined that 10 of the 11 health plans that submitted *FUH* measure rates and for which HSAG performed PMV audits followed the State's specifications and reporting requirements, and that the rates were valid, reliable, and accurate. The remaining PMHP was unable to report valid rates and was assigned an audit designation of *Not Reported* (NR).

PERFORMANCE MEASURE RESULTS

For reporting year (RY) 2019, 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.

[1-10] Findings for individual health plans can be found in Section 3 of this report, "Evaluation of Utah Medicaid and CHIP Health Plans."

Based on performance measure outcomes, five PMHPs exceeded the statewide PMHP average for both *FUH* indicators, and two PMHPs fell below the statewide average for both indicators. Additionally, the rates for one PMHP were determined to be materially biased (NR) for both indicators. HOME was not included in or compared to the statewide PMHP average.

SUD PAHP

VALIDATION FINDINGS

HSAG determined that the SUD PAHP's IS and processes were compliant and had a status of *Reportable* (R) with the reporting requirements for the performance measure validation performed in 2019.

The SUD PAHP calculated and reported the *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)* measure. This measure helps the SUD PAHP to monitor and ensure that members receive timely initiation and engagement of AOD treatment services after a new episode of AOD abuse or dependence. The initiation and engagement of AOD treatment can help reduce AOD-associated morbidity and mortality, and can improve health, productivity, and social outcomes. 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.

PERFORMANCE MEASURE RESULTS

Because Utah County was the only health plan that reported *IET* measure rates, HSAG could not compare results to other health plans for this measure.

Medicaid and CHIP Dental PAHPs

VALIDATION FINDINGS

One Medicaid dental PAHP began its contract with UDOH in September 2018; therefore, it was not required to submit performance measures during CY 2019. UDOH contracted with one other dental PAHP, Premier Access, to serve both the CHIP and Medicaid populations. The PAHP's HEDIS compliance auditor determined that the PAHP's IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2019.

PERFORMANCE MEASURE RESULTS

The PAHP's performance for the Medicaid population exceeded the 2019 NCQA Quality Compass average for the *Annual Dental Visits—2–3 Years of Age* and *Total* measure rates but fell below the average for the *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* measure rates. These results indicate opportunities for improvement for Premier Access.

The PAHP's performance for the CHIP population exceeded the 2019 NCQA Quality Compass average for four of the seven *Annual Dental Visit* measure rates, indicating overall strength for the CHIP dental PAHP.

Validation of Performance Improvement Projects

The focus of a health plan's PIP is to improve performance related to health care quality, timeliness, or access. However, the PIP validation activities HSAG performed are designed to evaluate the validity and quality of the health plan's process for conducting its PIP. Therefore, HSAG assigned all PIPs to the quality domain.

Health plans that earned a *Met* validation status demonstrated a strong application of PIP study design principles, use of appropriate quality improvement (QI) activities to support improvement of PIP outcomes, and achievement of statistically significant outcomes across all study indicators. All 21 health plans were required to conduct one PIP during the reporting period. Eleven of the 21 PIPs received an overall *Met* validation status for the CY 2019 validation. Five PIPs received an overall *Partially Met* validation status, and the remaining five PIPs received a *Not Met* validation status. 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.

Validation of Network Adequacy

The findings from the provider Data Structure Questionnaire highlighted differences in the methods being used to collect and store provider data. The findings also highlighted the inconsistent collection and use of some crucial fields in the provider data (i.e., provider type and provider specialty). While the provider Data Structure Questionnaire identified some inconsistencies in data collection and storage, it also highlighted that all health plans are conducting some monitoring and maintenance of the provider data regularly.

HSAG collaborated with UDOH to build provider crosswalks, which describe how to identify a variety of providers in the following categories: primary care providers (PCPs), specialists, behavioral health

providers, health care facilities, and dental providers. Provider categories were identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree.

In using the crosswalks to conduct the network adequacy validation (NAV), HSAG found that, in general, members had access to the provider categories within the time/distance standards. Across the health plans, access to pediatric specialty providers was limited, which may be due to an ability to identify pediatric providers in the selected data. Additionally, some provider categories were not noted in the provider data, such as general hospitals with a psychiatric unit in the MCO CHIP data. This may be due to the inability to confirm the presence of a psychiatric unit at the hospitals from the available data.

The State of Utah Managed Care Quality Strategy

Utah's Managed Care Quality Strategy (Quality Strategy) addresses the key elements recommended in the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, as well as in the guidance published on the Medicaid.gov website. 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. UDOH's Strategic Quality Improvement Goals stated in the Quality Strategy are as follows:

1. Promote effective coordination of care between ACOs and PMHPs.
2. Promote preventive care for women and children.
3. Improve the access to and quality of services provided to Medicaid members in ACOs, PMHPs, dental plans, HOME, and CHIP plans.
4. Control health care costs while improving quality care through innovative strategies with all health plans and other stakeholders.

Utah's Quality Strategy addresses the following key recommendations provided in CMS guidance documents and the Quality Strategy Toolkit for States:

- Initial stakeholder feedback
- Use of Utah's ACO contracts to further the goals stated in the CMS National Quality Strategy
- The use of Utah's EQRO to produce the annual EQR technical report of results
- Use of standardized performance metrics such as HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-11] to measure and monitor progress toward goal achievement
- Consideration of value-based payment strategies

[1-11] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

As UDOH is currently engaged in revising its Quality Strategy, HSAG recommends that UDOH address:

- Ongoing solicitation of beneficiary and stakeholder feedback during annual revision processes.
- The statewide Quality Improvement Committee's (QIC's) responsibilities as a powerful vehicle to:
  - Ensure that health plans remain informed on national health care trends, legislative changes, statewide performance on selected measures, and QI initiatives identified as priorities in the State's Quality Strategy.
  - Ensure ongoing communication among the health plans and between the health plans and UDOH by distributing information about UDOH priorities and goals and encouraging feedback from health plans regarding operational issues. To achieve these goals, HSAG recommends a monthly agenda that includes exploration of health plans' challenges, celebration of successes as shared by the health plans, and problem-solving common barriers to improving statewide population health. UDOH may want to consider:
    - Standing monthly meetings (scheduled in advance for the same day of the month and time of day) so health plan leadership can anticipate meetings and UDOH can expect regular participation.
    - Mandatory attendance from each health plan and UDOH representatives from QI and contract management departments.
    - Standing agenda items that may include a brief review of EQR mandatory activity status and/or each health plan's status and questions related to completion of activities to ensure consistency of information distributed to the health plans. Other agenda items may include rotating health plans' brief presentations of QI activity challenges or successes, and statewide sharing of ideas, best practices, and problem solving.
- UDOH's goal to continually assess the quality and appropriateness of care and services provided by Utah's health plans, by considering leveraging the expertise of the health plans' staff and requiring standardized topics for inclusion in the health plans' QI program descriptions and requiring each health plan to perform an evaluation of the impact and effectiveness of its own Quality Assessment and Performance Improvement (QAPI) program.
- Mechanisms to ensure that ongoing revisions of the Quality Strategy accurately reflect the EQR compliance monitoring schedules and the EQRO's participation in conducting the four mandatory EQR-related activities to produce the annual EQR technical report of results.

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 Utah's 12th 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.

2. Objectives and Methodology for External Quality Review by EQR Activity

Assessment of Compliance With Medicaid Managed Care Regulations

Objectives

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 site reviews to assess compliance with Medicaid managed care regulations was to provide meaningful information to UDOH and the health plans regarding:

- The health plans' compliance with federal regulations and contract requirements.
- The quality and timeliness of, and access to, health care furnished by the health plan.
- Required actions and interventions needed to improve quality.
- Activities to sustain and enhance performance and processes.

Technical Methods of Data Collection and Analysis

To accomplish the stated objectives for the site reviews, for assessing each MCO's, ACO's, PMHP's, and PAHP's compliance with Medicaid and CHIP managed care regulations found at 42 CFR §438, in CY 2019, 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.
- Collaborated with the health plans to explain the follow-up compliance monitoring processes and address questions.
- Collected and reviewed data and documents before and during the telephonic reviews.
- Analyzed and compiled the data and information collected.
- Prepared a report of findings and continued required actions (if applicable) for UDOH and each health plan.

HSAG conducted compliance review activities consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (cited earlier in this report). HSAG organized the Medicaid managed care regulations into eight standards as follows:

Table 2-1—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	438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424
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

In CY 2019, HSAG completed follow-up document review and telephonic interviews for any requirement scored *Partially Met* or *Not Met* in CY 2018 for each ACO, MCO, PMHP, and PAHP. 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.

How Conclusions Were Drawn

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 these domains. 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.

Validation of Performance Measures

Objectives—Physical Health

The primary objectives of the performance measure validation (PMV) were to:

- Evaluate the accuracy of the performance measure data collected by the health plans.
- Determine the extent to which the specific performance measures calculated by the ACOs, MCOs, and dental PAHPs followed the specifications established for each measure.

Objectives—Behavioral Health

The primary objectives of the PMV were to:

- Evaluate the accuracy of the performance measure data collected by the PMHPs and HOME.
- Determine the extent to which the specific performance measures calculated by the PMHPs, HOME, and the SUD PAHP followed the specifications established for each measure.

Technical Methods of Data Collection and Analysis

UDOH required ACOs and CHIP MCOs to undergo NCQA HEDIS Compliance Audits for the reporting of HEDIS measures using CY 2018 data. HSAG obtained and reviewed the HEDIS Final Audit Reports (FARs) for each Medicaid ACO and CHIP MCO.

In addition, UDOH contracted with HSAG to validate the state-specific performance measure, *Follow-Up After Hospitalization for Mental Illness (FUH)* for the PMHPs and HOME; and to validate the state-specific performance measure, *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)* performance measure for the SUD PAHP. 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)*, Version 2.0, September 2012 (CMS PMV protocol) cited earlier in this report. These activities included collecting and reviewing relevant documentation, rate review, conducting site visits, compiling and analyzing findings, and reporting results to UDOH.

How Conclusions Were Drawn

Medicaid ACOs and CHIP MCOs—Description of Validation Activities

At the end of the NCQA HEDIS Compliance Audit season, the ACOs and MCOs submitted their FARs and final auditor-locked Interactive Data Submission System (IDSS) rate submissions to UDOH. HSAG reviewed and evaluated the FARs to assess health plan compliance with the NCQA HEDIS Compliance Audit standards. The information system (IS) standards are:[2-1]

- 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.

To draw conclusions about the quality and timeliness of, and access to care provided by the ACOs and CHIP MCOs, HSAG assigned each of the performance measures reported to one or more of these three care domains, depicted in Table 2-2.

Table 2-2—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains for ACOs and CHIP MCOs

Performance Measures	Quality	Timeliness	Access
Antidepressant Medication Management—Effective Acute Phase Treatment	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Childhood Immunization Status—Combination 3	✓		
Chlamydia Screening in Women—Total	✓		
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing and *Eye Exam (Retinal) Performed*	✓		
Controlling High Blood Pressure	✓		

[2-1] 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.

Performance Measures	Quality	Timeliness	Access
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—Body Mass Index (BMI) Percentile—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	✓		

PMHPs, HOME, and SUD PAHP—Description of Validation Activities

HSAG conducted the validation activities as outlined in the CMS PMV protocol. 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 on-site visit activities, including the type of staff needed for each session. HSAG forwarded the agendas to the respective organizations prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with each organization to discuss any outstanding ISCAT questions and on-site visit activities.

HSAG conducted an on-site visit 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.

To draw conclusions about the quality and timeliness of, and access to, care provided by the PMHPs and HOME, HSAG assigned each of the performance measures reviewed one or more of these three care domains, depicted in Table 2-3.

Table 2-3—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains for PMHPs and HOME

Performance Measures	Quality	Timeliness	Access
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days and *Follow-Up Within 30 Days*	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD Treatment and *Engagement of AOD Treatment*	✓	✓	✓

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 2-4) 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 3 contains information about the health plan-specific performance measure rates and validation status.

Table 2-4—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.

Dental Health—Description of Validation Activities

At the end of the NCQA HEDIS Compliance Audit season, the dental PAHPs submitted their FARs and final, auditor-locked IDSS rate submissions to UDOH. HSAG reviewed and evaluated the FARs to assess each dental PAHP's compliance with NCQA HEDIS Compliance Audit standards.

To draw conclusions about the quality and timeliness of, and access to, care the dental PAHPs provided, HSAG assigned each performance measure to one or more of these three care domains: Quality, Timeliness, and Access. HSAG assigned the *Annual Dental Visit* measure (the only measure reviewed) to the Access domain of care.

Validation of Performance Improvement Projects

Objectives

The purpose of performance improvement projects (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 a health plan's compliance with the requirements of 42 CFR §438.330(d) 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.

Technical Methods of Data Collection and Analysis

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).

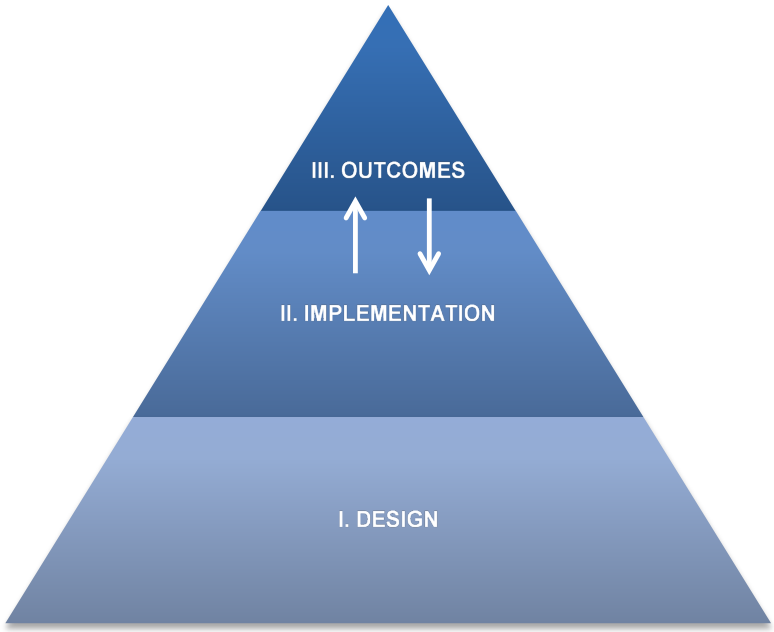
HSAG evaluates the following components of the quality improvement (QI) process:

1. The technical structure of the PIPs to ensure the MCOs, ACOs, PMHPs, and PAHPs designed, conducted, and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs. HSAG's review determined whether a PIP could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring real and sustained improvement.
2. The outcomes of the PIPs to ensure that once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. Evaluation of each PIP's outcomes determined whether the MCO, ACO, PMHP, and PAHP improved its rates through the implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results) and, through these processes, achieved statistically significant improvement over the baseline rate. Once statistically significant

improvement is achieved across all study indicators, HSAG evaluates whether the MCOs, ACOs, and PMHPs were successful in sustaining the improvement. The goal of HSAG's PIP validation is to ensure that UDOH and key stakeholders can have confidence that reported improvement in study indicator outcomes is supported by statistically significant change and the MCOs', ACOs', and PMHPs' improvement strategies.

Figure 2–1 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 topic, question, population, indicators, sampling techniques, and data collection. To implement successful improvement strategies, a methodologically sound study design is necessary.

Figure 2–1—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 and statistical testing.

Sustained improvement is achieved when outcomes exhibit statistically 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 statistical improvement is achieved.

How Conclusions Were Drawn

HSAG obtained the information needed to conduct the annual validation from the health plan PIP Summary Form. This form provided detailed information about completed PIP activities.

Each required activity is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given 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*.

For CY 2019, HSAG validated 21 PIPs. The health plans submitted PIP topics that included:

- *Asthma Medication Management.*
- *Breast Cancer Screening.*
- *HPV Vaccine Prior to 13th Birthday for Female Medicaid Members.*
- *Impact of clinical and educational interventions on progression of pre-diabetes to Type II Diabetes Mellitus.*
- *Suicide Prevention.*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*
- *Annual Dental Visits.*
- *Improving Dental Sealant Rates in Members Ages 6–9.*

The following table lists each PIP; whether the PIP topic was related to measuring quality, timeliness, and/or access to care; and whether the PIP received an overall *Met* status. The focus of a health plan's

PIP was to improve performance related to health care quality, timeliness, or access. However, the PIP validation activities that HSAG performed were designed to evaluate the validity and quality of the health plan's process for conducting its PIP. Therefore, HSAG assigned all PIPs to the quality domain.

Table 2-5—2019 PIP Topics, Domains of Care, and Overall Status = *Met*

Health Plan	PIP Name	Access	Timeliness	Quality	Overall PIP Validation Status Was *Met*
Health Choice	*Breast Cancer Screening*	✓	✓	✓	✓
Healthy U	*Asthma Medication Management*			✓	
Molina	*Breast Cancer Screening for Women Ages 50–74*	✓	✓	✓	
SelectHealth	*Improving the percentage of 13-year-old female Medicaid members who had 3 doses of Human Papillomavirus (HPV) vaccine prior to their 13th birthday*		✓	✓	✓
HOME	*Impact of clinical and educational interventions on progression of pre-diabetes to Type II Diabetes Mellitus*	✓	✓	✓	✓
Bear River	*Suicide Prevention*		✓	✓	✓
Central	*Suicide Prevention*		✓	✓	✓
Davis	*Suicide Prevention*		✓	✓	
Four Corners	*Suicide Prevention*		✓	✓	✓
Northeastern	*Suicide Prevention*		✓	✓	✓
Salt Lake	*Suicide Prevention*		✓	✓	
Southwest	*Suicide Prevention*		✓	✓	✓
Utah County Department of Drug and Alcohol Treatment and Prevention	*Suicide Prevention*		✓	✓	
Valley	*Suicide Prevention*		✓	✓	✓
Wasatch	*Suicide Prevention*		✓	✓	
Weber	*Suicide Prevention*		✓	✓	
Molina CHIP	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	✓	✓	✓	

Health Plan	PIP Name	Access	Timeliness	Quality	Overall PIP Validation Status Was *Met*
SelectHealth CHIP	*Improving the percentage of 13-year-old female Children's Health Insurance Program (CHIP) members who had 3 doses of Human Papillomavirus (HPV) vaccine prior to their 13th birthday*		✓	✓	✓
Managed Care North America (MCNA)	*Annual Dental Visits*	✓	✓	✓	✓
Premier Access	*Improving Dental Sealant Rates in Medicaid Members Ages 6–9*		✓	✓	
Premier Access CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*		✓	✓	

Validation of Network Adequacy

Objectives

The focus for developing the provider crosswalk was to generate standardized definitions consisting of provider types, specialties, credentials, and/or taxonomy codes to be used in identifying managed care providers classified into the categories UDOH selected. The goal of the network adequacy validation (NAV) analysis was to apply the proposed provider crosswalk to the health plans' provider networks to assess network capacity and geographic distribution.

Technical Methods of Data Collection and Analysis

HSAG used a desk review approach to collect the provider data needed to develop the provider crosswalks and conduct the baseline NAV analysis. UDOH provided HSAG with provider network documentation and standards, including the health plans' contract requirements for network adequacy. In addition, HSAG requested that UDOH provide supplemental data for all ordering, referring, servicing, and billing providers active with UDOH. During this time, along with collecting data from UDOH, HSAG requested that each health plan complete a brief Data Structure Questionnaire, consisting of eight subjective questions, to share targeted information regarding provider data structure(s) and methods for classifying providers. Finally, HSAG requested that each health plan submit provider network data using a standardized data requirements document that UDOH approved. HSAG and UDOH developed a list of provider categories applicable to each health plan type and aligned

with the minimum provider categories identified in 42 CFR §438.68 of the federal network adequacy standard requirement.

Using the health plans' provider data files, HSAG evaluated the provider classification fields available from each health plan (e.g., provider type, specialty, credential, and/or taxonomy codes). HSAG then mapped this classification information to the provider categories specific to each health plan type, producing the preliminary provider crosswalks. HSAG assessed and reconciled the crosswalk results within each health plan type, and collaborated with UDOH to review the resulting provider category definitions and finalize the crosswalks.

HSAG applied the results of the provider crosswalk to data the health plans submitted to conduct a baseline NAV analysis. The NAV analysis evaluated two 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 for each provider category.
- **Geographic Network Distribution Analysis:** The second dimension of this study evaluated the geographic distribution of the providers relative to member populations. For each health plan, HSAG calculated the average time and distance from each member to the nearest three providers.

How Conclusions Were Drawn

The data supplied from the health plans' Data Structure Questionnaire allowed HSAG to review the files and request for additional follow-up information if it was needed. Following evaluation of the provider classification fields from the health plans, HSAG mapped the classification information to the provider categories specific to each health plan type, producing the preliminary provider crosswalks. These crosswalks clarified definitions for each provider category, including a description of the logic needed to identify corresponding providers from each health plan's submitted data. HSAG then assessed and reconciled the crosswalk results within each health plan type and collaborated with UDOH to review the resulting provider category definitions and finalized the crosswalks. HSAG applied the results of the corresponding provider crosswalk to the health plans' provider data to conduct a baseline NAV analysis. The NAV analysis included network capacity and geographic network distribution analysis by provider category for each health plan.

3. Evaluation of Utah Medicaid and CHIP Health Plans

A. Description of Data Obtained

Assessment of Compliance With Medicaid Managed Care Regulations

Documents reviewed during the CY 2019 compliance review activities 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

During the follow-up reviews, HSAG conducted telephonic interviews with key health plan staff members to clarify or verify information obtained to confirm that processes reported in documentation were carried out in practice. During the review, HSAG may have also reviewed other documents requested as a result of the document review and telephonic interviews.

Validation of Performance Measures

The Medicaid ACOs, CHIP MCOs, and dental PAHPs were required to do the following:

- Collect HEDIS measures following HEDIS technical specifications.
- Undergo an NCQA HEDIS Compliance Audit performed by an NCQA licensed organization (LO).
- Provide the HEDIS data, FARs, and a copy of the ACO, CHIP MCO, and dental PAHP auditor's certification to UDOH.

HSAG obtained the HEDIS data, auditor certification, and FARs for each Medicaid ACO, CHIP MCO, and dental PAHP from UDOH for inclusion in this annual EQR technical report.

The dental PAHPs calculated and submitted rates for the HEDIS 2019 measure, *Annual Dental Visit (ADV).* The measure year was for CY 2018.

For the PMHPs, HOME, and the SUD PAHP, UDOH contracted with HSAG to conduct performance measure validation (PMV). HSAG's role in the validation of performance measures was to ensure that validation activities conducted were consistent with the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*,

Version 2.0, September 1, 2012 (cited earlier in this report) and to confirm the independent auditing process already conducted.

For the 11 PMHPs contracted with UDOH (10 PIHPs and one SUD PAHP) and HOME, an MCO, HSAG was responsible for conducting the 2019 validation of performance measures. The purpose of the PMV was to assess the accuracy of performance measure rates reported by PMHPs and HOME and to determine the extent to which performance measures calculated by the PMHPs and HOME followed State-developed specifications and reporting requirements. HSAG validated the rate for the performance measures that UDOH had selected for validation. The PMHPs jointly agreed to adopt the HEDIS 2019 measure, *Follow-Up After Hospitalization for Mental Illness (FUH)* with modifications to the specifications as approved by UDOH. HOME also chose the *FUH* measure with the UDOH-approved modifications. The SUD PAHP chose the *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)* HEDIS 2019 performance measure, also with modifications to the specifications as approved by UDOH. UDOH identified the measurement period for measure reporting as CY 2018 (January 1, 2018, through December 31, 2018).

Validation of Performance Improvement Projects

HSAG obtained the data needed to conduct the PIP validations from the health plans' CY 2019 PIP Submission Form. The form provided detailed information about each health plan's PIP as it related to the 10 activities reviewed and evaluated for the CY 2019 validation cycle. The form is consistent with the CMS protocol.

Each section of the submission form includes one of 10 activities to be undertaken when conducting PIPs. The form presents instructions for documenting information related to each of the 10 activities. The health plans could also attach relevant supporting documentation with the PIP Summary Form. Each health plan filled out the form for PIP activities completed during the measurement year and submitted it to HSAG for validation.

Validation of Network Adequacy

HSAG requested provider network files from UDOH and the health plans, using a detailed data requirements document to define the requested provider data. HSAG requested data for all ordering, referring, servicing, and billing providers active with UDOH or the health plans as of June 1, 2019, including the following key data elements: unique provider identifier, provider street address and county, provider type, provider specialty, provider taxonomy code, and primary care provider (PCP) indicator.

Additionally, HSAG requested Medicaid member eligibility, enrollment, and demographic information from UDOH for all members as of June 1, 2019. HSAG requested these key data elements: unique

member identifier, gender, age, and residential address as of a specific date to be identified in collaboration with UDOH.

Concurrent with provider data collection from UDOH, HSAG requested that all health plans complete a brief Data Structure Questionnaire to share targeted information regarding their provider data structure(s) and methods for classifying providers (e.g., methods for identifying PCPs).

B. Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement

ACOs Operating Under the Choice of Health Care Delivery 1915(b) Waiver

Steward Health Choice Utah (Health Choice)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the CY 2019 review, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all MCOs. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Health Choice's credentialing files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 compliance follow-up review, HSAG also reviewed Health Choice for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Health Choice indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care (quality, access, and timeliness) and found that Health Choice had made updates to its member-facing documents and related policies to:

- Inform members that content on the website could be provided in paper form.
- Ensure the required font sizes are used in member-facing documents.
- Ensure notice of adverse benefit determination (NABD) letters include accurate timelines and member rights information and were written at the appropriate grade level and language for members' ease of understanding of content.

- Ensure the definition used for "medical necessity" is consistent with the definition found in federal regulations.
- Include all circumstances under which Health Choice might provide the member notice of its proposal to reduce, suspend, or terminate a previously authorized service before the end of the authorization period.
- Ensure that members are included as a party on all appeals.
- Remove the timeline requirement for members to follow an oral request for an appeal with a written request within five days, as there may not be a time limit imposed for this requirement.
- Meet the requirements for scheduling preventive care appointments.

HSAG also found Health Choice had revised processes, staff training materials, and provider informational materials to:

- Implement a process to collect the information required for the provider directory.
- Ensure that providers receive accurate information about the Medicaid member grievance and appeal system.
- Ensure that letters declining providers' acceptance into the network include the reason for the decision.
- Ensure that delegation agreements include the federally required provisions.

Conclusions and Recommendations for Improvement

As a result of findings during the 2019 review, Health Choice demonstrated improvement in all three domains of care; however, a few issues to address remained in access and quality domains. Although Health Choice reduced the quantity of contrast and accessibility errors in its electronic information as compared to the CY 2018 review, HSAG found continued errors on Health Choice's website and in documents hosted on its website. Additionally, in CY 2019 Health Choice's provider directory was missing required information about its providers, including information about the provider's cultural competency training and office accommodations for people with physical disabilities.

To address the lingering issues, HSAG recommends that Health Choice's leadership identify measures to ensure that information provided electronically to members is complete and fully accessible based on federal 508 guidelines.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Health Choice's HEDIS compliance auditor found Health Choice's information systems and processes to be compliant with the applicable IS standards and reporting requirements for HEDIS 2019. Health Choice contracted with an

external software vendor with HEDIS Certified Measures℠,[3-1] 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 validation results.

Performance Measure Outcomes

Table 3-1 shows Health Choice's HEDIS 2019 results as compared to the 2019 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 3-1—Health Choice HEDIS 2019 Results

HEDIS Measure	Health Choice 2019 Rate	2019 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	53.43%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.13%	90.45%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**28.60%**	58.41%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**43.80%**	59.34%
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)	72.26%	68.08%
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)	**33.18%**	58.19%
Comprehensive Diabetes Care		

[3-1] HEDIS Certified Measures℠ is a service mark of the NCQA.

HEDIS Measure	Health Choice 2019 Rate	2019 NCQA Quality Compass Average
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	**81.94%**	87.79%
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)	**48.79%**	57.34%
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%	58.87%
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%	79.19%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 21 and 56 days after delivery. (Postpartum Care)	65.93%	63.59%
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.	80.36%	71.72%
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%**	74.27%
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%**	62.84%
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.	**58.02%**	72.08%

*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—Validation of Performance Measures

Strengths

Health Choice exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*

- *Childhood Immunization Status—Combination 3*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Health Choice fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—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*

Conclusions and Recommendations for Improvement

Health Choice exceeded the 2019 NCQA Quality Compass average for only six of the 14 applicable measure rates (42.9 percent), indicating several opportunities for improvement. Health Choice could focus its improvement efforts on the following:

- Increasing screenings for women (breast cancer, cervical cancer, and chlamydia)
- Required well-child visits for infants and young children
- Documentation of BMI percentile for children ages 3 to 17
- Appropriate management of diabetes

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Health Choice submitted a new PIP topic: *Breast Cancer Screening.*

Validation Results

Table 3-2 summarizes the validation findings for each stage validated for CY 2019. Overall, 91 percent of all applicable evaluation elements received a score of *Met.*

Table 3-2—CY 2019 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 Assessed*		
	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	67% (2/3)	33% (1/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**67% (2/3)**	**33% (1/3)**	**0% (0/3)**
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*		**91% (10/11)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (6/6)**		
Validation Status		***Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Health Choice implemented a new topic and submitted baseline data for its PIP.

For the baseline measurement period, Health Choice reported that the rate of members receiving a breast cancer screening was 28.6 percent.

Table 3-3 displays the data for Health Choice's *Breast Cancer Screening* PIP.

Table 3-3—PIP—*Breast Cancer Screening*
Health Choice

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Sustained Improvement
Breast Cancer Screening	N: 123*	28.6%	*Not Assessed*
	D: 430*		

*N–Numerator D–Denominator

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. 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.

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 and analyzed its baseline data accurately. Health Choice has not progressed to reporting its quality improvement (QI) activities, including barriers and interventions for this validation cycle.

Conclusions and Recommendations for Improvement

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 91 percent of overall evaluation elements across all activities completed and validated. The performance suggests that the PIP study design was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

As the PIP progresses, HSAG recommends the following:

- Health Choice must document factors that could affect the validity of the data reported. If no such factors exist, Health Choice should document this in Step VII of the PIP Summary Form.
- Health Choice must complete a causal/barrier analysis to identify barriers to desired PIP 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.
- Health Choice 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.
- Health Choice must implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Health Choice must have a process in place for evaluating the performance of each intervention and its impact on the study indicator and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention must identify the individual impact of that intervention on the study indicator rate.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Health Choice's Provider Data Structure Questionnaire responses indicated that Health Choice validated providers' self-report type and specialty information during the credentialing process. Health Choice noted that it does not maintain provider taxonomy information. Health Choice does not contract with or load providers who execute under single case agreements. Rather, they are reflected in the system as "out of network" providers. Health Choice uses a weekly report generated by the Credentialing Department to identify newly credentialed providers, and the Network Services Department reviews and is responsible for the data integrity.

Health Choice reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or public health and general preventive medicine specialties. Additionally, nurse practitioners and physician assistants who practice with PCPs are recognized as nonphysician primary care providers. Health Choice identified prenatal care (PNC) providers as individuals with an OB/GYN, maternal fetal medicine, or nurse midwifery specialty.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Health Choice's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Health Choice's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the ACO's data values for provider type, specialty, and credentials. Therefore, Health Choice should assess available data values in its provider data systems and standardize available data value options to ensure complete, accurate data are used for assessments of network adequacy.

Health Choice met the statewide compliance time/distance standards for 29 of the 56 provider categories (51.8 percent). For the provider categories for which Health Choice did not meet the time/distance standard, Health Choice should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Health Choice, the inability to identify the providers in the data using the standard definitions, or other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Specialist Providers
  - Allergy & Immunology, Pediatric
  - Dermatology, Pediatric
  - Endocrinology
  - Endocrinology, Pediatric
  - Gastroenterology, Pediatric
  - General Surgery, Pediatric
  - Infectious Disease
  - Infectious Disease, Pediatric
  - Nephrology, Pediatric
  - Neurology, Pediatric
  - Oncology/Hematology, Pediatric
  - Ophthalmology, Pediatric
  - Orthopedic Surgery, Pediatric
  - Other Surgery
  - Other Surgery, Pediatric
  - Otolaryngology, Pediatric
  - Physical Medicine, Pediatric
  - Psychiatry
  - Psychiatry, Pediatric

  - Pulmonology, Pediatric
  - Rheumatology
  - Rheumatology, Pediatric
  - Urology, Pediatric
- Additional Physical Health Specialties
  - Diagnostic Radiology
  - Laboratory
  - Mammography
  - Outpatient Infusion/Chemotherapy

Healthy U

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all MCOs. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Healthy U's credentialing files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed Healthy U for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Healthy U showed improvement from CY 2018 to CY 2019. HSAG identified improvement in the quality, access, and timeliness domains of care during the follow-up compliance review conducted in CY 2019, as Healthy U made updates to its member-facing documents and related policies to:

- Define "emergency services" consistently with federal and State requirements.
- Include provisions related to advance directives requirements.
- Ensure member communications are at a sixth-grade reading level.
- Depict the correct time frames and requirements related to grievance and appeal requirements.

Healthy U also revised organizational processes, staff training, and provider informational materials to:

- Ensure proper claims processing of emergency medical conditions.
- Meet timely access standards for scheduling preventive care appointments.
- Ensure that delegation agreements include the federally required provisions.
- Strengthen its compliance plan to include training and education for the compliance officer and contracted providers, and develop improved communication with staff and monitoring processes.

Conclusions and Recommendations for Improvement

Healthy U demonstrated improvement in all three domains of care; however, HSAG identified several ongoing opportunities for improvement as a result of the 2019 follow-up compliance review. HSAG found that while the quantity of accessibility errors and contrast issues in electronic information provided for members was reduced, significant accessibility issues remained in Healthy U's portable

document format (PDF) member handbook and online provider directory. To address the lingering issues, HSAG recommended that Healthy U's leadership identify measures to ensure that information provided electronically to members is complete and readily accessible (based on Section 508 guidelines).

In CY 2018, Healthy U's cultural competency training did not meet the requirements, and Healthy U did not track any employee or provider participation in cultural competency training. In CY 2019, Healthy U stated that it was still working to address the requirement. Additionally, for the CY 2019 follow-up compliance review, Healthy U had developed a comprehensive Assessment and Attestation Tool for Americans with Disabilities Act (ADA) Compliance to assess whether its facilities meet requirements for physical access, accommodations, and accessible equipment; however, Healthy U had not yet distributed the tool to providers to collect the information. Once these areas are addressed, Healthy U will need to update its provider directory to include whether each provider has completed cultural competency training and whether providers' offices have accommodations for members with disabilities.

In CY 2018, Healthy U did not have a process to verify with members that they received services that were represented as delivered to them. Although HSAG found in CY 2019 that Healthy U had developed a process to meet this requirement, Healthy U had not yet implemented the process.

Further, in CY 2019 HSAG found that for many of the items that were found to be ongoing issues, Healthy U had a plan and process in place, but had not yet implemented the plan. HSAG recommended that leadership consider how to ensure that proposed corrective actions are implemented in a timely manner.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Healthy U's HEDIS compliance auditor found Healthy U's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. 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 validation results.

Performance Measure Outcomes

Table 3-4 shows Healthy U's HEDIS 2019 results as compared to the 2019 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 3-4—Healthy U HEDIS 2019 Results

HEDIS Measure	Healthy U 2019 Rate	2019 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)	**47.22%**	53.43%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	95.26%	90.45%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**48.04%**	58.41%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**56.58%**	59.34%
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)	78.59%	68.08%
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)	**43.75%**	58.19%
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%	87.79%
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)	**56.20%**	57.34%
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.	76.40%	58.87%
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)	90.75%	79.19%

HEDIS Measure	Healthy U 2019 Rate	2019 NCQA Quality Compass Average
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 21 and 56 days after delivery. (Postpartum Care)	**55.47%**	63.59%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	72.02%	71.72%
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)	84.18%	74.27%
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)	**60.34%**	62.84%
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.	**63.66%**	72.08%

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

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

Strengths

Healthy U exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood 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*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

Opportunities for Improvement

Healthy U fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Postpartum Care*
- *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*

Conclusions and Recommendations for Improvement

Healthy U exceeded the 2019 NCQA Quality Compass average for only seven of the 15 measure rates (46.7 percent), indicating several opportunities for improvement. Improvement efforts could be focused 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
- Appropriate management of diabetes

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Healthy U submitted its PIP topic: *Asthma Medication Management*.

Validation Results

Table 3-5 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 3-5—CY 2019 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)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	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	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*	**95% (18/19)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**90% (9/10)**		
	Validation Status	***Not Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Healthy U progressed to reporting Remeasurement 3 and Remeasurement 4 results for its PIP.

The baseline rate for members 5 to 11 years old with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater was 58.0 percent, which increased to 64.9 percent during Remeasurement 1. For Remeasurement 2, the rate decreased by 3.3 percentage points over the Remeasurement 1 rate to 61.6 percent. Healthy U documented that, due to a smaller study population, it faced challenges toward achieving a statistically significant improvement in the study

outcomes. For Remeasurement 3, the rate was below the baseline at 52.5 percent; however, for Remeasurement 4, the rate increased to 71.4 percent, which demonstrated a non-statistically significant increase ($p = 0.0785$) of 13.4 percentage points over the baseline. The health plan documented that Remeasurement 4 data were based on claims received by March 14, 2019. It appears that Remeasurement 4 data may need to be updated in next year's submission, once the data are recalculated allowing for claims lag.

The PIP will be evaluated for sustained improvement when the study indicator has demonstrated statistically significant improvement over baseline and results from a subsequent measurement period have been reported.

Table 3-6 displays data for Healthy U's *Asthma Medication Management* PIP.

Table 3-6—PIP—*Asthma Medication Management*
Healthy U

Study Indicator	Baseline Period 01/01/2014–12/31/2014		Remeasurement 1 01/01/2015–12/31/2015		Remeasurement 2 01/01/2016–12/31/2016		Remeasurement 3 01/01/2017–12/31/2017		Remeasurement 4 01/01/2018–12/31/2018		Sustained Improvement
The percentage of members 5 to 11 years old who have persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	N: 47	58.0%	N: 61	64.9%	N: 69	61.6%	N: 53	52.5%	N: 65	71.4%	*Not Assessed*
	D: 81		D: 94		D: 112		D: 101		D: 91		

N–Numerator D–Denominator

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Healthy U's study topic addressed CMS' requirements related to outcomes—specifically, the quality of care and services. Healthy U's PIP aims to increase asthma medication compliance rates in members 5 to 11 years of age with a goal to improve outcomes and reduce costs. By increasing asthma medication compliance for members 5 to 11 years of age, the health plan increases the likelihood of desired health outcomes through providing services that are consistent with current professional, evidence-based knowledge.

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 CY 2017 (Remeasurement 3) and CY 2018 (Remeasurement 4) data accurately in this year's PIP submission. 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 executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

The PIP received an overall *Not Met* validation status, with *Met* scores for 90 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the sound PIP design, accurate analysis of results, and implementation of system interventions that were related to barriers identified through QI processes. Healthy U was not successful at achieving statistically significant improvement over the baseline. The lack of statistically significant improvement over the baseline led to the *Not Met* validation status for this PIP.

As the PIP progresses, HSAG recommends the following:

- Healthy U must continue to revisit the causal/barrier analysis and QI processes at least annually to identify and document new or revised barriers that have prevented improvement in PIP outcomes and should develop new or revised interventions to better address high-priority barriers associated with lack of improvement.
- Healthy U must evaluate the effectiveness of each individual intervention and make data-driven decisions when revising, continuing, or discontinuing interventions. The evaluation process for each intervention must identify the individual impact of that intervention on the study indicator rate.
- Healthy U should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Healthy U's Provider Data Structure Questionnaire responses indicated that Healthy U validated providers' self-report type and specialty information during the credentialing process. Healthy U noted that it does not maintain provider taxonomy information. Healthy U noted that all single case agreements with providers require prior authorization. Healthy U's contracted providers are credentialed every three years, and Healthy U sends an annual newsletter to providers to encourage them to update their address information.

Healthy U reported assigning providers a PCP indicator if these conditions were true:

- The provider has one or more of the following specialties: adolescent, family, general, geriatric, internal, naturopathy, pediatric, OB/GYN, or preventive medicine.
- The location has a specialty in one of the aforementioned specialties, or is a health center/clinic or a multispecialty clinic.

Additionally, Healthy U midlevel providers can be considered as PCPs if they are one of the following: advanced practice registered nurse, clinical nurse specialist, midwife, nurse practitioner, or physician assistant; have a PCP-specific location specialty; and their credentialing is delegated (or the provider does not have credentialing waived at the location and the network group does not have credentialing waived). Healthy U identified PNC providers as individuals with an OB/GYN or nurse midwifery specialty.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Healthy U's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Healthy U's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the ACO's data values for provider type, specialty, and credentials. Therefore, Healthy U should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Healthy U met the statewide compliance time/distance standards for 46 of the 56 provider categories (82.1 percent). For the provider categories for which Healthy U did not meet the time/distance standard, Healthy U should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Healthy U, the inability to identify the providers in the data using the standard definitions, or other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Specialist Providers
  - Allergy & Immunology, Pediatric
  - Oncology/Hematology, Pediatric
  - Ophthalmology, Pediatric
  - Orthopedic Surgery, Pediatric
  - Other Surgery
  - Other Surgery, Pediatric
  - Pulmonology, Pediatric
- Additional Physical Health Specialties

- Diagnostic Radiology
- Laboratory
- Outpatient Infusion/Chemotherapy

Molina Healthcare of Utah (Molina)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the 2019 compliance review, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all MCOs. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Molina's credential files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed Molina for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Molina had made updates to its member-facing documents and related policies to:

- Include the correct time frame for providing written notice to members upon termination of a contracted provider.
- Specify what constitutes "medically necessary services."
- Include the correct time frames and requirements related to service authorizations, grievances, and appeals.
- Ensure that member-facing documents are written at a sixth-grade reading level or below.

Molina revised its website information to:

- Include its drug formulary for its Medicaid line of business that included tiers, as required.
- Demonstrate that the drug utilization review program included quarterly Pharmacy and Therapeutics Committee meetings.
- Include the notice that paper documents are available upon request.

During the CY 2019 interview, HSAG also found that Molina had revised processes, staff training materials, and provider informational materials to:

- Ensure that its peer-to-peer process occurs prior to issuing the NABD letter so that Molina can work more closely with providers before making a full or partial denial determination, improving quality and access for members.

- Include a process to regularly verify whether its Medicaid members received services that network providers represented as having been delivered.
- Ensure that current written delegation service agreements comply with federal health care regulations and State contract requirements.
- Implement a tracking mechanism to ensure that required contract provisions are included in all future delegation agreements.

Conclusions and Recommendations for Improvement

Molina demonstrated improvement in all three domains of care; however, HSAG identified several ongoing findings during the follow-up review. In CY 2019, HSAG found continued accessibility errors and contrast issues on Molina's website.

During both the CY 2018 and 2019 reviews, Molina's provider directory was missing required information on its providers. Therefore, HSAG recommended that Molina's leadership identify measures to ensure that information provided electronically to members is complete and fully accessible, including information available to members in the provider directory and PDF documents available on the website to ensure ongoing full accessibility.

In CY 2018, HSAG found that Molina's appeal process included a requirement for members to follow an oral request for an appeal with a written request in five days or the member would lose the right to appeal. For CY 2019, Molina had removed the statement that members would "lose their right to appeal" from its policies; however, the time frame for members to submit a written appeal request was still included, which conflicts with federal managed care regulations. In addition, in both the CY 2018 and 2019 reviews, Molina's Appeal procedure did not include the correct time frame for a member to file a request for a State fair hearing. HSAG recommended that Molina's appeal and grievance managers work to correct the recurring findings and review Molina's internal and member-facing documents to ensure that updates are reflected throughout.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Molina's HEDIS compliance auditor found Molina's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. Molina contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Molina's FAR revealed that Molina's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 3-7 shows Molina's HEDIS 2019 results as compared to the 2019 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 3-7—Molina HEDIS 2019 Results

HEDIS Measure	Molina 2019 Rate	2019 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	53.43%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.43%	90.45%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**40.36%**	58.41%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**53.28%**	59.34%
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)	71.29%	68.08%
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)	**39.95%**	58.19%
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)	**87.10%**	87.79%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**52.31%**	57.34%
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.	**55.47%**	58.87%

HEDIS Measure	Molina 2019 Rate	2019 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)	85.40%	79.19%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 21 and 56 days after delivery. (Postpartum Care)	**52.80%**	63.59%
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.	**66.89%**	71.72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**62.77%**	74.27%
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)	**60.83%**	62.84%
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.	**59.37%**	72.08%

*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—Validation of Performance Measures

Strengths

Molina exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*

Opportunities for Improvement

Molina fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *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*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—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*

Conclusions and Recommendations for Improvement

Molina exceeded the 2019 NCQA Quality Compass average for only three of the 14 applicable measure rates (21.4 percent), indicating several opportunities for improvement. Improvement efforts could be focused 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

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Molina submitted its PIP topic: *Breast Cancer Screening for Women Ages 50–74*.

Validation Results

Table 3-8 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 3-8—CY 2019 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% (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)
	X. Assess for Sustained Improvement	0% (0/1)	0% (0/1)	100% (1/1)
Outcomes Total		**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**95% (19/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**91% (10/11)**		
Validation Status		***Not Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Molina progressed to reporting Remeasurement 3 results.

For the baseline measurement period, Molina reported that 45.8 percent of women 50–74 years of age had a mammogram and were screened for breast cancer. The Remeasurement 1 rate was 55.4 percent and demonstrated a statistically significant increase over the baseline.

For Remeasurement 2, the study indicator rate decreased by 5.6 percentage points below the Remeasurement 1 rate and demonstrated a non-statistically significant improvement ($p < 0.084$) of 4.0 percentage points over the baseline to 49.8 percent and was below the goal of 51.0 percent. Molina was not able to sustain a statistically significant improvement over the baseline for two consecutive reporting periods.

Molina explained the reason for the decrease in the study population over the measurement periods. Molina reported that from Remeasurement 1 onward, members who did not have Molina as their primary insurance were excluded from the study population. The health plan added that this exclusion did not bias the rates according to HEDIS audit specifications and could be trended over time. The decrease in the study population during Remeasurement 2 was attributed to the advent of Marketplace, stricter qualifications of Medicaid continuation, and changing age demographics of the study population.

For Remeasurement 3, the study indicator rate was 2.3 percentage points below the baseline at 43.5 percent. The health plan did not sustain the statistically significant improvement over the baseline that was achieved during Remeasurement 1.

Table 3-9 displays data for Molina's PIP.

Table 3-9—PIP—*Breast Cancer Screening for Women Ages 50–74*
Molina

Study Indicator	Baseline Period 01/01/2014–12/31/2014		Remeasurement 1 01/01/2015–12/31/2015		Remeasurement 2 01/01/2016–12/31/2016		Remeasurement 3 01/01/2017–12/31/2017		Sustained Improvement
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer during the measurement period.	N: 713 D: 1,558	45.8%	N: 689 D: 1,243	55.4%*	N: 326 D: 654	49.8%	N: 257 D: 591	43.5%	*No*

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

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Molina's study topic addressed CMS' requirements related to outcomes—specifically, the quality, timeliness, and accessibility of care and services. Molina's PIP aims to improve the breast cancer screening rates in its Medicaid female population 50 to 74 years of age. By increasing the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer, 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; providing timely care; and using services to achieve optimal outcomes.

Strengths

Molina 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. Molina reported and analyzed its Remeasurement 3 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.

Conclusions and Recommendations for Improvement

The PIP received an overall *Not Met* validation status, with *Met* scores for 91 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the sound PIP design, and implementation of system interventions that were related to barriers identified through QI processes. The interventions implemented were logically linked to the barriers and appear to have the potential to drive improvement; however, for Remeasurement 3, Molina was not successful in sustaining statistically significant improvement over the baseline that was achieved during Remeasurement 1. This lack of statistically significant improvement led to the *Not Met* validation status for this PIP.

As the PIP progresses, HSAG recommends the following:

- Molina must ensure that the documented narrative interpretation of results is accurate.
- Molina must ensure that the documented Barriers/Interventions table is accurate.
- Molina must revisit the causal/barrier analysis and QI processes at least annually to reevaluate barriers and develop new interventions as needed.
- Molina must identify and document new or revised barriers that have prevented improvement in PIP outcomes and must develop new or revised interventions to better address high-priority barriers associated with lack of improvement.

- Molina must evaluate the effectiveness of each intervention throughout the measurement period. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention should identify the individual impact of that intervention on the study indicator rate.
- Molina should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Molina's Provider Data Structure Questionnaire responses indicated that Molina validated providers' self-report type. The provider specialty field information is collected via the National Plan and Provider Enumeration System (NPPES) data and the credentialing data. Molina noted provider taxonomy information is based on the provider specialty information. Molina also noted that single case agreements require a Letter of Agreement (LOA) or prior authorization. Molina's data validation team reaches out to all provider groups quarterly to verify information.

Molina reported assigning providers a PCP indicator if the practicing specialty includes pediatrics, pediatric nurse practitioner, family medicine, family nurse practitioner, internal medicine, adult health nurse practitioner, OB/GYN, OB/GYN nurse practitioner, advance practice midwife, women's health nurse practitioner, geriatrics, geriatric nurse practitioner, general practice, or physician's assistant. Molina's physician's assistants must be in a rural location to act as a PCP. Molina does not specifically identify PNC providers.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Molina's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Molina's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the ACO's data values for provider type, specialty, and credentials. Therefore, Molina should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Molina met the statewide compliance time/distance standards for 35 of the 56 provider categories (62.5 percent). For the provider categories for which Molina did not meet the time/distance standard, Molina should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Molina, the inability to identify the providers in the data using the standard definitions, or other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Specialist Providers
  - Allergy & Immunology, 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
  - Other Surgery
  - Other Surgery, Pediatric
  - Otolaryngology, Pediatric
  - Physical Medicine, Pediatric
  - Pulmonology, Pediatric
  - Rheumatology, Pediatric
  - Urology, Pediatric
- Additional Physical Health Specialties
  - Diagnostic Radiology
  - Mammography
  - Outpatient Infusion/Chemotherapy

SelectHealth Community Care (SelectHealth)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of initial credentialing records for all MCOs. SelectHealth submitted a sample of 10 records with an oversample of five records. HSAG reviewed a sample of only nine records because many of the records originally submitted consisted of dental providers that were not from SelectHealth's Utah market, as required. The focus of HSAG's review pertained to the timeliness and quality characteristics of provider credentialing. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. HSAG found that SelectHealth's credential files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 compliance review, HSAG also reviewed SelectHealth for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. SelectHealth demonstrated overall improvement across all three domains of care during the CY 2019 follow-up compliance review, making changes to member-facing documents and related policies to:

- Ensure members have accurate and timely information about changes in the provider network, member rights and protections, and the drug formulary.
- Ensure members understand the requirements and time frames related to authorization of services, adverse benefit determinations, grievances, and appeals.
- Define "emergency services" to comply with federal regulations and State contract requirements and ensure that processing of claims for emergency services complies with federal regulations.

HSAG also found SelectHealth had revised processes, staff training materials, and provider informational materials to:

- Conduct staff trainings on the grievance and appeal system and health literacy to ensure member-facing documents are written at a sixth-grade reading level or below.
- Ensure that members are not charged more for out-of-network poststabilization services than when those services are furnished by in-network providers.
- Collect information about providers' cultural competence training and site accommodations for members with disabilities.
- Ensure a more reliable means for monitoring timeliness of access to services.

- Address provider retention and provide information about the False Claims Act.
- Ensure monthly screening of all employees for exclusion from federal health care participations.

Conclusions and Recommendations for Improvement

SelectHealth's overall performance was strong as improvement was identified in all three domains of care, and the quantity of issues over CY 2018 results were greatly reduced; however, HSAG found continued accessibility errors and contrast issues on SelectHealth's website and in PDF documents associated with the website during the CY 2019 review. HSAG recommended that SelectHealth continue its efforts toward ongoing full compliance with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines and takes measures to ensure that information provided to members on its website, specifically in the provider directory, is complete and readily accessible (based on Section 508).

In addition, during both the CY 2018 and 2019 reviews, SelectHealth's provider directory was missing required information on providers. HSAG recommended that SelectHealth continue its efforts to ensure completeness of provider-specific information in the provider directory.

SelectHealth's provider agreements continued to lack the provisions regarding U.S. Department of Health and Human Services' access to records. HSAG recommended that SelectHealth revise its provider agreements to include all federally required provisions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that SelectHealth's HEDIS compliance auditor found SelectHealth's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. 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 Molina's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 3-10 shows SelectHealth's HEDIS 2019 results as compared to the 2019 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 3-10—SelectHealth HEDIS 2019 Results

HEDIS Measure	SelectHealth 2019 Rate	2019 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)	54.17%	53.43%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	95.44%	90.45%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**46.63%**	58.41%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**56.97%**	59.34%
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)	75.91%	68.08%
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)	**42.71%**	58.19%
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)	88.92%	87.79%
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)	65.98%	57.34%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	72.75%	58.87%
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)	85.79%	79.19%

HEDIS Measure	SelectHealth 2019 Rate	2019 NCQA Quality Compass Average
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 21 and 56 days after delivery. (Postpartum Care)	75.52%	63.59%
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.	74.41%	71.72%
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)	90.63%	74.27%
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)	63.42%	62.84%
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.	**64.47%**	72.08%

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

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

Strengths

SelectHealth exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood 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—BMI Percentile—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Opportunities for Improvement

SelectHealth fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Conclusions and Recommendations for Improvement

SelectHealth exceeded the 2019 NCQA Quality Compass for 11 of 15 measure rates (73.3 percent), indicating several strengths. Of note, targeted improvement efforts could be focused on increasing screenings for women (breast cancer, cervical cancer, and chlamydia) and required well-child visits for young children.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, SelectHealth submitted its PIP topic: *Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday.*

Validation Results

Table 3-11 summarizes the validation findings for each stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 3-11—CY 2019 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)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	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)
	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***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

SelectHealth progressed to reporting Remeasurement 2 data this year. For the baseline measurement period, the rate of eligible 13-year-old Medicaid females who received three doses of the HPV vaccine prior to their 13th birthday was 26.7 percent. The Remeasurement 1 rate was marginally lower than the baseline rate at 26.6 percent. For Remeasurement 2, the study indicator rate of 35.0 percent was 8.4 percentage points higher than the Remeasurement 1 rate and demonstrated a statistically significant increase ($p < 0.0001$) of 8.3 percentage points over the baseline. It should be noted that there was a change in the HEDIS 2018 *Immunizations for Adolescents (IMA)* measure numerator

specifications, which may impact the comparability of the Remeasurement 2 data to the baseline. In HEDIS 2018, a two-dose HPV vaccination series was added to the numerator specifications.

The PIP will be evaluated for sustained improvement when the study indicator has demonstrated a statistically significant improvement over baseline and results from a subsequent measurement period have been reported.

Table 3-12 displays data for SelectHealth's *Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday* PIP.

Table 3-12—PIP—*Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of HPV Vaccine Prior to Their 13th Birthday*
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		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%*	*Not Assessed*
	D: 961		D: 1,157		D: 1,060		

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

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. 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.

Strengths

SelectHealth designed a scientifically sound project supported by the use of 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. SelectHealth reported and analyzed its Remeasurement 2 data accurately and conducted appropriate QI processes to identify and prioritize barriers. SelectHealth implemented interventions that were logically linked to those barriers and have the potential to impact the study indicator outcomes and evaluated the effectiveness of those interventions.

Conclusions and Recommendations for Improvement

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. SelectHealth designed a methodologically sound PIP, reported and summarized the Remeasurement 2 data accurately, and used appropriate QI processes and tools to identify barriers. The interventions developed and implemented were logically linked to the barriers, and the health plan achieved statistically significant improvement over the baseline.

As the PIP progresses, HSAG recommends the following:

- SelectHealth must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- SelectHealth must continue to evaluate the effectiveness of each intervention throughout the measurement period. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention should identify the individual impact of that intervention on the study indicator rate.
- SelectHealth should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- SelectHealth should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

SelectHealth's Provider Data Structure Questionnaire responses indicated that SelectHealth validated providers' self-reported specialty, taxonomy, and type which were submitted via the provider application. SelectHealth noted that single case agreements require a prior authorization. SelectHealth's data are cleaned before they are entered into the data systems; additionally, new providers must pass the credentialing process. All providers are required to update their information via quarterly attestations, and the Provider Relations team engages in monthly phone calls to confirm the accuracy of the provider data.

SelectHealth reported assigning providers a PCP indicator if the practicing specialty includes general medicine, family practice, internal medicine, geriatrics, or pediatrics. SelectHealth noted the Health Services or Advocates Department would assist a member in finding an OB/GYN or equivalent PNC provider.

Conclusions and Recommendations for Improvement

As the first comprehensive review of SelectHealth's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing SelectHealth's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the ACO's data values for provider type, specialty, and credentials. Therefore, SelectHealth should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

SelectHealth met the statewide compliance time/distance standards for 37 of the 56 provider categories (66.1 percent). For the provider categories for which SelectHealth did not meet the time/distance standard, SelectHealth should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with SelectHealth, the inability to identify the providers in the data using the standard definitions, or other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Specialist Providers
  - Allergy & Immunology, Pediatric
  - Dermatology, Pediatric
  - Endocrinology, Pediatric
  - General Surgery, Pediatric
  - Infectious Disease, Pediatric
  - Nephrology, Pediatric
  - Oncology/Hematology, Pediatric
  - Orthopedic Surgery, Pediatric
  - Other Surgery
  - Other Surgery, Pediatric
  - Otolaryngology, Pediatric
  - Physical Medicine, Pediatric
  - Pulmonology, Pediatric
  - Rheumatology, Pediatric
  - Urology, Pediatric
- Additional Physical Health Specialties
  - Diagnostic Radiology
  - Laboratory
  - Mammography
  - Outpatient Infusion/Chemotherapy

MCO Providing Both Physical Health and Mental Health Services for Individuals With Developmental Disabilities and a Mental Illness

Healthy Outcomes Medical Excellence (HOME)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the CY 2019 review, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all MCOs. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that HOME's credential files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed HOME for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for HOME indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that HOME had made updates to its member-facing documents and related policies to:

- Remove the timeline requirement for members to follow an oral request for an appeal with a written request within five days, as a time limit cannot be imposed for this requirement.
- Ensure that its NABD template is written at a sixth-grade reading level or below and includes accurate and complete information related to grievances and appeals.
- Ensure that the member handbook includes all required information regarding alternative formats and languages, auxiliary aids, and the grievance and appeal system.
- Meet the requirements for scheduling preventive care appointments.
- Develop a process to ensure that its provider directory includes the required provider information such as whether the provider has completed cultural competency training, and site accommodations for members with disabilities.
- Ensure that policies and procedures include all requirements and time frames related to grievances and appeals.

HSAG also found HOME had revised processes, staff training materials, and provider informational materials to:

- Establish a Grievance Committee to oversee and manage the processing, acknowledgement, review, and resolution of grievances and appeals.
- Include all required provisions in its provider agreement template.
- Develop a process to verify whether members received services that were billed by providers.

Conclusions and Recommendations for Improvement

In CY 2019, HSAG found that HOME had remedied the majority of findings from CY 2019; however, HSAG found that HOME had not yet added the notice to its website to inform members that if requested, electronic information found on the website would be sent to the member in paper form within five business days.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-13 presents HOME's reporting year (RY) 2019 performance measure results.

Table 3-13—HOME RY 2019 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	45.45%
Follow-Up Within 30 Days	93.94%

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

Strengths

Based on HSAG's PMV activities, HSAG determined that HOME demonstrated the following strengths:

- HOME used appropriate processes to receive and process eligibility data.
- HOME had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- HOME had appropriate processes to receive and process claims and encounters.

Conclusions and Recommendations for Improvement

Based on the results of the PMV process, HOME used acceptable processes related to eligibility, provider data, and claims and encounters. HSAG noted that HOME did not use a separate column in its tracking spreadsheet to denote who was or was not counted in the calculation of the performance measure, although this did not negatively impact the measure results. HSAG recommended that HOME add this column in its tracking spreadsheet to ensure accuracy and completeness of data.

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. HSAG recommended that HOME 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.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, HOME submitted its PIP topic: *Impact of clinical and educational interventions on progression of pre-diabetes to Type II Diabetes Mellitus.*

Validation Results

Table 3-14 summarizes the validation findings for each stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 3-14—CY 2019 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)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	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)
	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***		

*Percentage totals may not equal 100 due to rounding.

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 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. Forty-three members in the study cohort had their most recent HbA1c reading of less than 5.7 during CY 2018. This represents a statistically significant improvement in the study indicator result over the baseline.

The PIP will be evaluated for sustained improvement when the study indicator has demonstrated statistically significant improvement over baseline and results from a subsequent measurement period have been reported.

Table 3-15 displays data for HOME's *Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus* PIP.

Table 3-15—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%*			*Not Assessed*
	D: 103		D: 100				

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

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

While the focus of a health plan's PIP may be to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. HOME's study topic addressed CMS' requirements related to outcomes, specifically, the quality, access, and timeliness of care and services. HOME's PIP aims 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.

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 and prioritize barriers and implemented interventions that were logically linked to the barriers and have the potential to impact study indicator outcomes. The PIP had not progressed to evaluating interventions for effectiveness.

Conclusions and Recommendations for Improvement

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. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. HOME used appropriate QI processes and tools to identify and prioritize barriers. The interventions developed and implemented were logically linked to the barriers and have the potential to drive improvement toward the desired outcomes. HOME demonstrated a statistically significant increase in the study indicator rate over the baseline.

As the PIP progresses, HSAG recommends the following:

- 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.
- HOME should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

HOME's Provider Data Structure Questionnaire responses indicated that HOME validated providers' self-report type and specialty information during the credentialing process. HOME noted that it does not maintain provider taxonomy information. HOME noted that all single case agreements with providers require prior authorization. HOME's contracted providers are credentialed every three years, and HOME sends an annual newsletter to providers to encourage them to update their address information.

HOME reported assigning providers a PCP indicator if these conditions exist:

- The provider has one or more of the following specialties: adolescent, family, general, geriatric, internal, naturopathy, pediatric, OB/GYN, or preventive medicine.
- The location has a specialty in one of the aforementioned specialties, or is a health center/clinic or a multispecialty clinic.

Additionally, midlevel providers can be considered a PCP if they are one of the following: advanced practice registered nurse, clinical nurse specialist, midwife, nurse practitioner, or physician assistant; have a PCP-specific location specialty; and the credentialing is delegated (or the provider does not have credentialing waived at the location and the network group does not have credentialing waived). HOME identified PNC providers as individuals with an OB/GYN or nurse midwifery specialty.

Conclusions and Recommendations for Improvement

As the first comprehensive review of HOME's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing HOME's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the MCO's data values for provider type, specialty, and credentials. Therefore, HOME should assess available data values in its

provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

HOME met the statewide compliance time/distance standards for 52 of the 62 provider categories (83.9 percent). For the provider categories for which HOME did not meet the time/distance standard, HOME should assess if this is due to 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 other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Behavioral Health Providers
  - Behavioral Substance—Pediatric
  - General Hospitals with a Psychiatric Unit
- Specialist Providers
  - Allergy & Immunology, Pediatric
  - Ophthalmology, Pediatric
  - Orthopedic Surgery, Pediatric
  - Other Surgery
  - Other Surgery, Pediatric
- Additional Physical Health Specialties
  - Diagnostic Radiology
  - Laboratory
  - Outpatient Infusion/Chemotherapy

PMHPs Providing Mental Health Services Under Medicaid

Bear River Mental Health Services (Bear River)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the CY 2019 compliance review, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Bear River's credential files met the requirements for the timely collection of information verifying that providers were not excluded from participation in federal programs.

For the CY 2019 follow-up compliance review, HSAG also reviewed Bear River for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Bear River indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Bear River had made updates to its member-facing documents and related policies to:

- Update its website to include the required language informing members of the availability of information in paper form.
- Eliminate accessibility and contrast errors on its website and electronic documents, with only two accessibility issues in the electronic provider directory remaining.
- Ensure the inclusion of taglines in large print in written member communications.
- Develop a template letter and process to notify members of a termination or change in provider status.
- Ensure that policies, procedures, and processes include accurate and complete timelines and requirements related to service authorizations, grievances, and appeals.

HSAG also found Bear River had revised processes, staff training materials, and provider informational materials to:

- Implement a new software system (Streamline) used for correctly logging, tracking, trending, and reporting grievances to the QI committee.
- Provide practice guidelines to providers, members, and potential members upon request.

- Operationalize a corporate compliance committee that reports to the Board of Directors and senior management and is charged with overseeing the organization's compliance program.

Conclusions and Recommendations for Improvement

Based on the CY 2019 credentialing record review for Bear River, HSAG found that Bear River did not retrieve licensure or education verification in a timely manner for five of the 10 provider files reviewed; did not provide evidence of collecting any licensure or education verification for one provider; and did not collect a completed application for one of the 10 providers until after the hire date. HSAG recommended that Bear River's management team evaluate its procedures for credentialing new providers to determine the root cause preventing complete documentation collection prior to hire.

As a result of the CY 2019 compliance follow-up review, HSAG identified ongoing required actions for Bear River related to the three domains of care. Following the CY 2018 review, Bear River posted a provider directory for its Medicaid population on its website and included all required elements. However, during the CY 2019 follow-up review, HSAG found that the directory was not current (2015 edition) and did not include complete information about providers' linguistic capacity. In addition, in 2019 Bear River had updated its policies to include provisions regarding the member's right to request a State fair hearing; however, Bear River did not include the correct time frame for a member to file a State fair hearing in its State Fair Hearing Form provided to members. HSAG recommended that Bear River's management team perform a review of its website and member-facing documents to ensure that the content is up to date and includes required information.

During the CY 2019 follow-up compliance review, HSAG found that Bear River had not yet implemented a method to regularly verify with members whether they received services that were billed by network providers, in order to detect fraudulent billing. HSAG recommended that the Bear River management team develop and implement a method to query members to determine whether members received services for which they were billed.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-16 presents Bear River's RY 2019 performance measure results.

Table 3-16—Bear River RY 2019 *FUH* Results

Indicator	Bear River Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**36.49%**	52.28%
Follow-Up Within 30 Days	**45.95%**	68.30%

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

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

Strengths

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

Conclusions and Recommendations for Improvement

The rate for members hospitalized for mental illness who received a follow-up visit within seven days of discharge and within 30 days of discharge demonstrated performance below the statewide PMHP average. Therefore, HSAG recommended that Bear River focus improvement efforts designed to ensure that members receive a Bear River-furnished service within seven days and within 30 days following discharge from a hospitalization.

Based on the results of the PMV process, Bear River used acceptable processes related to eligibility, provider data, and claims and encounters for performance measure reporting; however, Bear River did not have any processes in place to track authorizations and document the number of inpatient hospitalization days and authorized services. HSAG recommended that Bear River have processes in place to document and track authorizations for inpatient hospitalization to ensure accurate performance measure calculation.

In addition, Bear River erroneously excluded members from the denominator who had received a follow-up service on the same day as the hospital discharge, and although the members were not numerator-compliant, they needed to remain in the denominator. HSAG recommended that Bear River implement quality checks to ensure that State specifications are followed during the measure calculation process.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Bear River submitted its PIP topic: *Suicide Prevention.*

Validation Results

Table 3-17 summarizes the validation findings for each stage validated for CY 2019. Overall, 90 percent of all applicable evaluation elements received a score of *Met.*

Table 3-17—CY 2019 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	33% (1/3)	67% (2/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	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*		**90% (18/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Bear River progressed to reporting Remeasurement 3 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 and 54.1 percent for Remeasurement 2. For Remeasurement 3, the rate increased by 1.8 percentage points over the Remeasurement 2 rate to 55.9 percent and demonstrated a statistically significant increase ($p < 0.0001$) of 48 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. For Remeasurement 3, the rate increased by 24 percentage points over the Remeasurement 2 rate to 83.5 percent and demonstrated a statistically significant increase ($p < 0.0001$) of 47.3 percentage points over the baseline.

Table 3-18 displays data for Bear River's *Suicide Prevention* PIP.

Table 3-18—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		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 D: 2,746	7.9%	N: 820 D: 2,966	27.6%*	N:1,440 D: 2,660	54.1%*	N: 1,857 D: 3,323	55.9%*	*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: 38 D: 105	36.2%	N: 342 D: 441	77.6%*	N: 261 D: 439	59.5%*	N: 222 D: 266	83.5%*	*Yes*

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

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. 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.

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 3 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, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 90 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the sound PIP design; accurate data reporting; implementation of system interventions that were related to barriers identified through QI processes; and achievement of a statistically significant, sustained improvement in the study indicator rates over the baseline. Bear River was able to sustain improvement for three consecutive measurement periods for both study indicators.

As the PIP progresses, HSAG recommends the following:

- Bear River must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Bear River must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Bear River should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

- Bear River should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Bear River's Provider Data Structure Questionnaire responses indicated that Bear River does not collect provider type or provider specialty; however, it does collect provider taxonomy, degree, and licensure information upon hiring new providers. Bear River noted that it has a very low number of subcontractors, so they are not tracked and identified in the system. Bear River did not specify a data verification or cleaning process but noted that the employed providers self-report their address and credential information.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Bear River's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Bear River's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Bear River should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Bear River did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Bear River met the time/distance standards for all categories except Substance Abuse in rural and frontier areas. For the provider categories for which Bear River did not meet the time/distance standard, Bear River should assess if this is due to 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 other reasons.

Central Utah Counseling Center (Central)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of initial credentialing records for all health plans. Central submitted eight records, indicating that only eight new providers joined Central's network during the period under review, July 1, 2018, through May 31, 2019. HSAG reviewed State contract requirements for initial credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Central's credentialing files demonstrated that Central collected applications in a timely manner.

For the CY 2019 follow-up compliance review, HSAG also reviewed Central for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Central indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Central had made updates to its member-facing documents and related policies to:

- Eliminate electronic accessibility and contrast errors on its website and in PDF documents posted on the website and to inform members via the website that the information on the website is available in paper format.
- Develop policies and template letters to notify members of a termination or change in provider status.
- Ensure that the member handbook included all required information and format notifications as required.
- Ensure that policies, procedures, and member notifications include accurate timelines and requirements related to service authorizations, grievances, and appeals.

HSAG also found Central had revised processes, staff training materials, and provider informational materials to ensure that staff who process grievances and appeals understand the federal regulations related to the grievance and appeal system.

Conclusions and Recommendations for Improvement

Based on the review of credentialing records, HSAG found that Central did not conduct timely licensure or education verification in three of the eight provider files reviewed. In addition, in two provider files,

HSAG found that Central did not conduct timely verification to ensure that providers were not excluded from participation in federal health care programs. HSAG recommended that Central's management team evaluate its procedures for credentialing new providers to determine the root cause preventing timely primary source verification (PSV) prior to hire.

Based on the 2019 follow-up compliance review of Central's 2018 corrective actions, HSAG did not identify any opportunities for improvement resulting in continued required corrective actions.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-19 presents Central's RY 2019 performance measure results.

Table 3-19—Central RY 2019 *FUH* Results

Indicator	Central Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**NA**	52.28%
Follow-Up Within 30 Days	**NA**	68.30%

NA *indicates that the PMHP followed the specifications, but the denominator was too small (<30) to report a valid rate.*

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

Strengths

- Central used appropriate processes to receive and process eligibility data.
- Central had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Central had adequate processes to receive and process claims and encounters.
- Central had adequate validation processes in place to ensure the data integrity of provider information.

Conclusions and Recommendations for Improvement

Based on the results of the PMV process, Central used acceptable processes related to eligibility, provider data, and claims and encounters for performance measure reporting. Central's QI efforts should be focused on data integration processes. HSAG found that Central did not include in its tracking spreadsheet additional columns to identify cases that are either numerator or denominator compliant. Therefore, HSAG recommended that Central add 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.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Central submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 3-20 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 3-20—CY 2019 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% (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	83% (5/6)	17% (1/6)	0% (0/6)
	Implementation Total	**89% (8/9)**	**11% (1/9)**	**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*		**95% (20/21)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Central progressed to reporting Remeasurement 3 results for the two study indicators.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 61.8 percent, which increased to 80.1 percent for Remeasurement 1, and then decreased to 77.4 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 1 rate of 82.2 percent exceeded the Remeasurement 2 rate by 4.8 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 20.4 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 19.4 percent, which increased to 51.3 percent for Remeasurement 1 and 78.4 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 2 rate of 74.7 percent fell below the Remeasurement 2 rate by 3.7 percentage points; however, the Study Indicator 2 rate demonstrated a statistically significant increase ($p < 0.0001$) of 55.3 percentage points over the baseline.

Table 3-21 displays data for Central's *Suicide Prevention* PIP.

Table 3-21—PIP—*Suicide Prevention*
Central

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
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 519	61.8%	N: 728	80.1%*	N:661	77.4%*	N: 730	82.2%*	*Yes*
	D: 840		D: 909		D: 854		D: 888		
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: 18	19.4%	N: 60	51.3%*	N: 76	78.4%*	N: 118	74.7%*	*Yes*
	D: 93		D: 117		D: 97		D: 158		

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

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, 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, 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.

Strengths

Central designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Central reported and analyzed its Remeasurement 3 data accurately. Central 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, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

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. The performance suggests a thorough application of the PIP design; accurate analysis of results; implementation of system interventions that were related to barriers identified through QI processes; and achievement of a statistically significant, sustained improvement in the study indicator rates over the baseline. Central was able to sustain improvement for three consecutive measurement periods for both study indicators.

As the PIP progresses, HSAG recommends the following:

- Central must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Central should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- Central should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Central's Provider Data Structure Questionnaire responses indicated provider type, educational degree, and licensure information are self-reported by the providers and verified by Central through Utah's Division of Occupational and Professional Licensing (DOPL). Provider taxonomy is assigned by the center. Providers licensed under single case agreements are listed as a "facility" or are maintained as an independent contractor in a spreadsheet separate from the electronic health record (EHR). Central verifies all providers using the DOPL system and through a triennial credentialing process.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Central's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Central's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Central should assess available data values in

its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Central did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Central met the time/distance standards for all categories except Substance Abuse in rural and frontier areas. For the provider categories for which Central did not meet the time/distance standard, Central should assess if this is due to 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 other reasons.

Davis Behavioral Health (Davis)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Davis' initial credentialing files met the requirements for the timely collection of information verifying that providers were not excluded from participation in federal health care programs.

For the CY 2019 follow-up compliance review, HSAG also reviewed Davis for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Davis indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Davis had made updates to its member-facing documents and related policies to:

- Include taglines in large print (18-point font) and prevalent non-English languages describing how a member could request auxiliary aids and services and ensure the readability of member communications at the sixth-grade reading level.
- Include information about how to report suspected fraud, waste, or abuse.
- Ensure policies and member communications include accurate time frames and requirements related to service authorizations and the grievance and appeal system.

HSAG also found Davis had revised processes, staff training materials, and provider informational materials to:

- Ensure staff understanding of how to use the Flesch-Kincaid scale as a method to monitor readability.
- Detect underutilization of services and use existing census reports to identify trends related to underutilization occurring in specific programs throughout the agency.

Conclusions and Recommendations for Improvement

Based on the credentialing record review, HSAG found that Davis had not obtained licensure or education verification for one of the 10 providers or an application within the required time frame for one other provider prior to hire. HSAG recommended that the management team at Davis evaluate its

procedures for credentialing new providers to determine the root cause preventing some PSV prior to hire.

Based on the CY 2019 follow-up review, while Davis demonstrated improvement in all three domains of care, areas for improvement remained. Upon review of grievance records during CY 2018, HSAG found that Davis was not responding to written grievances with a written acknowledgment or written resolution and was not documenting when and how members were provided a notice of resolution. Although in CY 2019, Davis provided a newly created spreadsheet which documents that the grievance was acknowledged and resolved, Davis did not include the date of acknowledgement and date of resolution in the tracking mechanism.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-22 presents Davis' RY 2019 performance measure results.

Table 3-22—Davis RY 2019 *FUH* Results

Indicator	Davis Rate	Statewide PMHP Average
Follow-Up Within 7 Days	80.00%	52.28%
Follow-Up Within 30 Days	85.83%	68.30%

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

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

Strengths

- The rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge were both more than 15 percentage points above the statewide PMHP average.
- Davis used appropriate processes to receive and process eligibility data.
- Davis had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Davis had adequate processes to receive and process claims and encounters.
- Davis had adequate validation processes in place to ensure the data integrity of provider information.
- Davis had adequate processes in place to ensure the integrity of data integration and measure calculation.

Conclusions and Recommendations for Improvement

During the PMV process, HSAG did not identify any recommendations.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Davis submitted its PIP topic: *Suicide Prevention.*

Validation Results

Table 3-23 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 3-23—CY 2019 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% (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	50% (1/2)	50% (1/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**50% (1/2)**	**50% (1/2)**	**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***		

* Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Davis progressed to reporting Remeasurement 3 results. The baseline rate for the percentage of eligible members who received the C-SSRS screening was 7.9 percent, which increased to 72.8 percent for Remeasurement 1 and 80.7 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 1 rate of 85.3 percent exceeded the Remeasurement 2 rate by 4.6 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 77.4 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 79.3 percent, which decreased to 53.7 percent for Remeasurement 1 and then increased to 73.8 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 2 rate of 82.3 percent exceeded the Remeasurement 2 rate by 8.5 percentage points but did not demonstrate a statistically significant improvement ($p = 0.3238$) over the baseline.

Table 3-24 displays data for Davis' *Suicide Prevention* PIP.

Table 3-24—PIP—*Suicide Prevention*
Davis

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
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 286	7.9%	N: 2,591	72.8%*	N: 2,707	80.7%*	N: 2,967	85.3%*	*Not Assessed*
	D: 3,601		D: 3,561		D: 3,353		D: 3,478		
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: 149	79.3%	N: 378	53.7%	N: 526	73.8%	N: 685	82.3%	*Not Assessed*
	D: 188		D: 704		D: 713		D: 832		

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

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Davis' study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Davis' 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.

Strengths

Davis designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Davis reported and analyzed its Remeasurement 3 data accurately. Davis 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, and executed appropriate processes to evaluate the effectiveness of interventions.

Conclusions and Recommendations for Improvement

The PIP received an overall *Partially Met* validation status, with *Met* scores for 90 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the sound PIP design, accurate analysis of results, and implementation of system interventions that were related to barriers identified through QI processes. Davis sustained a statistically significant improvement over baseline for Study Indicator 1; however, Study Indicator 2 did not demonstrate statistically significant improvement over the baseline.

As the PIP progresses, HSAG recommends the following:

- Davis must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Davis should build on its momentum of improvement to ensure it is able to sustain the improvement achieved for Study Indicator 1.
- For Study Indicator 2, Davis must identify and document new or revised barriers that have prevented improvement in PIP outcomes and must develop new or revised interventions to better address high-priority barriers associated with lack of improvement.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Davis' Provider Data Structure Questionnaire indicated that it does not collect provider specialty information; however, Davis does collect information provider taxonomy, NPI, licensure information, and clinician capacity provider type. Davis does not maintain a separate database of providers contracted under single case agreements. The Human Resources credentialing specialist is responsible for performing all credentialing and recredentialing activities and for ensuring the provider information is up to date.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Davis' provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Davis' compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Davis should assess available data values in its

provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Davis did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Davis met the time/distance standards for all categories except Substance Abuse in frontier areas. For the provider categories for which Davis did not meet the time/distance standard, Davis should assess if this is due to 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 other reasons.

Four Corners Community Behavioral Health (Four Corners)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Four Corners' credential files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed Four Corners for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Four Corners indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Four Corners had made updates to its member-facing documents and related policies to:

- Eliminate accessibility and contract errors on its website and most errors within the PDF documents posted on the website.
- Ensure the member's right to freely exercise his or her rights without adverse treatment from staff or providers.
- Inform members how to report suspected fraud, waste, or abuse.

- Ensure that policies, procedures and member communications include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found Four Corners had revised processes, staff training materials, and provider informational materials to:

- Ensure documentation of grievances and appeals included all required elements.
- Ensure that a written acknowledgment and written resolution of grievances and a written resolution of appeals (oral or written) are provided to members.
- Include, in its appeal process, the mechanism for ensuring that members (or authorized representatives) have access to documents and records related to the appeal, as required by federal regulations.

Conclusions and Recommendations for Improvement

Based on the CY 2019 follow-up compliance review, Four Corners' overall performance was improved in all three domains of care; however, during CY 2019, Four Corners remained unable to provide evidence that cultural competency activities were conducted, as outlined in the cultural competency plan. HSAG recommended that Four Corners management staff collaborate to determine what activities the cultural competency committee can undertake that are most relevant and beneficial to staff and members to ensure that the activities going forward not only meet regulatory requirements but add the most value for providing culturally competent services.

In CY 2019, Four Corners improved its performance regarding the inclusion of member information and the provider directory requirements; however, the taglines in the member handbook and other member communications were not in large print (18-point font). HSAG recommended that Four Corners revise its member-facing documents to include taglines in large print as required at 42 CFR §438.10.

Also, in CY 2019, HSAG found that although Four Corners had developed a provider directory, it was missing required information about the providers, such as provider's telephone number(s), whether the providers will accept new members, and the cultural and linguistic capabilities offered by the provider or provider's office. HSAG recommended that Four Corners update its provider directory to ensure that the required information is included.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-25 presents Four Corners' RY 2019 performance measure results.

Table 3-25—Four Corners RY 2019 *FUH* Results

Indicator	Four Corners Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**NA**	52.28%
Follow-Up Within 30 Days	**NA**	68.30%

NA *indicates that the PMHP followed the specifications, but the denominator was too small (<30) to report a valid rate.*

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

Strengths

- Four Corners used appropriate processes to receive and process eligibility data.
- Four Corners had adequate processes to receive and process claims and encounters.
- Four Corners had adequate validation processes in place to ensure the data integrity of provider information.

Conclusions and Recommendations for Improvement

Based on the results of the PMV process, Four Corners used acceptable processes related to eligibility, provider data, and claims and encounters for performance measure reporting; however, HSAG found potential data integration issues. HSAG recommended that Four Corners 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. HSAG also recommended that Four Corners use its EHR, Credible, as well as claims information when conducting its secondary review, to ensure members who meet the performance measure specifications are accurately included, which could result in an improvement in the measure rates. During the on-site review, Four Corners indicated that it did not date stamp paper claims received via mail. HSAG recommended that Four Corners date stamp any paper claims received via mail to ensure inclusion of appropriate members in the rate calculations.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Four Corners submitted its PIP topic: *Suicide Prevention.*

Validation Results

Table 3-26 summarizes the validation findings for each stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 3-26—CY 2019 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	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)
	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***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Four Corners progressed to reporting Remeasurement 2 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 58.7 percent, which increased to 85.3 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 1 rate of 89.3 percent exceeded the Remeasurement 1 rate by 4.0 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 30.6 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 45.5 percent, which increased to 69.5 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 2 rate of 76.8 percent exceeded the Remeasurement 1 rate by 7.3 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 31.3 percentage points over the baseline.

Table 3-27 displays data for Four Corners' *Suicide Prevention* PIP.

Table 3-27—PIP—*Suicide Prevention*
Four Corners

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		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: 502	58.7%	N:717	85.3%*	N: 714	89.3%*	*Yes*
	D: 855		D: 841		D: 800		
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: 25	45.5%	N: 73	69.5%*	N: 109	76.8%*	*Yes*
	D: 55		D: 105		D:142		

*Indicates statistically significant improvement over the Remeasurement 1 rate. N–Numerator D–Denominator

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Four Corners' study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Four Corners' 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.

Strengths

Four Corners designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Four Corners reported and analyzed its Remeasurement 2 data accurately. Four Corners 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, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

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. The performance suggests a thorough application of the PIP study design, implementation of system interventions that were related to barriers identified through appropriate QI processes. Both study indicators demonstrated sustained improvement over the baseline for Remeasurement 2.

As the PIP progresses, HSAG recommends the following:

- Four Corners must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Four Corners should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- Four Corners should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Four Corners' Provider Data Structure Questionnaire responses indicated provider type, taxonomy, educational degree, and licensure information are self-reported by the providers and verified by Four Corners through Utah's DOPL. Four Corners indicated it did not contract with providers under single

case agreements. All provider data are stored in Credible, and providers notify the PMHP of any changes. Additionally, Four Corners staff members annually review and validate the provider data.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Four Corners' provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Four Corners' compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Four Corners should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Four Corners did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Four Corners met the time/distance standards for all categories except Substance Abuse in rural and frontier areas. For the provider categories for which Four Corners did not meet the time/distance standard, Four Corners should assess if this is due to 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 other reasons.

Northeastern Counseling Center (Northeastern)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal health care programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Northeastern's initial credentialing files met the requirements for the timely collection of provider applications.

For the CY 2019 follow-up compliance review, HSAG also reviewed Northeastern for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Northeastern indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Northeastern had made updates to its member-facing documents and related policies to:

- Ensure that required font sizes are used in member-facing documents.
- Inform members how to request auxiliary aids and services.
- Include information about how members can report suspected fraud, waste, or abuse.
- Eliminate accessibility and contrast errors on its website and inform members that documents found in electronic form on the website can be obtained in paper form upon request.
- Ensure that the provider directory includes all required provider information.
- Ensure that policies and member communications include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found Northeastern had revised processes, staff training materials, and provider informational materials to:

- Ensure that staff use language in member communications that supports members' ease of understanding.
- Ensure staff members understand the required time frames for members to file an appeal and request a State fair hearing.

Conclusions and Recommendations for Improvement

Based on the credentialing record review, HSAG found that Northeastern did not obtain licensure or education verification in a timely manner for three of the 10 provider files reviewed, and one file did not contain evidence that Northeastern verified that the provider was not excluded from participation in federal health care programs. HSAG recommended that Northeastern's management team evaluate its procedures for credentialing new providers to determine the root cause preventing some PSV prior to hire.

Based on the CY 2019 follow-up compliance review, HSAG did not identify any opportunities for improvement that resulted in continued required corrective actions.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-28 presents Northeastern's RY 2019 performance measure results.

Table 3-28—Northeastern RY 2018 *FUH* Results

Indicator	Northeastern Rate	Statewide PMHP Average
Follow-Up Within 7 Days	71.88%	52.28%
Follow-Up Within 30 Days	81.25%	68.30%

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

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

Strengths

- The rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge demonstrated performance above the PMHP average. Of note, the *Follow-Up Within 7 Days* indicator exceeded the statewide PMHP average by more than 15 percentage points.
- Northeastern used appropriate processes to receive and process eligibility data.
- Northeastern had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Northeastern had adequate processes to receive and process claims and encounters.
- Northeastern had adequate validation processes in place to ensure the data integrity of provider information.
- Northeastern had adequate processes in place to ensure the integrity of data integration and measure calculation.

Conclusions and Recommendations for Improvement

During the PMV process, HSAG did not identify any recommendations.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Northeastern submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 3-29 summarizes the validation findings for each stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of Met.

Table 3-29—CY 2019 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% (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)	100% (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***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Northeastern progressed to reporting Remeasurement 2 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 57.9 percent, which increased to 65.5 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 1 rate of 67.6 percent exceeded the Remeasurement 1 rate by 2.1 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 9.7 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 77.1 percent, which increased to 89.8 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 2 rate of 88.6 percent fell below the Remeasurement 1 rate by 1.2 percentage points; however, the Study Indicator 2 rate demonstrated a statistically significant increase ($p = 0.0089$) of 11.5 percentage points over the baseline.

Table 3-30 displays data for Northeastern's *Suicide Prevention* PIP.

Table 3-30—PIP—*Suicide Prevention*
Northeastern

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		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: 757	57.9%	N:895	65.5%*	N: 858	67.6%*	*Yes*
	D: 1,308		D: 1,366		D: 1270		
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: 111	77.1%	N: 149	89.8%*	N: 140	88.6%*	*Yes*
	D: 144		D: 166		D: 158		

*Indicates statistically significant improvement over Remeasurement 1 rate. N–Numerator D–Denominator

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Northeastern's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Northeastern' 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.

Strengths

Northeastern designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Northeastern reported and analyzed its Remeasurement 2 data accurately. Northeastern conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and have the potential to impact the study indicator outcomes, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

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. The performance suggests a thorough application of the PIP study design; implementation of system interventions that were related to barriers identified through QI processes; and achievement of a statistically significant, sustained improvement in the study indicator rates over the baseline. Northeastern was able to sustain a statistically significant improvement that was achieved at Remeasurement 1 for the subsequent measurement period for both study indicators.

The health plan documented that this is the final year for the *Suicide Prevention* PIP topic. In next year's PIP submission, the health plan will be submitting a new PIP topic. HSAG recommends that the health plan continue its QI efforts and build on its momentum of improvement to ensure it is able to sustain the improvement achieved during this PIP.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Northeastern's Provider Data Structure Questionnaire responses indicated provider type, educational degree, and licensure information are self-reported by the providers and verified by Northeastern through Utah's DOPL. The same taxonomy code is used for all providers, and provider specialty is not collected. Northeastern indicated all single case agreements are identified in the systems as off-panel providers. All provider data are stored in Credible, and providers notify the PMHP of any changes. The provider data are verified annually with a yearly credentialing questionnaire.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Northeastern's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Northeastern's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Northeastern should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Northeastern did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Northeastern met the time/distance standards for all categories except Substance

Abuse in frontier areas. For the provider categories for which Northeastern did not meet the time/distance standard, Northeastern should assess if this is due to 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 other reasons.

Salt Lake County Division of Mental Health (Salt Lake)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Salt Lake—Quality, Timeliness, and Access to Care—Compliance Reviews

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal health care programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Salt Lake/Optum's credentialing files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed Salt Lake for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Salt Lake indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Salt Lake had made updates to its member-facing documents and related policies to:

- Include members' right to freely exercise their rights without adverse treatment.
- Ensure that its provider directory includes provider website URLs and whether the provider completed cultural competency training.
- Ensure that policies, procedures, and member communication include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found Salt Lake had revised processes, staff training materials, and provider informational materials to:

- Develop a monitoring mechanism to ensure that grievances are resolved in a timely manner.
- Reinstate its Cultural Responsiveness Committee to address cultural competency efforts within its organization.
- Provide an introductory training on cultural competency to its providers with an opportunity for attendees to earn continuing education credits.
- Ensure provider selection and retention processes and policies comply with federal health care regulations.
- Ensure that delegation agreements include the federally required provisions.

Conclusions and Recommendations for Improvement

As a result of the CY 2019 follow-up compliance review, Salt Lake/Optum demonstrated improvement in all three domains of care, resulting in full compliance. Therefore, HSAG did not identify any opportunities for improvement resulting in continued required corrective actions.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-31 presents Salt Lake's RY 2019 performance measure results.

Table 3-31—Salt Lake RY 2019 *FUH* Results

Indicator	Salt Lake Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**43.62%**	52.28%
Follow-Up Within 30 Days	**61.61%**	68.30%

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

Salt Lake—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

- Salt Lake used appropriate processes to receive and process eligibility data.
- Salt Lake had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Salt Lake had adequate processes to receive and process claims and encounters.
- Salt Lake had adequate validation processes in place to ensure the data integrity of provider information.
- Salt Lake had adequate processes in place to ensure the integrity of data integration and measure calculation.

Conclusions and Recommendations for Improvement

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

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Salt Lake submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 3-32 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 3-32—CY 2019 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	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	50% (1/2)	50% (1/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	Outcomes Total	**50% (1/2)**	**50% (1/2)**	**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***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Salt Lake progressed to reporting Remeasurement 2 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 42.4 percent, which increased to 50.6 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 1 rate of 52.1 percent exceeded the Remeasurement 1 rate by 1.5 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 9.7 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 93.6 percent, which increased to 97.1 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 2 rate of 95.2 percent fell below the Remeasurement 1 rate by 1.9 percentage points and did not demonstrate statistically significant improvement ($p = 0.0181$) over the baseline.

Table 3-33 displays data for Salt Lake's *Suicide Prevention* PIP.

Table 3-33—PIP—*Suicide Prevention*
Salt Lake

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		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: 5,803 D: 13,681	42.4%	N:6,345 D: 12,546	50.6%*	N: 6,795 D: 13,037	52.1%*	*Yes*

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		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: 973 D: 1,039	93.6%	N: 1,181 D: 1,216	97.1%*	N: 1,630 D: 1,713	95.2%	*Not Assessed*

*Indicates statistically significant improvement over the Remeasurement 1 rate. N–Numerator D–Denominator

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Salt Lake's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Salt Lake'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.

Strengths

Salt Lake designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Salt Lake reported and analyzed its Remeasurement 2 data accurately. Salt Lake conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and had a positive impact on Study Indicator 1 outcome, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

The PIP received an overall *Met* validation status, with a *Partially Met* score for 90 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. The performance suggests a thorough application of the PIP study design and implementation of system interventions that were related to barriers identified through QI processes. Salt Lake sustained a statistically significant improvement over the baseline for Study Indicator 1; however, Study Indicator 2 did not demonstrate statistically significant improvement over the baseline.

HSAG understands that this is the final year for the *Suicide Prevention* PIP topic. In next year's PIP submission, the health plan will be submitting a new PIP topic. HSAG recommends that the health plan continue its QI efforts and build on its momentum of improvement to ensure it is able to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

Salt Lake—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Salt Lake's Provider Data Structure Questionnaire responses indicated provider taxonomy, educational degree, and licensure information are self-reported by the providers. The provider type is assigned on the commencement of the provider contract. Salt Lake indicated all single case agreements are identified in the provider data system with a suffix of "SCA" after the provider name. All provider data are stored in Credible, and providers notify the PMHP of any changes. The provider data are verified and validated during provider directory and credentialing audits. Additionally, Salt Lake reported conducting a mass clean-up of provider Medicaid data in March 2018 to ensure provider data were correct and accurate.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Salt Lake's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Salt Lake's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Salt Lake should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Salt Lake did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Salt Lake met the time/distance standards for all categories except Substance Abuse in urban areas, and it met the time/distance standards for Behavioral Health—Pediatric and Behavioral Therapist—Pediatric in frontier areas. For the provider categories for which Salt Lake did not meet the time/distance standard, Salt Lake should assess if this is due to 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 other reasons.

Southwest Behavioral Health Center (Southwest)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the CY 2019 follow-up compliance review, HSAG reviewed Southwest for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Southwest indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Southwest had made updates to its member-facing documents and related policies to:

- Include taglines in large print (18-point font) and in prevalent non-English languages.
- Inform members about how to report suspected fraud, waste, or abuse and to accurately depict all required content for the member handbook.
- Revise policies, procedures, and member communications to include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found Southwest had revised processes, staff training materials, and provider informational materials to:

- Implement a new process to correctly log grievances.
- Establish a cultural competency committee, which was approved by the QI Committee.
- Ensure that provider agreements include the federally required provisions.

Conclusions and Recommendations for Improvement

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that while Southwest had a credentialing program, it struggled to meet all the requirements for the provider files reviewed. In one file, HSAG did not find any evidence of an application; and in two files, Southwest did not obtain the application prior to hire. HSAG also found that seven records were out of compliance for obtaining licensure or education verification and for verifying that the providers were eligible for participation in federal health care programs. HSAG recommended that Southwest's management team review the processes in place for credentialing to ensure that all credentialing documents are received and reviewed prior to hire.

For the CY 2019 follow-up compliance review, Southwest's overall performance was improved in all three domains of care, and Southwest greatly reduced the quantity of issues over CY 2018 results. However, HSAG found that Southwest's provider directory did not note the languages (including American Sign Language) offered by the provider or provider's office as required, which negatively impacted the access and quality domains. In addition, Southwest had a general statement in its provider directory that all staff are required to complete cultural competency trainings; however, subcontracted providers did not have a contract requirement to complete training, and the provider directory did not delineate which providers are employed and which are contracted. HSAG recommended that Southwest management revisit its provider directory to ensure that the information provided is complete and accurate.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-34 presents Southwest's RY 2019 performance measure results

Table 3-34—Southwest RY 2019 *FUH* Results

Indicator	Southwest Rate	Statewide PMHP Average
Follow-Up Within 7 Days	61.62%	52.28%
Follow-Up Within 30 Days	75.76%	68.30%

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

Southwest—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

- The rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge demonstrated performance above the statewide PMHP average.
- Southwest had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Southwest had adequate processes to receive and process claims and encounters.
- Southwest had adequate validation processes in place to ensure the data integrity of provider information.
- Southwest had adequate processes in place to ensure the integrity of data integration and measure calculation.

Conclusions and Recommendations for Improvement

Based on the results of the PMV process, Southwest used acceptable processes related to provider data and claims and encounters for performance measure reporting; however, HSAG noted that Southwest did not have a process to ensure consistency with documenting member enrollment dates. Southwest's QI efforts should be focused on eligibility processes. Southwest indicated that a member's eligibility was checked when the 834 enrollment file was received; however, the member's enrollment begin date remained the first date of service, and the enrollment begin date may not have matched the date provided in the 834 file. Additionally, Southwest's managed care coordinator documented and modified members' enrollment dates to align with the dates of inpatient hospitalization if a hospital claim was received prior to the member's first service with Southwest. HSAG recommended that Southwest exercise consistency with documenting member enrollment dates.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Southwest submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 3-35 summarizes the validation findings for each stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 3-35—CY 2019 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)**

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	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% (21/21)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Southwest progressed to reporting Remeasurement 2 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 86.1 percent, which increased to 93.2 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 1 rate of 96.7 percent exceeded the Remeasurement 1 rate by 3.5 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 10.6 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 27.0 percent, which increased to 55.1 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 2 rate of 77.8 percent exceeded the Remeasurement 1 rate by 22.7 percentage points and demonstrated a statistically significant increase ($p = 0.0021$) of 50.8 percentage points over the baseline.

Table 3-36 displays data for Southwest's *Suicide Prevention* PIP.

Table 3-36—PIP—*Suicide Prevention*
Southwest

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		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: 2,114	86.1%	N:2,452	93.2%*	N: 2,617	96.7%*	*Yes*
	D: 2,456		D: 2,632		D: 2,707		
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: 75	27.0%	N: 312	55.1%*	N: 437	77.8%*	*Yes*
	D: 278		D: 566		D: 562		

*Indicates statistically significant improvement over the Remeasurement 1 rate. N–Numerator D–Denominator

Southwest—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Southwest's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Southwest'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.

Strengths

Southwest designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Southwest reported and analyzed its Remeasurement 2 data accurately. Southwest conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and had a positive impact on both the study indicator outcomes, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

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. The performance suggests a thorough application of the sound PIP study design; accurate data reporting; implementation of system interventions that were related to barriers identified through QI processes; and achievement of a statistically significant, sustained improvement in the study indicator rates over the baseline. Southwest was able to sustain improvement for two consecutive measurement periods for both study indicators.

Southwest documented that this is the final year for the *Suicide Prevention* PIP topic. In next year's PIP submission, the health plan will submit a new PIP topic. HSAG recommends that the health plan continue its QI efforts and build on its momentum of improvement to ensure it is able to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

Southwest—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Southwest's Provider Data Structure Questionnaire responses indicated provider specialty, taxonomy, educational degree, and licensure information are self-reported by the providers. Provider type is based on the state licensure data. Southwest indicated all providers contracted under single case agreements would appear in the EHR system like other network providers; however, they would not be published on the Network Provider List. All provider data are stored in Credible, and providers notify the PMHP of any changes. The provider data are reviewed and cleaned monthly by Southwest's data manager.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Southwest's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Southwest's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Southwest should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Southwest did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and

frontier areas. Southwest met the time/distance standards for Behavioral Therapist—Adult and Behavioral Therapist—Pediatric in frontier and rural areas. For the provider categories for which Southwest did not meet the time/distance standard, Southwest should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Southwest, the inability to identify the providers in the data using the standard definitions, or other reasons.

Valley Behavioral Health (Valley)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Valley's credentialing files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed Valley for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Valley indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Valley had made updates to its member-facing documents and related policies to ensure that policies, procedures, and member communication included accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found Valley had revised processes, staff training materials, and provider informational materials to:

- Improve processes related to overpayments.
- Ensure ongoing monitoring of sanctions and eligibility to participate in federal health care programs.
- Provide the State written disclosure of ownership and control.
- Educate providers and encourage use of practice guidelines.
- Analyze staffing levels, the provider network, recruiting methods, and the federally mandated criteria when maintaining its provider network.
- Ensure that delegation agreements include the federally required provisions.

Conclusions and Recommendations for Improvement

Valley demonstrated improvement in all three domains of care and greatly reduced the quantity of issues in CY 2019 when compared to CY 2018 compliance monitoring results. However, HSAG found that Valley's website continued to show accessibility errors and contrast issues in the webpages and in the PDF documents posted on the website. In addition, HSAG found that required content was still missing

from Valley's website. To address the lingering issues, HSAG recommended that Valley's leadership identify measures to ensure that information provided electronically to members is complete and fully accessible based on federal 508 guidelines.

In CY 2019, HSAG found that Valley had developed a provider directory; however, it lacked much of the required information about Valley's providers and was not updated as frequently as required. HSAG recommended that Valley leadership review the current and previous years' findings to ensure that the provider directory includes the required information.

During the 2019 follow-up compliance review, HSAG noted that Valley had not yet made required changes to the grievance and appeals documentation. HSAG recommended that Valley leadership review the current and previous years' findings to ensure that the policies, procedures, and organizational processes align with federal health care regulations and State contract requirements.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-37 presents Valley's RY 2019 performance measure results.

Table 3-37—Valley RY 2019 *FUH* Results

Indicator	Valley Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**NR**	52.28%
Follow-Up Within 30 Days	**NR**	68.30%

NR *indicates the rate was not reported because HSAG determined the rate to be materially biased.*

Valley—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

Valley had adequate validation processes in place to ensure the data integrity of provider information.

Conclusions and Recommendations for Improvement

Based on the results of the PMV process, Valley used acceptable processes related to provider data for performance measure reporting: however, HSAG identified concerns during the on-site portion of the PMV process that related to overall processes for integrating eligibility and claims data. HSAG found that Valley was not tracking retroactive (retro-) enrollment and disenrollment information in its transactional system, SmartCare, which affected claims processing and performance measure calculation. Although Valley extracted metrics from SmartCare for performance measure rate reporting, the extracted data were not accurate. As a result, HSAG assigned Valley a *Not Reported* (NR) designation for the *Follow-Up*

After Hospitalization for Mental Illness (FUH) measure. HSAG also identified concerns with Valley's data integration and measure calculation process. Valley used programming code to pull the final analytic data set. HSAG identified that there were members improperly included in the measure calculation, as well as members who were excluded from the denominator when they should have been included. HSAG also identified that the claims data for some members indicated that they were enrolled in Medicaid on the date of discharge, but not on the admission date. While on-site, HSAG recommended more quality checks and oversight beyond the built-in system validations. This would ensure that staff members at different locations follow processes consistently and that there is a process for communicating data errors. HSAG also recommended that Valley implement rigorous quality checks for measure reporting to the State, including appropriately tracking retro-enrollment and disenrollment segments in SmartCare.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Valley submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 3-38 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 3-38—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	100% (3/3)	0% (0/3)	0% (0/3)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	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)**
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% (19/20)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100% (11/11)**		
	Validation Status	***Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Valley progressed to reporting Remeasurement 2 results.

For Summit County, the baseline rate for the percentage of eligible members who received the C-SSRS screening was 45.5 percent, which increased to 84.3 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 1 rate of 84.0 percent decreased slightly from the Remeasurement 1 rate (by 0.3 percentage points) and demonstrated a statistically significant increase ($p < 0.0001$) of 38.5 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 1, the Study Indicator 2 rate of 100 percent exceeded the baseline rate by 9.5 percentage points. The health plan's performance was at 100 percent even though this does not represent statistically significant improvement over the revised baseline (CY 2017) results.

For Tooele County, the baseline rate for the percentage of members who received the C-SSRS screening was 39.8 percent, which increased to 62.9 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 1 rate of 71.2 percent exceeded the Remeasurement 1 rate by 8.3 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 31.4 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, which increased to 88.8 percent for Remeasurement 1. For Remeasurement 2, the Study Indicator 2 rate of 87.8 percent fell below the Remeasurement 1 rate by 1.0 percentage point; however, the Study Indicator 2 rate demonstrated a statistically significant increase ($p < 0.0001$) of 24.6 percentage points over the baseline.

Table 3-39 displays data for Valley's *Suicide Prevention* PIP.

Table 3-39—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		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%*	*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: D:		*Not Assessed*
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**		**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%*	*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%*	*Yes*

*Indicates statistically significant improvement over the Remeasurement 1 rate. N–Numerator D–Denominator

Valley—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of

the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, 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. 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.

Strengths

Valley designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Valley reported and analyzed its Remeasurement 2 data accurately. Valley conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and have the potential to impact the study indicator outcomes, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

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. The performance suggests a methodologically sound improvement project, a thorough application of the PIP study design, implementation of system interventions that were related to barriers identified through QI processes, and achievement of statistically significant improvement for Study Indicator 1 in both counties and for Study Indicator 2 in Tooele County. For Summit County, the Study Indicator 2 rate was 100 percent; therefore, a statistically significant improvement over 100 percent is not attainable.

As the PIP progresses, HSAG recommends the following:

- Valley must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Valley 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.
- Valley must continue to evaluate the effectiveness of each intervention throughout the measurement period. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention should identify the individual impact of that intervention on the study indicator rate.

- Valley should continue to build on its momentum of improvement to ensure it is able to sustain the improvement achieved.
- Valley should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

Valley—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Valley's Provider Data Structure Questionnaire responses indicated provider type, specialty, taxonomy, educational degree, and licensure information are self-reported by the internal providers and external subcontractors. Valley indicated all providers contracted under single case agreements for internal services or external subcontracted services are tracked in spreadsheets. Provider data are validated during the credentialing process, which is delegated to Precision Credentialing.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Valley's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Valley's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Valley should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Valley did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. Valley met the time/distance standards for all provider categories except Substance Abuse providers in frontier and rural areas. For the provider categories for which Valley did not meet the time/distance standard, Valley should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Valley, the inability to identify the providers in the data using the standard definitions, or other reasons.

Wasatch Mental Health (Wasatch)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the CY 2019 follow-up compliance review, HSAG reviewed Wasatch for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Wasatch indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Wasatch had made updates to its member-facing documents and related policies to:

- Ensure all member materials use the required font sizes and include taglines informing members how to request auxiliary aids and services.
- Inform members how to report suspected fraud or abuse.
- Ensure that the provider directory includes the provider's website URL and whether the provider has completed cultural competency training.
- Ensure that policies, procedures, and member materials include accurate requirements and time frames related to service authorizations, grievances, and appeals.

HSAG also found that Wasatch had revised processes, staff training materials, and provider informational materials to:

- Use a flow chart to ensure that written grievances are resolved in writing.
- Ensure adequate documentation of grievances and appeals.
- Ensure compliance with State contract requirements related to overpayments and reporting changes in member and provider circumstances that may impact their respective eligibility to participate in the Medicaid program.

Conclusions and Recommendations for Improvement

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal health care programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that three records did not contain evidence that Wasatch obtained an application, one file did not contain evidence that Wasatch verified education and licensure, and in three files the PSV for licensure and education was not obtained prior to hire. In seven of the 10 provider files reviewed, Wasatch had not searched the

federal databases to ensure that providers had not been excluded from federal healthcare participation. In three files, HSAG found that Wasatch had performed this search; however, it was not conducted prior to hire. HSAG recommended that Wasatch management develop processes to ensure that all required credentialing information is collected and reviewed prior to hire.

Based on the CY 2019 follow-up compliance review for Wasatch, overall performance improved in all three domains of care; however, a few issues remained. HSAG found that, although Wasatch made updates to its provider directory to include requirements that were missing during the CY 2018 review, Wasatch's provider directory was still missing required information about the provider's cultural and linguistic capabilities and whether the provider's office has accommodations for people with physical disabilities. HSAG recommended that Wasatch ensure that its provider directory include all required information.

In CY 2018, HSAG found that Wasatch did not have a method to ensure members received the services for which providers had billed the PMHP. HSAG recommended that Wasatch leadership develop a method to query its members about services billed to the PMHP to provide an extra layer of fraud prevention, as required.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-40 presents Wasatch's RY 2019 performance measure results.

Table 3-40—Wasatch RY 2019 *FUH* Results

Indicator	Wasatch Rate	Statewide PMHP Average
Follow-Up Within 7 Days	56.07%	52.28%
Follow-Up Within 30 Days	77.50%	68.30%

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

Wasatch—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

- The rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge demonstrated performance above the statewide PMHP average.
- Wasatch used appropriate processes to receive and process eligibility data.
- Wasatch had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Wasatch had adequate processes to receive and process claims and encounters.

- Wasatch had adequate validation processes in place to ensure the data integrity of provider information.

Conclusions and Recommendations for Improvement

Based on the results of the PMV process, Wasatch used acceptable processes related to eligibility, provider data, and claims and encounters for performance measure reporting; however, HSAG identified that there were cases included in the incorrect numerator category. HSAG recommended that Wasatch focus QI around its data integration processes, specifically to add a simple formula to the tracking spreadsheet that will calculate the number of days between follow-up (i.e., 1–7, 8–30) to ensure that Wasatch includes cases in the appropriate numerator category. HSAG also recommended that Wasatch provide and insert a date stamp identifier on the final source code used to calculate the rates for HSAG's review.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Wasatch submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 3-41 summarizes the validation findings for each stage validated for CY 2019. Overall, 89 percent of all applicable evaluation elements received a score of *Met.*

Table 3-41—CY 2019 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% (2/2)	0% (0/2)	0% (0/2)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	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)**
Outcomes	IX. Assess for Real Improvement Achieved	50% (1/2)	50% (1/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
	Outcomes Total	**50% (1/2)**	**50% (1/2)**	**0% (0/2)**
	Percentage Score of Applicable Evaluation Elements *Met*	**89% (17/19)**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**90% (9/10)**		
	Validation Status	***Partially Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Wasatch progressed to reporting Remeasurement 3 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 0.2 percent, which increased to 14.8 percent during Remeasurement 1 and to 18.7 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 1 rate of 19.6 percent exceeded the Remeasurement 2 rate by 0.9 percentage points and demonstrated a statistically significant increase ($p < 0.0001$) of 19.4 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 9.1 percent, which increased to 25.6 percent during Remeasurement 1 and to 26.5 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 2 rate of 24.3 percent fell below the

Remeasurement 2 rate by 2.2 percentage points. Although this rate was 15.2 percentage points above the baseline, the increase was not statistically significant (p = 0.2426).

For Remeasurement 3, the PIP was not evaluated for sustained improvement because both study indicators did not demonstrate statistically significant improvement over the baseline during the previous measurement periods.

Table 3-42 displays data for Wasatch's *Suicide Prevention* PIP.

Table 3-42—PIP—*Suicide Prevention*
Wasatch

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
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 11	0.2%	N: 891	14.8%*	N: 1,140	18.7%*	N: 1,257	19.6%*	*Not Assessed*
	D: 6,633		D: 6,011		D: 6,091		D: 6,401		
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: 1	9.1%	N: 100	25.6%	N: 129	26.5%	N: 180	24.3%	*Not Assessed*
	D:11		D: 390		D: 487		D: 742		

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

Wasatch—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Wasatch's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Wasatch'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.

Strengths

Wasatch designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Wasatch reported and analyzed its Remeasurement 3 data accurately. Wasatch conducted appropriate QI processes to identify barriers, implemented interventions that were logically linked to the barriers and had a positive impact on the Study indicator 1 outcomes, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

The PIP received an overall *Partially Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 89 percent of overall evaluation elements across all activities completed and validated. Wasatch's performance suggests multiple opportunities for improving the PIP in the Implementation and Outcomes stages of the PIP process. Study Indicator 1 was able to sustain statistically significant improvement over the baseline during Remeasurement 3. The improvement from baseline to Remeasurement 3 for Study Indicator 2 was not statistically significant.

Wasatch documented that this is the final year for the *Suicide Prevention* PIP topic. In next year's PIP submission, the health plan will be submitting a new PIP topic. HSAG recommends that the health plan continue its QI efforts and build on its momentum of improvement to ensure it is able to sustain the improvement achieved during this PIP.

VALIDATION OF NETWORK ADEQUACY

Wasatch—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Wasatch's Provider Data Structure Questionnaire responses indicated provider type, specialty, educational degree, and licensure information are self-reported by the providers. Wasatch's questionnaire responses indicate that all providers are Wasatch employees and that it does not have subcontracted providers or single case agreements. Wasatch verifies the provider's license, education, and other information upon hire.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Wasatch's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Wasatch's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Wasatch should assess available data values in

its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Wasatch did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. For the provider categories for which Wasatch did not meet the time/distance standard, Wasatch should assess if this is due to 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 other reasons.

Weber Human Services (Weber)

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Results for CY 2019 Review Activities

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and ability to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Weber's initial credentialing files met the requirements for the timely collection of applications.

For the CY 2019 follow-up compliance review, HSAG also reviewed Weber for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Weber indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Weber had made updates to its member-facing documents and related policies to:

- Include taglines in large print (18-point font) and prevalent non-English languages describing how a member could request auxiliary aids and services.
- Inform members how to report suspected fraud, waste, or abuse.
- Make available an electronic provider directory.
- Ensure that policies, procedures, and member communications include accurate time frames and requirements related to service authorization, grievances, and appeals.
- Ensure that advance directive policies include the required provisions.

HSAG also found Weber had revised processes, staff training materials, and provider informational materials to:

- Implement a new protocol used for tracking, trending, and reporting all member grievances.
- Enhance tracking mechanisms to ensure the provision of appeal acknowledgements.
- Implement a mechanism to ensure providers receive complete information about the grievance and appeal system at the time of contracting.
- Ensure compliance with regulations related to overpayments.

Conclusions and Recommendations for Improvement

Based on the review of credentialing records, HSAG found that in two provider files Weber did not obtain licensure or education verification prior to hire. In one file HSAG found that Weber had not conducted the search to verify that the provider was not excluded from participation in federal health care programs. HSAG recommended that Weber's management team evaluate its procedures for credentialing new providers to determine the root cause preventing some PSV prior to hire.

As a result of the CY 2019 follow-up compliance review, HSAG found Weber's overall performance was improved in all three domains of care; however, HSAG was unable to locate a statement on Weber's website notifying members that the information on the website is available in paper form without charge. Further, Weber's provider directory did not note the languages offered by the provider or provider's office as required. HSAG recommended that Weber review its website for completeness regularly.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-43 presents Weber's RY 2019 performance measure results.

Table 3-43—Weber RY 2019 *FUH* Results

Indicator	Weber Rate	Statewide PMHP Average
Follow-Up Within 7 Days	59.53%	52.28%
Follow-Up Within 30 Days	74.71%	68.30%

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

Weber—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

- The rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge demonstrated performance above the statewide PMHP average.
- Weber used appropriate processes to receive and process eligibility data.
- Weber had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy.
- Weber had adequate processes to receive and process claims and encounters.
- Weber had adequate validation processes in place to ensure the data integrity of provider information.
- Weber had adequate processes in place to ensure the integrity of data integration and measure calculation.

Conclusions and Recommendations for Improvement

During the PMV process, HSAG did not identify any recommendations.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Weber submitted its PIP topic: *Suicide Prevention.*

Validation Results

Table 3-44 summarizes the validation findings for each stage validated for CY 2019. Overall, 70 percent of all applicable evaluation elements received a score of *Met*.

Table 3-44—CY 2019 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	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	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**88% (7/8)**	**13% (1/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	33% (1/3)	67% (2/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	50% (3/6)	50% (3/6)	0% (0/6)
Implementation Total		**44% (4/9)**	**56% (5/9)**	**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*		**70% (14/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**73% (8/11)**		
Validation Status		***Partially Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Weber progressed to reporting Remeasurement 3 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 9.3 percent, which increased to 16.6 percent for Remeasurement 1, and 18.9 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 1 rate of 16.1 percent fell below the Remeasurement 2 rate by 2.8 percentage points; however, the Remeasurement 3 rate demonstrated a statistically significant improvement ($p < 0.0001$) of 6.8 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 17.0 percent, which increased to 24.0 percent for Remeasurement 1 and then decreased to 16.7 percent for Remeasurement 2. For Remeasurement 3, the Study Indicator 2 rate of 24.0 percent exceeded the Remeasurement 2 rate by 7.3 percentage points and demonstrated a statistically significant improvement ($p = 0.0021$) of 7.0 percentage points over the baseline.

Table 3-45 displays data for Weber's *Suicide Prevention* PIP.

Table 3-45—PIP—*Suicide Prevention*
Weber

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
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 406	9.3%	N: 704	16.6%*	N: 813	18.9%*	N: 681	16.1%*	*Yes*
	D: 4,362		D: 4,246		D: 4,303		D: 4.243		
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: 69	17.0%	N: 246	24.0%*	N: 281	16.7%	N: 436	24.0%*	*Yes*
	D: 406		D: 1,026		D: 1,681		D: 1,818		

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

Weber—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Weber's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Weber'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.

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. The interventions appeared to be logically linked to the barriers with the potential to impact study indicator outcomes.

Conclusions and Recommendations for Improvement

The PIP received an overall *Partially Met* validation status, with a *Met* score for 73 percent of critical evaluation elements and 70 percent of overall evaluation elements across all activities completed and validated. Weber designed a scientifically sound project supported by using key research principles. There were multiple opportunities for improving the PIP documentation in the Implementation stage of the PIP process. Weber was able to sustain statistically significant improvement over the baseline during Remeasurement 3 for both study indicators.

As the PIP progresses, HSAG recommends the following:

- Weber must ensure that the narrative interpretation and statistical analysis of results are accurate and include all the required components in accordance with the PIP Completion Instructions.
- Weber must provide a comprehensive description of the causal/barrier analysis process. The health plan 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.
- Weber must describe the process for the priority ranking of barriers.
- Weber must evaluate the effectiveness of each intervention throughout the measurement period and document the findings in the PIP Submission Form. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention must identify the individual impact of that intervention on the study indicator rate. In addition to qualitative data, Weber must provide quantitative data for intervention evaluation.
- Weber must reference the PIP Completion Instructions annually to ensure that all requirements for each completed activity have been addressed.
- Weber should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

Weber—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Weber's Provider Data Structure Questionnaire responses indicated provider type is collected for each provider and is verified by licensure or certification information. Additionally, Weber confirmed provider type annually. Weber indicated that it does not contract with providers through single case agreements. Weber reported that provider data are validated during the initial credentialing and recredentialing process.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Weber's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Weber's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PMHP's data values for provider type, specialty, and credentials. Therefore, Weber should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Weber met the statewide compliance time/distance standards for four of the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, and Behavioral Therapist—Pediatric). Substance Abuse was the only provider category for which Weber did not meet the statewide compliance time/distance standards. For this category, Weber should assess if this is due to 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 other reasons.

PAHP Providing Substance Use Disorder Services

Utah County Department of Drug and Alcohol Prevention and Treatment

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

Strengths

For the CY 2019 follow-up compliance review, HSAG reviewed Utah County for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Utah County indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Utah County had made updates to its member-facing documents and related policies to:

- Use the required font sizes.
- Inform members about how to report suspected fraud or abuse.
- Ensure that policies, procedures, and member communications include accurate time frames and requirements related to services authorizations, grievances, and appeals.
- Ensure that services are sufficient in amount, duration, and scope and ensure compliance with network adequacy, timely access, and availability requirements.

HSAG also found Utah County had revised processes, staff training materials, and provider informational materials to:

- Implement staff training to ensure that all expressions of dissatisfaction (not regarding an action/adverse benefit determination) are treated as grievances.
- Ensure that the content of oral acknowledgements are adequately documented.
- Implement a mechanism to provide written notice of the reason for denying providers participation in the network.
- Ensure that provider agreements include the federally required provisions.
- Implement a mechanism to obtain ownership and control disclosure from contracted providers.
- Implement its Compliance Plan and Fraud Prevention policy to ensure compliance with requirements under the contract.
- Develop a QAPI program plan and conduct QI activities to ensure timely access to services.

Conclusions and Recommendations for Improvement

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that one intern's file did not include evidence that Utah County obtained an application prior to hire. HSAG also found that in three provider files Utah County had not obtained licensure or education verification. One provider file did not contain evidence of verification that the provider had not been excluded from federal participation, and four files indicated that the verification of eligibility for participation in federal health care programs was not conducted prior to hire. HSAG recommended that Utah County's management team evaluate its procedures for credentialing new providers to determine the root cause preventing some PSV prior to hire.

Utah County demonstrated improvement in all three domains of care; however, several corrective actions remained in place during the CY 2019 review year. In the CY 2019 review, HSAG found that the provider directory hosted on its website lacked much of the required information. HSAG recommended that Utah County review the federal regulations related to required content of provider directories and ensure that revisions meet those requirements.

Utah County's NABD template did not include the correct time frames for requesting an appeal or for requesting a State fair hearing while continuing benefits during the appeal or State fair hearing. HSAG recommended that Utah County focus attention on member-facing documents, including information provided in written documents and on its website, to ensure accuracy and completeness.

HSAG also found that Utah County's authorization decision process did not include an interrater reliability process to ensure that decision makers consistently apply criteria. Utah County's QAPI program plan did not provide evidence that Utah County produced comprehensive reports or considered the data contained in its EHR for aggregate, regular assessment of its program or for development of initiatives for improving the quality, timeliness, and accessibility of services and appropriateness of service provision at a systemic level.

HSAG also found that Utah County had not yet implemented a process for determining whether a service had been provided as indicated through the provider billing or encounter reporting process. Further, Utah County did not have a formal process to detect and analyze ongoing utilization of its services to identify under- and overutilization. HSAG recommended that Utah County implement a process to identify over- and underutilization and prevent potential fraud.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 3-46 shows Utah County's RY 2019 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 included below were not comparable to NCQA's Quality Compass benchmarking data.

Table 3-46—Utah County RY 2018 *IET* Results

Indicator	Utah County 2019 Rate
Alcohol Abuse or Dependence—Initiation of AOD Treatment—Total	**NA**
Opioid Abuse or Dependence—Initiation of AOD Treatment—Total	50.00%
Other Drug Abuse or Dependence—Initiation of AOD Treatment—Total	**NA**
Initiation of AOD Treatment—Total—Total	43.84%
Alcohol Abuse or Dependence—Engagement of AOD Treatment—Total	**NA**
Opioid Abuse or Dependence—Engagement of AOD Treatment—Total	42.86%
Other Drug Abuse or Dependence—Engagement of AOD Treatment—Total	**NA**
Engagement of AOD Treatment—Total—Total	34.25%

***NA** indicates that the PAHP followed the specifications, but the denominator was too small (<30) to report a valid rate.*

Utah County—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

- Utah County used appropriate processes to receive eligibility data.
- Utah County had adequate processes to receive and process claims and encounters.
- Utah County had adequate validation processes in place to ensure the data integrity of provider information.

Conclusions and Recommendations for Improvement

HSAG performed the 2019 PMV activities on CY 2018 data for Utah County. HSAG did not identify any concerns related to how Utah County received eligibility data or how it processed claims and encounters, or provider information.

HSAG identified concerns with how Utah County processed and documented enrollment data, specifically with processing and documentation of members' enrollment data including eligibility effective dates, termination dates, and historical eligibility spans. Therefore, HSAG determined that Utah County lacked adequate processes to ensure that only accurate and complete eligibility and enrollment information was housed in the data systems and used for measure reporting. During the on-site visit, Utah County demonstrated the Credible system, the Medicaid eligibility tool, and MMCS. HSAG identified a discrepancy in the eligibility start date for some members. Utah County reported that its process of verifying eligibility included entering the eligibility start date, which was usually the first of the month, into Credible. During the demonstration of Credible, HSAG noticed members' eligibility start dates were mid-month. Confirmation from the State Medicaid eligibility tool showed members' start dates to be the first of the month. Therefore, HSAG determined that Utah County lacked adequate processes to ensure that only accurate and complete eligibility and enrollment information was housed in the data systems and used for measure reporting. HSAG recommended that Utah County incorporate consistency around the enrollment dates that are entered into Credible.

HSAG also identified an error regarding Utah County's measure calculation process related to source code and data manipulation. During PSV, Utah County indicated that it used both source code and manual steps to calculate performance measure rates. HSAG recommended that Utah County create documentation to show all manual steps used to calculate the performance measure to ensure consistency.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Utah County submitted its PIP topic: *Suicide Prevention*

Validation Results

Table 3-47 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 3-47—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)**
Outcomes	IX. Assess for Real Improvement Achieved	50% (1/2)	50% (1/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**50% (1/2)**	**50% (1/2)**	**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***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Utah County reported Remeasurement 1 results.

The baseline rate for the percentage of eligible members who received the C-SSRS screening was 30.0 percent. For Remeasurement 1, the Study Indicator 1 rate remained at 30.0 percent, which did not demonstrate statistically significant improvement 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 1, the Study Indicator 2 rate of 26.1 percent exceeded the baseline rate by and demonstrated a statistically significant (p = 0.0001) increase of 26.1 percentage points over the baseline.

The PIP will be evaluated for sustained improvement when both study indicators have demonstrated statistically significant improvement over the baseline and results from a subsequent measurement period have been reported.

Table 3-48 displays data for Utah County's *Suicide Prevention* PIP.

Table 3-48—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 (MM/DD/YYYY)–(MM/DD/YYYY)		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 D: 497	30%	N: 172 D: 573	30%	N: D:	*NA*	*NA*
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 D: 51	0.0%	N: 12 D: 46	26.1%*	N: D:	*NA*	*NA*

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator NA-Not Applicable

Utah County—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality

domain. Additionally, 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. 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.

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 1 data accurately. Utah County 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 2 outcomes, and executed appropriate processes to evaluate the effectiveness of the interventions.

Conclusions and Recommendations for Improvement

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. This performance suggests a thorough application of the PIP design, accurate analysis of results, and implementation of system interventions that were related to barriers identified through QI processes. Utah County achieved statistically significant improvement from baseline to Remeasurement 1 for one of the two study indicators.

As the PIP progresses, HSAG recommends the following:

- Utah County must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Utah County must continue to evaluate the effectiveness of each intervention throughout the measurement period. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention should identify the individual impact of that intervention on the study indicator rate.
- Utah County should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

Utah County—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Utah County's Provider Data Structure Questionnaire responses indicated provider type, specialty, taxonomy, educational degree, and licensure information are self-reported by the providers. Utah County verifies provider educational degree and licensure data through Utah's DOPL. Utah County indicated that it does not contract with providers through single case agreements. Utah County verifies the providers' license and education through DOPL upon hire and during recredentialing. Utah County also verifies addresses through the United States Postal Service (USPS) and Google Maps.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Utah County's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Utah County's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PAHP's data values for provider type, specialty, and credentials. Therefore, Utah County should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Utah County did not meet the statewide compliance time/distance standards for the five behavioral health provider categories (i.e., Behavioral Medical—Adult, Behavioral Medical—Pediatric, Behavioral Therapist—Adult, Behavioral Therapist—Pediatric, and Substance Abuse). However, it should be noted that to meet the standard statewide, the PMHP had to meet the requirements in urban, rural, and frontier areas. For the provider categories for which Utah County did not meet the time/distance standard, Utah County should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Utah County, the inability to identify the providers in the data using the standard definitions, or other reasons.

CHIP MCOs Providing Both Physical Health and Mental Health Services

Molina Healthcare of Utah CHIP

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.

Strengths

For the 2019 compliance review, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all MCOs. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that Molina CHIP's credentialing files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed Molina's CHIP program for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Molina indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Molina had made updates to its member-facing documents and related policies to:

- Provide written notice to members upon termination of a contracted provider within the required time frame.
- Ensure that member communications are written in language that is easy to understand.
- Inform members that documents available electronically through the website are available in paper format upon request.
- Ensure that policies, procedures, and member communications include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found that Molina had revised processes, staff training materials, and provider informational materials to:

- Implement a Pharmacy and Therapeutics Committee as part of its drug utilization review program.
- Ensure that its peer-to-peer process occurs prior to issuing the NABD letter so that Molina can work more closely with providers before making a full or partial denial determination, improving quality and access for members.
- Ensure that current written delegation service agreements comply with federal health care regulations and State contract requirements.

Conclusions and Recommendations for Improvement

Molina demonstrated improvement in its CHIP program compliance in all three domains of care; however, HSAG identified several ongoing findings during the CY 2019 follow-up compliance review. In CY 2019, HSAG found continued accessibility errors and contrast issues on Molina's website. During both the CY 2018 and 2019 reviews, Molina's provider directory was missing required information about its providers. HSAG recommended that Molina's leadership identify measures to ensure that information provided electronically to members is complete and fully accessible, including information available to members in the electronic provider directory and other PDF documents available on the website.

HSAG also recommended that Molina revise its drug formulary for the CHIP line of business, posted on its website, to include drug tiers for each medication.

In CY 2018, HSAG found that Molina's appeal process included a requirement for members to follow an oral request for an appeal with a written request in five days or the member would lose the right to appeal. For CY 2019, Molina removed the statement that members "lose their right to appeal" from its policies; however, the time frame for members to submit a written appeal request was still included, which conflicts with federal managed care regulations. In addition, in both the CY 2018 and 2019 reviews, Molina's Appeal procedure did not include the correct time frame for a member to file a request for a State fair hearing. HSAG also recommended that Molina's appeal and grievance managers work to correct the recurring findings and review Molina's internal and member-facing documents to ensure that updates are reflected throughout.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Molina's HEDIS compliance auditor found Molina's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. 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 documented did not identify any specific strengths, opportunities for improvement, or recommendations related to the PMV process.

Performance Measure Outcomes

Table 3-49 shows Molina's CHIP HEDIS 2019 results as compared to the 2019 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 3-49—Molina CHIP HEDIS 2019 Results

HEDIS Measure	Molina CHIP 2019 Rate	2019 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection		
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	95.09%	90.45%
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)	78.51%	68.08%
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)	90.10%	79.19%
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)	**64.48%**	74.27%
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)	72.57%	62.84%
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.	**69.34%**	72.08%

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

Molina CHIP—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

Molina CHIP exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Opportunities for Improvement

Molina CHIP fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Conclusions and Recommendations for Improvement

Molina CHIP exceeded the 2019 NCQA Quality Compass average for all performance measure rates except two: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Therefore, improvement efforts could be focused on increasing required well-child visits for young children and ensuring that BMI percentiles are documented for children and adolescents ages 3 to 17 years.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Molina CHIP submitted its PIP topic: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

Validation Results

Table 3-50 summarizes the validation findings for each stage validated for CY 2019. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 3-50—CY 2019 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)	*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	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*		**95% (18/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**90% (9/10)**		
Validation Status		***Not Met***		

Indicator Outcomes

For CY 2019, Molina CHIP progressed to reporting Remeasurement 3 results.

For the baseline measurement period, Molina reported that 62.0 percent of children 3 to 6 years of age had one or more well-child visits with a PCP during the measurement year. For Remeasurement 1, the study indicator rate was essentially the same as the baseline rate, at 61.9 percent. The Remeasurement 2 rate was 1.0 percentage point below the baseline at 61.0 percent. For Remeasurement 3, the study indicator rate remained 1.6 percentage points below the baseline at 60.4 percent. The health plan did not achieve statistically significant improvement in any of the remeasurement periods.

The PIP will be evaluated for sustained improvement when the study indicator has demonstrated a statistically significant improvement over baseline and results from a subsequent measurement period have been reported.

Table 3-51 displays data for Molina CHIP's *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.

Table 3-51—PIP—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Molina CHIP

Study Indicator	Baseline Period 01/01/2014–12/31/2014		Remeasurement 1 01/01/2015–12/31/2015		Remeasurement 2 01/01/2016–12/31/2016		Remeasurement 3 01/01/2017–12/31/2017		Sustained Improvement
The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	N: 458	62.0%	N: 581	61.9%	N: 667	61.0%	N: 664	60.4%	*Not Assessed*
	D: 739		D: 939		D: 1,094		D: 1,099		

N–Numerator D–Denominator

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Molina CHIP's study topic addressed CMS' requirements related to outcomes—specifically, the quality, timeliness, and accessibility of care and services. Molina CHIP's PIP aims to increase the well-child visits rate among its CHIP members. By increasing the percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year, 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; providing timely care; and using services to achieve optimal outcomes.

Strengths

Molina CHIP designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Molina CHIP reported its Remeasurement 3 data accurately. Molina CHIP conducted appropriate QI processes to identify and prioritize barriers and implemented interventions that appeared to be logically linked to the barriers.

Conclusions and Recommendations for Improvement

The PIP received an overall *Not 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. The performance suggests a thorough application of the sound PIP design, accurate analysis of results, and implementation of system interventions that were related to barriers identified through QI processes. The interventions implemented appear to have the potential to drive improvement; however, Molina was not successful at achieving statistically significant improvement over the baseline. The lack of statistically significant improvement over the baseline led to the *Not Met* validation status for this PIP.

As the PIP progresses, HSAG recommends the following:

- Molina must revisit the causal/barrier analysis and QI processes at least annually to reevaluate and document new barriers that have prevented improvement in PIP outcomes and develop new or revised interventions to better address high-priority barriers associated with lack of improvement.
- Molina must evaluate the effectiveness of each intervention throughout the measurement period. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention should identify the individual impact of that intervention on the study indicator rate.
- Molina should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF NETWORK ADEQUACY

Molina CHIP—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Molina's Provider Data Structure Questionnaire responses indicated that Molina validated providers' self-report type. The provider specialty field information is collected via the NPPES data and the credentialing data. Molina noted provider taxonomy information is based on the provider specialty

information. Molina noted that single case agreements require a LOA or prior authorization. Molina's data validation team reaches out to all provider groups quarterly to verify information.

Molina reported assigning providers a PCP indicator if the practicing specialty includes pediatrics, pediatric nurse practitioner, family medicine, family nurse practitioner, internal medicine, adult health nurse practitioner, OB/GYN, OB/GYN nurse practitioner, advance practice midwife, women's health nurse practitioner, geriatrics, geriatric nurse practitioner, general practice, or physician's assistant. Molina's physician's assistants must be in a rural location to act as a PCP. Molina does not specifically identify PNC providers.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Molina's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Molina's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the CHIP MCO's data values for provider type, specialty, and credentials. Therefore, Molina should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Molina CHIP met the statewide compliance time/distance standards for 35 of the 60 provider categories (58.3 percent). For the provider categories for which Molina did not meet the time/distance standard, Molina should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Molina, the inability to identify the providers in the data using the standard definitions, or other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Behavioral Health Specialists
  - Behavioral Health Hospital
  - Behavioral Substance—Adult
  - Behavioral Substance—Pediatric
  - General Hospitals with a Psychiatric Unit
- Specialist Providers
  - Allergy & Immunology, 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
  - Other Surgery
  - Other Surgery, Pediatric
  - Otolaryngology, Pediatric
  - Physical Medicine, Pediatric
  - Pulmonology, Pediatric
  - Rheumatology, Pediatric
  - Urology, Pediatric
- Additional Physical Health Specialties
  - Diagnostic Radiology
  - Laboratory
  - Outpatient Infusion/Chemotherapy

SelectHealth CHIP

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.

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of initial credentialing records for all MCOs. SelectHealth CHIP submitted a sample of 10 records with an oversample of five records. HSAG reviewed a sample of only nine records because many of the records originally submitted consisted of dental providers that were not from SelectHealth CHIP's Utah market, as required. The focus of HSAG's review pertained to the timeliness and quality domains. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal health care programs prior to hire. HSAG found that SelectHealth's CHIP credentialing files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed SelectHealth CHIP for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for SelectHealth CHIP indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that SelectHealth had made updates to its member-facing documents and related policies to:

- Notify members of changes to SelectHealth CHIP member materials within the required time frame.
- Ensure members receive accurate information about advance directives.
- Ensure members the right to freely exercise those rights without fear of retaliation.
- Provide complete information about benefits and services.
- Ensure that policies, procedures, and member communications include accurate timelines and requirements related to service authorizations, grievances, and appeals.
- Ensure that member communications are written at the sixth-grade reading level.

HSAG also found that SelectHealth CHIP had revised processes, staff training materials, and provider informational materials to:

- Ensure that organizational practices related to processing claims for emergency and poststabilization services comply with federal health care regulations.
- Ensure that the provider directory includes the required information about providers, which includes whether the provider has had cultural competency information and the provider site's accommodations for people with disabilities.
- Develop a mechanism for monitoring timeliness of access to services furnished by providers.
- Develop a monitoring mechanism to ensure that grievance processing complies with federal health care regulations.
- Ensure that providers are screened to ensure eligibility for participation in federal health care programs.

Conclusions and Recommendations for Improvement

In CY 2019, HSAG found SelectHealth CHIP's overall performance improved in all three domains of care and SelectHealth CHIP's quantity of issues over CY 2018 results were greatly reduced. In CY 2019, HSAG found that SelectHealth's provider directory remained out of compliance. It was also noted during both the CY 2018 and 2019 review years that the CHIP member handbook did not include the correct time frame for filing member appeals. HSAG recommended that SelectHealth CHIP's leadership further examine electronic and paper-based member-facing information to ensure accuracy, accessibility, and completeness.

Further, as it relates to the quality domain, while SelectHealth CHIP revised its provider agreements to include details regarding audits conducted by the State and federal entities, the provider agreements did not include language pertaining to the access of its facilities, equipment, books, records, contracts, computers, and electronic systems as required by federal health care regulations.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that SelectHealth CHIP's HEDIS compliance auditor found SelectHealth CHIP's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. SelectHealth CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of SelectHealth CHIP's FAR revealed that SelectHealth CHIP's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations.

Performance Measure Outcomes

Table 3-52 shows SelectHealth CHIP's HEDIS 2019 results as compared to the 2019 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 3-52—SelectHealth CHIP HEDIS 2019 Results

HEDIS Measure	SelectHealth CHIP 2019 Rate	2019 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection		
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.02%	90.45%
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)	77.62%	68.08%
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%	79.19%
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)	88.66%	74.27%
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)	73.52%	62.84%
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.	**70.32%**	72.08%

*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—Validation of Performance Measures

Strengths

SelectHealth CHIP exceeded the 2019 NCQA Quality Compass average 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—BMI Percentile—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Opportunities for Improvement

SelectHealth CHIP fell below the 2019 NCQA Quality Compass average for the following measure rate:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Conclusions and Recommendations for Improvement

SelectHealth CHIP exceeded the 2019 NCQA Quality Compass average for all but one performance measure rate; therefore, improvement efforts could be focused on increasing required well-child visits for young children.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, 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 Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday.*

Validation Results

Table 3-53 summarizes the validation findings for each stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 3-53—CY 2019 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)
	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 2019, SelectHealth CHIP progressed to reporting Remeasurement 2 results.

For the baseline measurement period, the rate of eligible 13-year-old CHIP female members who received three doses of the HPV vaccine prior to their 13th birthday was 23.4 percent. The Remeasurement 1 rate demonstrated a non-statistically significant increase of 8.5 percentage points over the baseline.

For Remeasurement 2, the study indicator rate of 37.1 percent was 5.2 percentage points higher than the Remeasurement 1 rate and demonstrated a statistically significant increase ($p = 0.0083$) of 13.7 percentage points over the baseline. It should be noted that there was a change in the HEDIS 2018 *Immunizations for Adolescents (IMA)* measure numerator specifications, which may impact the comparability of the Remeasurement 2 data to the baseline. In HEDIS 2018, a two-dose HPV vaccination series was added in the numerator specifications.

The PIP will be evaluated for sustained improvement when the study indicator has demonstrated a statistically significant improvement over baseline and results from a subsequent measurement period have been reported.

Table 3-54 displays data for SelectHealth CHIP's *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday* PIP.

Table 3-54—PIP—*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday*
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: *NA*	*NA*	*Not Assessed*
	D: 154		D: 163		D: 175		D: *NA*		

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

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

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, SelectHealth's study topic for the CHIP population addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. SelectHealth CHIP's PIP aims to improve HPV vaccination rates in its female CHIP population. By increasing the percentage of 13-year-old female CHIP 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.

Strengths

SelectHealth CHIP designed a scientifically sound project supported by the use of 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. SelectHealth CHIP reported and analyzed its Remeasurement 2 data accurately and conducted appropriate QI processes to identify and prioritize barriers. SelectHealth CHIP implemented interventions that were logically linked to those barriers and have the potential to impact the study indicator outcomes and evaluated the effectiveness of those interventions.

Conclusions and Recommendations for Improvement

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. SelectHealth CHIP designed a methodologically sound PIP, reported and summarized the Remeasurement 2 data accurately, and used appropriate QI processes and tools to identify barriers. The interventions developed and implemented were logically linked to the barriers, and the health plan achieved statistically significant improvement over the baseline.

As the PIP progresses, HSAG recommends the following:

- SelectHealth CHIP must continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- SelectHealth CHIP must continue to evaluate the effectiveness of each intervention throughout the measurement period. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention should identify the individual impact of that intervention on the study indicator rate.

- SelectHealth CHIP should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- SelectHealth CHIP should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF NETWORK ADEQUACY

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

SelectHealth CHIP's Provider Data Structure Questionnaire responses indicated that IT validated providers' self-reported specialty, taxonomy, and type which were submitted via the provider application. SelectHealth CHIP noted that single case agreements require a prior authorization. SelectHealth CHIP's data are cleaned before they are entered into the data systems; additionally, new providers must pass the credentialing process. All providers are required to update their information via quarterly attestations, and the Provider Relations team engages in monthly phone calls to confirm the accuracy of the provider data.

SelectHealth CHIP reported assigning providers a PCP indicator if the practicing specialty includes general medicine, family practice, internal medicine, geriatrics, or pediatrics. SelectHealth CHIP noted the Health Services or Advocates Department would assist a member in finding an OB/GYN or equivalent PNC provider.

Conclusions and Recommendations for Improvement

As the first comprehensive review of SelectHealth CHIP's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing SelectHealth CHIP's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the CHIP MCO's data values for provider type, specialty, and credentials. Therefore, SelectHealth CHIP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

SelectHealth CHIP met the statewide compliance time/distance standards for 38 of the 60 provider categories (63.3 percent). For the provider categories for which SelectHealth CHIP did not meet the time/distance standard, SelectHealth CHIP should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with SelectHealth CHIP, the inability to identify the providers in the data using the standard definitions, or other reasons. The provider categories that did not meet the time/distance standards are listed below:

- Behavioral Health Providers

  - Behavioral Health Hospital
  - Behavioral Substance—Adult
  - Behavioral Substance—Pediatric
  - General Hospitals with a Psychiatric Unit
- Specialist Providers
  - Allergy & Immunology, Pediatric
  - Dermatology, Pediatric
  - Endocrinology, Pediatric
  - General Surgery, Pediatric
  - Infectious Disease, Pediatric
  - Nephrology, Pediatric
  - Oncology/Hematology, Pediatric
  - Orthopedic Surgery, Pediatric
  - Other Surgery
  - Other Surgery, Pediatric
  - Otolaryngology, Pediatric
  - Physical Medicine, Pediatric
  - Pulmonology, Pediatric
  - Rheumatology, Pediatric
  - Urology, Pediatric
- Additional Physical Health Specialties
  - Diagnostic Radiology
  - Laboratory
  - Outpatient Infusion/Chemotherapy

PAHPs Providing Medicaid Dental Services

Premier Access

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

For the CY 2019 follow-up compliance review, HSAG reviewed Premier for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Premier indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Premier had made updates to its member-facing documents and related policies to:

- Include taglines in large print (18-point font) and in prevalent non-English languages and ensure that member materials are written in easy to understand language.
- Ensure that members are informed of all federally mandated member rights.
- Ensure that policies, procedures, and member communication include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found that Premier had revised processes, staff training materials, and provider informational materials to:

- Monitor and ensure timely appointment availability.
- Assess providers' accommodations for members with physical disabilities.
- Ensure that its compliance plan includes processes for required reporting to the State.
- Address provider selection and retention.
- Ensure non-discrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Conclusions and Recommendations for Improvement

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. In one provider file, HSAG did not find any evidence that Premier obtained the application or verification of licensure and credentials prior to hire.

In three provider files, HSAG did not find any evidence that Premier searched the required federal databases to ensure that the providers had not been excluded from federal health care participation. In one file the exclusion search was present, but it was not conducted prior to hire. HSAG recommended that Premier's management team evaluate its procedures for credentialing new providers to determine the root cause preventing some PSV prior to hire.

Based on the CY 2019 compliance follow-up review, Premier demonstrated improvement in all three domains of care. However, HSAG found that Premier's provider directory did not identify which providers had completed cultural competency training.

Further, in CY 2018, HSAG had 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 CY 2019, HSAG found that Premier had removed its requirement for the member to follow an oral request for an appeal with the request in writing; however, Premier must have the member follow the oral request with a written, signed appeal according to federal health care regulations (unless the request is for expedited resolution). Premier cannot, however, hold the member to an arbitrary time limit for providing the written request that follows an oral request for an appeal.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Premier's HEDIS compliance auditor found Premier's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. 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 3-55 shows Premier's HEDIS 2019 results as compared to the 2019 NCQA Quality Compass average rates for the *Annual Dental Visit* measure. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 3-55—Premier Access HEDIS 2019 Results

HEDIS Measure	Premier Access 2019 Rate	2019 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	46.11%	42.34%
4–6 Years of Age	**62.55%**	63.38%
7–10 Years of Age	**64.99%**	66.71%

HEDIS Measure	Premier Access 2019 Rate	2019 NCQA Quality Compass Average
11–14 Years of Age	**60.36%**	61.93%
15–18 Years of Age	**51.18%**	53.57%
19–20 Years of Age	**33.16%**	37.20%
Total	58.03%	55.79%

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

Premier—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

Premier exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Annual Dental Visit—2–3 Years of Age*
- *Annual Dental Visit—Total*

Opportunities for Improvement

Premier fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Annual Dental Visit—4–6 Years of Age*
- *Annual Dental Visit—7–10 Years of Age*
- *Annual Dental Visit—11–14 Years of Age*
- *Annual Dental Visit—15–18 Years of Age*
- Annual *Dental Visit—19–20 Years of Age*

Conclusions and Recommendations for Improvement

Premier fell below the 2019 NCQA Quality Compass average for five of the seven (71.4 percent) measure rates. Despite most indicators falling below the 2019 NCQA Quality Compass average, the *Total* rate exceeded the average, as a larger proportion of Premier's population fell in the school-aged children's age brackets compared to national trends, and school-aged members are typically expected to have higher rates of dental visits.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Premier submitted its PIP topic: *Improving Dental Sealant Rates in Members Ages 6–9.*

Validation Results

Table 3-56 summarizes the validation findings for each stage validated for CY 2019. Overall, 56 percent of all applicable evaluation elements received a score of *Met*.

Table 3-56—CY 2019 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	0% (0/1)	100% (1/1)	0% (0/1)
	IV. Review the Selected Study Indicators	0% (0/2)	50% (1/2)	50% (1/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	33% (1/3)	67% (2/3)	0% (0/3)
Design Total		**44% (4/9)**	**44% (4/9)**	**11% (1/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	50% (2/4)	25% (1/4)	25% (1/4)
Implementation Total		**71% (5/7)**	**14% (1/7)**	**14% (1/7)**
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*		**56% (9/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**50% (4/8)**		
Validation Status		***Not Met***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, Premier progressed to reporting baseline results.

Premier reported a baseline rate of 23.0 percent for members 6 to 9 years of age who received a dental sealant during CY 2018. Premier will be assessed for statistically significant improvement in the study indicator rate during Remeasurement 1.

Table 3-57 displays baseline data for Premier's *Improving Dental Sealant Rates in Members Ages 6–9* PIP.

Table 3-57—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
1. The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	N: 5,665	23.0%	N: *NA*	*NA*	*NA*
	D: 24,586		D: *NA*		

^Please note that HSAG modified the Remeasurement 1 period to be consistent with the baseline measurement period. Premier had documented a Remeasurement 1 period of 05/01/2019–04/30/2020; N–Numerator D–Denominator

Premier—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the dental PAHP's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, 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.

Strengths

The PIP topic was selected based on the data.

Conclusions and Recommendations for Improvement

The PIP received an overall *Not Met* validation status, with a *Met* score for 50 percent of critical evaluation elements and 56 percent of overall evaluation elements across all activities completed and validated. The performance suggests multiple opportunities for improvement in the PIP study design and in implementation of system interventions that were related to barriers identified through QI processes.

As the PIP progresses, HSAG recommends the following:

- Premier must define the study population accurately. The study population must be defined for each measurement year and must include the anchor date for age and continuous enrollment criteria for members.
- Premier must define the study indicator title, numerator, and denominator completely and accurately. The study indicator remeasurement periods must be consistent with the baseline measurement period.
- Premier must document the data collection methodology in detail.
- Premier must use, in addition to data mining, other QI tools; for example, process mapping, a fish bone diagram, or failure modes and effects analysis to identify barriers toward PIP outcomes. Barriers must be written clearly and must be related to the PIP study indicator.
- Premier must implement active, evidence-based, innovative interventions to improve study indicator outcomes. The interventions must be clearly linked to the barriers.
- Premier must include comprehensive evaluation results including quantitative data for each individual intervention for effectiveness.
- Premier must reference the PIP Completion Instructions to ensure that all requirements for each completed activity have been addressed.

VALIDATION OF NETWORK ADEQUACY

Premier—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Premier's Provider Data Structure Questionnaire responses indicated that Premier collects provider type, specialty, taxonomy, and licensure information during the contracting and credentialing process every three years or when there have changes to the provider's profile. Premier's single case agreements are documented in the provider data with the provider's effective time frame stating when the agreement is in effect. Premier's Provider Configuration team reviews and validates all provider information to ensure completeness of the data. After the completeness review of the credentialing systems, the Credentialing team verifies other data elements.

Premier reported classifying providers into the following specialties: anesthesiology, denturist, endodontic dentist, general dentist, hygienist, oral maxillofacial dentist, oral pathology, oral radiology, orthodontic dentist, pediatric dentist, periodontics dentist, and prosthodontic dentist.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Premier's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and

processes for overseeing Premier's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PAHP's data values for provider type, specialty, and credentials. Therefore, Premier should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Premier did not meet the State's compliance time/distance standards for either of the provider categories (i.e., all dental providers, including general dentists or general dentists) in rural or frontier areas. Premier Access should assess if this is due to 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 other reasons. It should be noted that the Premier contract did not have a specific requirement for rural and frontier areas, so for this analysis the standard for the urban areas (i.e., at least two dental providers within 40 miles of each enrollee's residence) was applied statewide. As Premier did meet the time/distance standard for both provider categories in urban areas only, HSAG recommends that UDOH consider implementing specific time/distance standards for rural and frontier areas.

MCNA

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Strengths

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal health care programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. HSAG found that MCNA's credential files contained all required documentation and that the documentation and verification were obtained prior to the date of hire for all providers in the sample.

For the CY 2019 follow-up compliance review, HSAG also reviewed MCNA for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for MCNA indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that MCNA had made updates to its member-facing documents and related policies to:

- Ensure that members are assigned to a primary dental provider (PDP) upon enrollment and that members are informed that they are free to change dental providers at any time.

- Ensure that policies, procedures, and member communications include accurate time frames and requirements related to service authorizations, grievances, and appeals.

HSAG also found that MCNA had revised processes, staff training materials, and provider informational materials to:

- Develop and implement internal training to ensure that grievances and appeals are identified and resolved according to federal regulations and State contract requirements and are forwarded to the grievance and appeals committee for further review
- Review grievances for potential quality of care concerns.
- Ensure that its Health Insurance Portability and Accountability Act (HIPAA) Compliance Program reflects processes specific to Utah operations and staff.

Conclusions and Recommendations for Improvement

As a result of findings in CY 2019, MCNA demonstrated improvement in all three domains of care, resulting in full compliance for the compliance follow-up review.

Based on the CY 2019 follow-up compliance review, HSAG did not identify any opportunities for improvement resulting in continued required corrective actions.

VALIDATION OF PERFORMANCE MEASURES

MCNA dental PAHP did not begin providing services to Utah Medicaid members until September 2018 and did not have adequate data to report rates for HEDIS 2019; therefore, MCNA rates are not included in this report.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, MCNA submitted its PIP topic: *Annual Dental Visits.*

Validation Results

Table 3-58 summarizes the validation findings for the Design stage validated for CY 2019. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 3-58—CY 2019 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	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
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***		

*Percentage totals may not equal 100 due to rounding.

Indicator Outcomes

For CY 2019, MCNA had not progressed to reporting study indicator results.

Table 3-59 displays the study indicators and baseline measurement period for MCNA's *Annual Dental Visits* PIP.

Table 3-59—PIP—*Annual Dental Visits*
MCNA

Study Indicator	Baseline Period (01/01/2019–12/31/19)		Sustained Improvement
1. The percentage of members ages 1–20 who had at least one dental visit during the measurement year.			*Not Assessed*
2. The percentage of members ages 21 and older who had at least one dental visit during the measurement year.			*Not Assessed*

MCNA—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the dental PAHP's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, MCNA's study topic addressed CMS' requirements related to outcomes—specifically, the quality, access and timeliness of care and services. MCNA's PIP aims to improve annual dental visit rates in 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.

Strengths

The PIP topic was selected based on the data. MCNA designed a scientifically sound project that was supported using key research principles. The PIP study indicators are based on the nationally recognized CMS 416 measure. The technical design of the PIP was sufficient to measure outcomes.

Conclusions and Recommendations for Improvement

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. The performance for this PIP suggests a thorough application of the PIP Design stage (Steps I through VI). A sound study design created the foundation for MCNA to progress to subsequent PIP stages—collecting data and implementing interventions with the potential to impact study indicator outcomes.

As the PIP progresses HSAG recommends the following:

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

- MCNA must ensure that it addresses the General Comments in the final PIP Validation Tool. Failure to address these comments may result in a decreased score of applicable evaluation elements.
- To impact the Remeasurement 1 study indicator rate, MCNA 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.
- MCNA 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.
- MCNA must implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- MCNA 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.
- MCNA should reference the PIP Completion Instructions annually to ensure that all requirements for each completed step have been addressed.

VALIDATION OF NETWORK ADEQUACY

MCNA—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

MCNA's Provider Data Structure Questionnaire responses indicated that MCNA collects provider type, specialty, taxonomy, and licensure information during the contracting and credentialing process every three years or when there have been changes to the provider's profile. MCNA's single case agreements are documented in the provider data with the provider's effective time frame starting when the agreement is in effect. MCNA's Provider Configuration team reviews and validates all provider information to ensure completeness of the data. After the completeness review of the credentialing systems, the Credentialing team verifies other data elements.

MCNA reported classifying providers into the following specialties: anesthesiology, denturist, endodontic dentist, general dentist, hygienist, oral maxillofacial dentist, oral pathology, oral radiology, orthodontic dentist, pediatric dentist, periodontics dentist, and prosthodontic dentist.

Conclusions and Recommendations for Improvement

As the first comprehensive review of MCNA's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing MCNA's compliance with network adequacy standards. HSAG's provider

crosswalk identified numerous spelling variations and/or special characters for the PAHP's data values for provider type, specialty, and credentials. Therefore, MCNA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

MCNA met the statewide compliance time/distance standards for both provider categories (100 percent). HSAG recommends continuing to monitor the time/distance analysis for MCNA to ensure continued compliance with these standards.

PAHP Providing CHIP Dental Services

Premier Access—CHIP

ASSESSMENT OF COMPLIANCE WITH CHIP MANAGED CARE REGULATIONS

Premier CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

Strengths

For the CY 2019 follow-up compliance review, HSAG reviewed Premier's CHIP program for requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance site visit and review of all standards. Overall findings for Premier CHIP indicated significant improvement from CY 2018 to CY 2019. As a result of the follow-up compliance review in CY 2019, HSAG identified improvement across all three domains of care and found that Premier CHIP had made updates to its member-facing documents and related policies to:

- Include taglines in large print (18-point font) and in prevalent non-English languages and include language that ensures members' ease of understanding.
- Ensure policies, procedures, and member communications related to service authorizations, grievances, and appeals.
- Include the definition of "medically necessary services" that complies with the federal definition.
- Inform the member of a provider's capability to provide accommodations for members with physical disabilities.

HSAG also found that Premier CHIP had revised processes, staff training materials, and provider informational materials to:

- Ensure network monitoring for timely appointment availability.
- Ensure compliance with State contract requirements related to overpayments and reporting changes in member and provider circumstances that may impact their respective eligibility to participate in the Medicaid program.
- Address provider selection and retention.
- Ensure that policies, procedures, and delegation agreements include the federally required provisions.
- Ensure nondiscrimination against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Conclusions and Recommendations for Improvement

In CY 2019, at UDOH's request, HSAG reviewed a sample of 10 initial credentialing records for all health plans. HSAG evaluated compliance with State contract requirements for credentialing, ensuring that the health plans reviewed the providers' application for appointment and verified education, licensure, certification, and eligibility to participate in federal health care programs prior to hire. The emphasis for HSAG's review aligned with the timeliness and quality domains. In one provider file, HSAG did not find any evidence that Premier CHIP obtained an application or verified licensure and credentials prior to hire. In three of the 10 provider files, HSAG did not find any evidence that Premier CHIP had conducted the required federal database searches to ensure that providers had not been excluded from federal health care participation. In one file, HSAG found that the required search had been conducted after hire. HSAG recommended that Premier CHIP's management team evaluate its procedures for credentialing new providers to determine the root cause preventing some PSV prior to hire.

Based on the CY 2019 follow-up compliance review, Premier CHIP demonstrated improvement in all three domains of care; however, HSAG found that Premier CHIP's provider directory did not identify which providers had completed cultural competency training.

Further, in CY 2018, HSAG had found that Premier CHIP'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 CY 2019, HSAG found that Premier CHIP had removed its requirement for the member to follow an oral request for an appeal with the request in writing; however, Premier CHIP must have the member follow the oral request with a written, signed appeal according to federal health care regulations (unless the request is for expedited resolution). Premier CHIP cannot, however, hold the member to an arbitrary time limit for providing the written request that follows an oral request for an appeal.

Additionally, in CY 2019 Premier had updated its Medicaid NABD letter template to include the correct time frame for members to file an appeal; however, it had not updated the CHIP NABD letter template.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Premier CHIP's HEDIS compliance auditor found Premier CHIP's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. Premier CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier CHIP's FAR revealed that Premier CHIP's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations.

Performance Measure Outcomes

Table 3-60 shows Premier CHIP's HEDIS 2019 results as compared to the 2019 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 3-60—Premier CHIP HEDIS 2019 Results

HEDIS Measure	Premier CHIP 2019 Rate	2019 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	49.02%	42.34%
4–6 Years of Age	**58.61%**	63.38%
7–10 Years of Age	**66.16%**	66.71%
11–14 Years of Age	63.83%	61.93%
15–18 Years of Age	56.06%	53.57%
19–20 Years of Age	**35.00%**	37.20%
Total	60.29%	55.79%

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

Premier CHIP—Quality, Timeliness, and Access to Care—Validation of Performance Measures

Strengths

Premier CHIP exceeded the 2019 NCQA Quality Compass average for the following measure rates:

- *Annual Dental Visit—2–3 Years of Age*
- *Annual Dental Visit—11–14 Years of Age*
- *Annual Dental Visit—15–18 Years of Age*
- *Annual Dental Visit—Total*

Opportunities for Improvement

Premier CHIP fell below the 2019 NCQA Quality Compass average for the following measure rates:

- *Annual Dental Visit—4–6 Years of Age*
- *Annual Dental Visit—7–10 Years of Age*
- *Annual Dental Visit—19–20 Years of Age*

Conclusions and Recommendations for Improvement

HSAG recommended that Premier CHIP focus improvement efforts designed to ensure that members 4 to 10 years of age and 19 to 20 years of age receive annual dental visits to prevent common, preventable dental conditions such as dental caries and tooth decay.

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2019, Premier CHIP submitted its PIP topic: *Improving Dental Sealant Rates in CHIP Members Ages 6–9.*

Validation Results

Table 3-61 summarizes the validation findings for each stage validated for CY 2019. Overall, 50 percent of all applicable evaluation elements received a score of *Met*.

Table 3-61—CY 2019 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	0% (0/1)	100% (1/1)	0% (0/1)
	IV. Review the Selected Study Indicators	0% (0/2)	50% (1/2)	50% (1/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	33% (1/3)	67% (2/3)	0% (0/3)
Design Total		**44% (4/9)**	**44% (4/9)**	**11% (1/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	25% (1/4)	25% (1/4)	50% (2/4)
Implementation Total		**57% (4/7)**	**14% (1/7)**	**29% (2/7)**

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*		**50% (8/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**50% (4/8)**		
Validation Status		***Not Met***		

Indicator Outcomes

For CY 2019, Premier CHIP progressed to reporting baseline results.

Premier CHIP reported a baseline rate of 15.5 percent for CHIP members 6 to 9 years of age who received a dental sealant during CY 2018. Premier CHIP will be assessed for statistically significant improvement in the study indicator rate during Remeasurement 1.

Table 3-62 displays baseline data for Premier CHIP's *Improving Dental Sealant Rates in CHIP Members Ages 6–9* PIP.

Table 3-62—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
1. The percentage of CHIP members 6–9 years of age who received a dental sealant during the measurement year.	N: 697	15.5%	N: *NA*	*NA*	*NA*
	D: 4492		D: *NA*		

^Please note that HSAG modified the Remeasurement 1 period to be consistent with the baseline measurement period. Premier CHIP had documented a Remeasurement 1 period of 05/01/2019–04/30/2020; N–Numerator D–Denominator

Premier CHIP—Quality, Timeliness, and Access to Care—Validation of Performance Improvement Projects

While the focus of a PIP may have been to improve performance related to health care quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the

dental PAHP's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, Premier CHIP's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Premier CHIP's PIP aims to improve dental sealant rates in children 6–9 years old. By increasing the dental sealant rates, Premier CHIP intends to prevent the occurrence of dental caries in permanent molars.

Strengths

The PIP topic was selected based on the data.

Conclusions and Recommendations for Improvement

The PIP received an overall *Not Met* validation status, with a *Met* score for 50 percent of critical evaluation elements and 50 percent of overall evaluation elements across all activities completed and validated. The performance suggests multiple opportunities for improvement in the PIP study design and in implementation of system interventions that were related to barriers identified through QI processes.

As the PIP progresses HSAG recommends the following:

- Premier CHIP must define the study population accurately. The study population must be defined for each measurement year and must include the anchor date for age and continuous enrollment criteria for members.
- Premier CHIP must define the study indicator title, numerator, and denominator completely and accurately. The study indicator remeasurement periods must be consistent with the baseline measurement period.
- Premier CHIP must document the data collection methodology in detail.
- Premier CHIP must use, in addition to data mining, other QI tools; for example, process mapping, a fish bone diagram, or failure modes and effects analysis to identify barriers toward PIP outcomes. Barriers must be written clearly and must be related to the PIP study indicator.
- Premier CHIP must implement active, evidence-based, innovative interventions to improve study indicator outcomes. The interventions must be clearly linked to the barriers.
- Premier CHIP must implement interventions in a timely manner to impact the remeasurement outcomes.
- Premier CHIP must include comprehensive evaluation results including quantitative data for each individual intervention for effectiveness.
- Premier CHIP must reference the PIP Completion Instructions to ensure that all requirements for each completed activity have been addressed.

VALIDATION OF NETWORK ADEQUACY

Premier CHIP—Quality, Timeliness, and Access to Care—Validation of Network Adequacy

Strengths

Premier CHIP's Provider Data Structure Questionnaire responses indicated that Premier CHIP collects provider type, specialty, taxonomy, and licensure information during the contracting and credentialing process every three years or when there have changes to the provider's profile. Premier CHIP's single case agreements are documented in the provider data with the provider's effective time frame stating when the agreement is in effect. Premier CHIP's Provider Configuration team reviews and validates all provider information to ensure completeness of the data. After the completeness review of the credentialing systems, the Credentialing team verifies other data elements.

Premier CHIP reported classifying providers into the following specialties: anesthesiology, denturist, endodontic dentist, general dentist, hygienist, oral maxillofacial dentist, oral pathology, oral radiology, orthodontic dentist, pediatric dentist, periodontics dentist, and prosthodontic dentist.

Conclusions and Recommendations for Improvement

As the first comprehensive review of Premier CHIP's provider networks, the current study established a foundation upon which UDOH can build robust managed care network adequacy expectations and processes for overseeing Premier CHIP's compliance with network adequacy standards. HSAG's provider crosswalk identified numerous spelling variations and/or special characters for the PAHP's data values for provider type, specialty, and credentials. Therefore, Premier CHIP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

Premier CHIP did not meet the State's compliance time/distance standards for either of the provider categories (i.e., all dental providers, including general dentists or general dentists) in rural or frontier areas. Premier CHIP should assess if this is due to a lack of providers in the area with whom to contract, providers who chose not to contract with Premier CHIP, the inability to identify the providers in the data using the standard definitions, or other reasons. It should be noted that the Premier CHIP contract did not have a specific requirement for rural and frontier areas, so for this analysis the standard for the urban areas (i.e., at least two dental providers within 40 miles of each enrollee's residence) was applied statewide. As Premier CHIP did meet the time/distance standard for both provider categories in urban areas only, HSAG recommends UDOH consider implementing specific time/distance standards for rural and frontier areas.

4. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Results

ACOs

For the 2019 compliance reviews, HSAG hosted webinar-based follow-up reviews of the ACOs' implementation of their CAPs from the CY 2018 on-site compliance reviews, which included a review of all standards. HSAG reviewed the four ACO health plans: Health Choice, Healthy U, Molina, and SelectHealth. HSAG identified trends between the findings in these four organizations. As a result of the CY 2019 follow-up compliance review, all ACOs exhibited significant improvement; however, none of the ACOs achieved full compliance.

As with all types of health plans, HSAG found that the most significant improvement for ACOs occurred in the health plans' policies and procedures. For the follow-up review, the ACOs submitted evidence of revised, rewritten, and clarified processes and procedures and successfully came into compliance with federal health care regulations and State contract requirements, primarily in the Member Information, and Grievance and Appeal System standards.

In addition to the follow-up compliance review, in CY 2019, HSAG reviewed a sample of initial credentialing records for new providers recently credentialed with each ACO, at UDOH's request. Upon review, HSAG found that Medicaid ACOs performed well on these reviews when considering whether all required documentation was collected and reviewed prior to granting the provider clinical privileges. The large, corporate nature of the ACOs, their experience in the industry, their ability to have staffing and policies sufficient to manage a large quantity of applicants, and in some cases the capacity to outsource credentialing to a credentials verification organization (CVO), if desired, may account for these positive results.

For the ACOs, Member Rights and Information was the most prevalent standard that remained not fully compliant. Related to member information, HSAG found that for two of the four ACOs, the provider directory did not include information about whether providers' offices had accessibility accommodations and whether providers had completed cultural competency training. Both of these ACOs stated that they had a process in place to obtain the information; however, they we not able to collect information to post to the provider directory prior to the compliance review.

Based on CY 2019 compliance follow-up reviews, HSAG found that all ACOs continued to struggle with the revised federal health care regulations pertaining to ensuring that information provided to

members electronically is readily accessible based on Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. HSAG presumes this is due to the amount and complexity of the content included on the ACOs' websites. For all ACOs, coming into compliance with electronic accessibility requirements continues to be a priority.

Finally, one of the ACOs had not properly updated information for members concerning accurate time frames for submitting a written appeal following an oral request for an appeal. This plan also had included in its policies an inaccurate time frame for members to request a State fair hearing following an appeal. The plan was encouraged to review the federally mandated time frames and its documents in whole to ensure accuracy of the time frames depicted.

HOME

Due to the unique nature of HOME's program, which serves individuals with both developmental disabilities and a mental illness, the health plan does not align well with other types of health plans for comparative analysis. Information concerning the specific findings for HOME can be found in Section 3—Evaluation of Utah Medicaid and CHIP Health Plans.

PMHPs

For the 2019 compliance reviews, HSAG hosted webinar-based follow-up reviews of the PMHPs' implementation of their CAPs from the CY 2018 on-site compliance reviews, which included review of all standards. HSAG met with leadership and subject matter experts from all 11 PMHPs, which included Bear River, Central, Davis, Four Corners, Northeastern, Salt Lake County, Southwest, Utah County, Valley, Wasatch, and Weber via webinar. One organization, Utah County, is unique in that it is a PAHP rather than a PIHP and provides specialized outpatient SUD services. While the PMHPs had different findings following the full review in CY 2018, HSAG was able to identify trends across these 11 organizations in both strengths and areas for improvement. As a result of the CY 2019 follow-up compliance review, three of the 11 PMHPs completed the review achieving full compliance with all requirements.

In addition to a review of the corrective actions from CY 2018, HSAG also reviewed a sample of initial credentialing records for new providers credentialed in the first half of 2019. Three of the 11 PMHPs demonstrated full compliance on the initial credentialing record review. One PMHP successfully achieved full compliance for both the follow-up compliance review and the initial credentialing record review.

PMHPs demonstrated significant improvement by revising policies, procedures, and organizational processes. PMHPs exhibited efforts to revise, rewrite, and ultimately clarify processes and procedures and, therefore, successfully achieved compliance with many federal regulations and State contract requirements, primarily in the Member Rights and Information, and the Grievances and Appeals standards. HSAG found significant improvement in the PMHPs' timeliness domain as PMHPs adjusted internal documents to reflect the revisions to federal health care regulations published in May 2016.

PMHPs also enhanced and improved member-facing documents and publications (electronic and paper) to include revisions designed to comply with federal health care regulations and State contract requirements. HSAG reviewed the revised letter templates, forms, handbooks, and information posted on websites and verified improved compliance in the alignment with information provided to members, most notably regarding communicating accurate timelines and describing all member rights as they pertain to service authorizations, appeals, and grievances.

Based on CY 2019 compliance follow-up reviews, HSAG found that most PMHPs demonstrated improved performance in complying with the revised federal health care regulations pertaining to ensuring that information provided to members electronically is readily accessible based on Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. Despite all of the PMHPs struggling with this issue during the full compliance review conducted in CY 2018, HSAG found ongoing concerns in only one PMHP for CY 2019.

For the PMHPs, the most prevalent standards that remained not fully in compliance—for the eight PMHPs that continued to have ongoing findings—included Coverage and Authorization of Services, Member Rights and Information, and Provider Participation and Program Integrity.

Two PMHPs continued to have findings in the Coverage and Authorization of Services standard following the CY 2019 review. One PMHP did not provide members information about their right to have access to all documents and records relevant to the adverse benefit determination. Related to authorization denials, another PMHP was unable to describe organizational procedures to ensure consistent application of any criteria the PMHP uses to make authorization decisions.

Based on the CY 2019 compliance follow-up reviews, HSAG found that in relation to member information, most PMHPs continued to struggle with ensuring their provider directory included all required information, particularly the provider's cultural and linguistic capabilities, including languages (e.g., American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training, as required at 42 CFR §438.10 (h)(1)–(3). In part this finding was often reflective of the PMHPs having not collected this information. However, HSAG also found that there seemed to be a gap between developing a process to collect provider information and publishing the information in the directory.

As it relates to findings in the Provider Participation and Program Integrity standard, three PMHPs continued to have findings. Often the findings were related to having provisions for a method to regularly verify, by sampling or other methods, whether services represented to have been delivered by network providers were received by the members.

CHIP MCOs

For the 2019 compliance reviews, HSAG hosted webinar-based conferences to discuss the CHIP MCOs' implementation of their CAPs following the CY 2018 on-site compliance reviews, which included a review of all standards. HSAG reviewed the two CHIP MCOs, which included Molina and SelectHealth.

As a result of the CY 2019 follow-up compliance review, both CHIP MCOs exhibited significant improvement; however, neither of the MCOs achieved full compliance.

As with all types of health plans, HSAG found that the most significant improvement for CHIP MCOs occurred in the health plans' policies and procedures. For the follow-up review, the CHIP MCOs submitted evidence of revised, rewritten, and clarified policies and procedures and successfully achieved full compliance with federal health care regulations and State contract requirements, the most significantly improved standards related to member information and grievances and appeals.

Across all CHIP MCOs, HSAG reviewed a sample of initial credentialing records for new providers recently credentialed with each CHIP MCO, at UDOH's request. Upon review, HSAG found that CHIP MCOs performed well on these reviews when considering whether all required documentation was collected and reviewed prior to granting the provider clinical privileges. The large, corporate nature of the CHIP MCOs, their experience in the industry, their ability to have staffing and policies sufficient to manage a large quantity of applicants, and in some cases the capacity to outsource credentialing to a CVO, if desired, may account for these positive results.

For the CHIP MCOs, the most prevalent standards that remained not fully in compliance included Member Rights and Information, Grievance and Appeal System, and Provider Participation and Program Integrity. Related to member information, HSAG found that for one of the two CHIP MCOs, the provider directory did not include information about whether providers' offices had accessibility accommodations or whether providers had completed cultural competency training.

Based on the CY 2019 compliance follow-up reviews, HSAG found that both CHIP MCOs continued to struggle with the revised federal health care regulations pertaining to ensuring that information provided to members electronically is readily accessible based on Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. HSAG presumes this is due to the amount and complexity of the content included on the CHIP MCOs' websites. For both CHIP MCOs, coming into compliance with accessibility requirements continues to be a priority.

HSAG also found that for one CHIP MCO, the CHIP-specific drug formulary did not include tiers for each drug. This same CHIP MCO did not update information for members concerning accurate time frames for submitting a written appeal following an oral request for an appeal and did not have CHIP-specific grievance policies.

One of the CHIP MCOs did not have a CHIP-specific policy which included a provision for a method to routinely verify, by sampling or other methods, whether CHIP members received services that network providers represented as having been delivered.

Dental PAHPs—Medicaid

For the CY 2019 follow-up compliance reviews, HSAG hosted webinar-based conferences to discuss the dental PAHPs' implementation of CAPs following the CY 2018 on-site compliance reviews, which

included review of all standards. HSAG reviewed the two Medicaid dental PAHPs, Premier and MCNA. As a result of the follow-up compliance review, one of the dental PAHPs exhibited significant improvement, and the other dental PAHP achieved full compliance.

Both Medicaid dental PAHPs achieved significant improvements in the grievances and appeals requirements. Both demonstrated improvement in revised policies, procedures, and organizational processes for defining and identifying grievances and appeals. In addition, the dental PAHPs developed and implemented processes to ensure appropriate staff reviewed or made decisions about grievances and appeals.

In CY 2019 HSAG reviewed a sample of initial credentialing records for new providers recently credentialed with each dental PAHP, at UDOH's request. Upon review, HSAG found that one dental PAHP had findings in all areas reviewed for one provider and with evidence of timely verification of exclusion information for several. The other dental PAHP performed well and did not have any negative findings.

For the dental PAHP that had ongoing required corrective actions based on the CY 2019 follow-up compliance review, the standards that remained not fully in compliance included Coverage and Authorization of Services, Member Rights and Information, and Grievance and Appeal System. In CY 2018, HSAG found that for one dental PAHP the CHIP NABD template was updated to state that members had 90 days instead of 60 days to file an appeal, which was accurate under the previous rule (prior to July 1, 2017) and not in alignment with timeline requirements at 42 CFR §438.404(b).

Based on the CY 2019 follow-up compliance reviews, HSAG found that one dental PAHP continued to struggle with ensuring its provider directory included whether the provider had completed cultural competency training, as required at 42 CFR §438.10 (h) (1)–(3). HSAG recommended that this PAHP continue to work toward collecting and developing a complete provider directory to support members as they try to access and establish a relationship with a provider that is the best fit for their dental care.

In addition, during the CY 2018 review HSAG had found that the provider directory for this dental PAHP did not identify which providers had completed cultural competency training. For CY 2019, HSAG reviewed the online provider directory and discovered the same finding.

Finally, In CY 2018, HSAG found that within policies, procedures, and member information the dental PAHP 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 appeal to follow an oral appeal is not permitted. In response to HSAG's 2018 findings, the dental PAHP removed its requirement for the member to follow an oral request for an appeal with a written, signed appeal rather than only removing the time limitation. HSAG advised the dental PAHP that it must require a written, signed appeal following any oral request for an appeal that is not a request for an expedited resolution.

Dental PAHP—CHIP

UDOH only contracted with one CHIP dental PAHP during CY 2018; therefore, comparative information is not available. Information concerning the specific findings for Premier's CHIP program can be found in Section 3—Evaluation of Utah Medicaid and CHIP Health Plans.

Statewide Conclusions and Recommendations—Compliance With Medicaid Managed Care Regulations

As a result of the 2019 follow-up compliance reviews, HSAG found that four health plans (three PMHPs and one dental PAHP) had successfully addressed all required actions and achieved full compliance. The remaining health plans exhibited substantial improvement, with most health plans having fewer than five required actions to address through a CAP.

HSAG reviewed policies, procedures, and related documents in preparation for the CY 2019 follow-up compliance reviews. HSAG found that revisions to these documents included accurately representing federal health care regulations and State contract requirements, specifically pertaining to service authorization denials, grievances, appeals, and continuation of benefits. Most policy and procedure revisions related to the revised federal regulations published in May 2016, effective July 2017 for Medicaid managed care and July 2018 for CHIP programs. HSAG also reviewed template letters, information on the health plans' website, and other member-facing documents and found significant revisions and improvements. The revisions to member-facing documents often related to correcting inaccurate time frames for members to file appeals or request State fair hearings, and for health plans to respond to expedited appeal requests and standard appeal requests, and to a make appeal and grievance decisions.

HSAG also found that while PMHPs did well with resolving issues associated with the accessibility of electronic member information and member materials, the ACO and CHIP MCO health plans still exhibited continued opportunities for improvement. Each plan with findings in this area should continue to investigate ongoing means with which to ensure that all members (including those with physical, language, visual, and intellectual barriers) have equal access to information, available in print and on its website, including information provided in PDF format, Hypertext Markup Language (HTML), JavaScript Object Notation (JSON), and other formats.

Finally, many health plans continued to struggle with ensuring that their provider directory included all required information about the providers in their network, pursuant to 42 CFR §438.10. HSAG found that the directories were most deficient in addressing the following:

- Whether each provider had completed cultural competency training.
- The provider's cultural and linguistic capabilities, including languages (e.g., American Sign Language).

- Whether the provider's office has accommodations for people with physical disabilities.

Of the plans that had this finding in their CY 2019 review, many had processes in place to collect the information but had neither collected sufficient information nor updated the provider directory. HSAG recommends that these plans continue their efforts to procure provider information and include the information in the provider directory.

Finally, HSAG extends its prior recommendation that each of the health plans assign a point person to follow CMS updates and ensure that changes to the federal health care regulations are identified and incorporated in a timely manner to maintain compliance.

Validation of Performance Measures

Statewide Results

Table 4-1 shows the ACOs' HEDIS 2019 results as compared to the 2019 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 4-1—ACOs' HEDIS 2019 Results

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2019 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**	**47.22%**	**NA**	54.17%	53.43%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)					
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.13%	95.26%	94.43%	95.44%	90.45%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**28.60%**	**48.04%**	**40.36%**	**46.63%**	58.41%
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**43.80%**	**56.58%**	**53.28%**	**56.97%**	59.34%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2019 NCQA Quality Compass Average
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)	72.26%	78.59%	71.29%	75.91%	68.08%
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)	**33.18%**	**43.75%**	**39.95%**	**42.71%**	58.19%
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)	**81.94%**	88.56%	**87.10%**	88.92%	87.79%
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)	**48.79%**	**56.20%**	**52.31%**	65.98%	57.34%
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%	76.40%	**55.47%**	72.75%	58.87%
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%	90.75%	85.40%	85.79%	79.19%
Prenatal and Postpartum Care					
The percentage of live birth deliveries that had a postpartum visit on or between 21 and 56 days after delivery. (Postpartum Care)	65.93%	**55.47%**	**52.80%**	75.52%	63.59%
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.	80.36%	72.02%	**66.89%**	74.41%	71.72%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2019 NCQA Quality Compass Average
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%**	84.18%	**62.77%**	90.63%	74.27%
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%**	**60.34%**	**60.83%**	63.42%	62.84%
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.	**58.02%**	**63.66%**	**59.37%**	**64.47%**	72.08%

*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 4-2 presents the findings reported by HOME for the *Follow-Up After Hospitalization for Mental Illness* (*FUH*) measure.

Table 4-2—HOME RY 2019 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	45.45%
Follow-Up Within 30 Days	93.94%

Table 4-3 presents the findings reported by the PMHPs for the *Follow-Up After Hospitalization for Mental Illness* (*FUH*) measure.

Table 4-3—PMHPs RY 2019 *FUH* Results

PMHP	Follow-Up Within 7 Days	Follow-Up Within 30 Days
Statewide PMHP Average	**52.28%**	**68.30%**
Bear River	**36.49%**	**45.95%**
Central	**NA**	**NA**
Davis	80.00%	85.83%

PMHP	Follow-Up Within 7 Days	Follow-Up Within 30 Days
Four Corners	**NA**	**NA**
Northeastern	71.88%	81.25%
Salt Lake	**43.62%**	**61.61%**
Southwest	61.62%	75.76%
Valley	**NR**	**NR**
Wasatch	56.07%	77.50%
Weber	59.53%	74.71%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*
NA indicates that the rate was not presented because the denominator was less than 30.
NR indicates that the rate was not presented because the rate was determined to be materially biased.

Table 4-4 presents the findings reported by Utah County for the *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure.

Table 4-4—Utah County RY 2019 *IET* Results

Indicator	Utah County 2019 Rate
Alcohol Abuse or Dependence—Initiation of AOD Treatment—Total	**NA**
Opioid Abuse or Dependence—Initiation of AOD Treatment—Total	50.00%
Other Drug Abuse or Dependence—Initiation of AOD Treatment—Total	**NA**
Initiation of AOD Treatment—Total—Total	43.84%
Alcohol Abuse or Dependence—Engagement of AOD Treatment—Total	**NA**
Opioid Abuse or Dependence—Engagement of AOD Treatment—Total	42.86%
Other Drug Abuse or Dependence—Engagement of AOD Treatment—Total	**NA**
Engagement of AOD Treatment—Total—Total	34.25%

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

Table 4-5 shows CHIP MCOs' HEDIS 2019 results as compared to the 2019 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 4-5—CHIP MCO HEDIS 2019 Results

HEDIS Measure	Molina CHIP	SelectHealth CHIP	2019 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection (URI)			
The percentage of children 3 months–18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	95.09%	94.02%	90.45%
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)	78.51%	77.62%	68.08%
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)	90.10%	90.74%	79.19%
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)	**64.48%**	88.66%	74.27%
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)	72.57%	73.52%	62.84%
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.	**69.34%**	**70.32%**	72.08%

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

Table 4-6 shows the HEDIS 2019 results for the dental PAHP serving the Medicaid population as compared to the 2019 NCQA Quality Compass average rates.[4-1] Rates that fell below the Quality Compass average rates are denoted in **red** font.

[4-1] MCNA dental PAHP did not begin providing services until September 2018 and did not have adequate data to report rates for HEDIS 2019; therefore, MCNA rates are not included in this report.

Table 4-6—Medicaid Dental PAHP HEDIS 2019 Results

HEDIS Measure	Premier	2019 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	46.11%	42.34%
4–6 Years of Age	**62.55%**	63.38%
7–10 Years of Age	**64.99%**	66.71%
11–14 Years of Age	**60.36%**	61.93%
15–18 Years of Age	**51.18%**	53.57%
19–20 Years of Age	**33.16%**	37.20%
Total	58.03%	55.79%

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

Table 4-7 shows the HEDIS 2019 results for the dental PAHP serving the CHIP populations compared to the 2019 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 4-7—CHIP Dental PAHP HEDIS 2019 Results

HEDIS Measure	Premier CHIP	2019 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	49.02%	42.34%
4–6 Years of Age	**58.61%**	63.38%
7–10 Years of Age	**66.16%**	66.71%
11–14 Years of Age	63.83%	61.93%
15–18 Years of Age	56.06%	53.57%
19–20 Years of Age	**35.00%**	37.20%
Total	60.29%	55.79%

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

Statewide Conclusions and Recommendations—Performance Measures

Medicaid ACOs

Most or all ACOs exceeded the 2019 NCQA Quality Compass average for the following measure rates, representing areas of strength. **Bold** text indicates those measures for which all ACOs with reportable rates exceeded the 2019 NCQA Quality Compass average.

- ***Appropriate Treatment for Children With Upper Respiratory Infection***
- ***Childhood Immunization Status—Combination 3***
- *Controlling High Blood Pressure*
- ***Immunizations for Adolescents—Combination 1***
- *Use of Imaging Studies for Low Back Pain*

Most or all ACOs fell below the 2019 NCQA Quality Compass average for the following measure rates, representing opportunities for improvement. **Bold** text indicates those measures for which all ACOs with reportable rates fell below the 2019 NCQA Quality Compass average.

- ***Breast Cancer Screening***
- ***Cervical Cancer Screening***
- ***Chlamydia Screening in Women—Total***
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *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 consistently falling below the 2019 NCQA Quality Compass average for the ACOs, improvement efforts could be focused on increasing screenings for women (breast cancer, cervical cancer, and chlamydia); eye examinations for members with diabetes; and required well-child visits for infants and young children.

HOME

For RY 2019, 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.

PMHPs

For RY 2019, five PMHPs (Davis, Northeastern, Southwest, Wasatch, and Weber) exceeded the statewide PMHP average for both state-modified *Follow-Up After Hospitalization for Mental Illness (FUH)* indicators, and two PMHPs (Bear River and Salt Lake) fell below the statewide average for both indicators. Additionally, the rates for one PMHP (Valley) were determined to be materially biased (NR) for both indicators.

Valley Behavioral Health received an NR rating because it was not tracking retro-enrollment and disenrollment in its transactional system (SmartCare), and HSAG could not verify that Valley's eligibility data were reliable. Valley's process for inputting and tracking authorizations for inpatient services was unreliable. Valley was using these data to identify the hospital discharges; therefore, the rate was

unreliable. In addition, Valley used programming code to produce the final analytic data set. HSAG's review of the final data set in the SQL database identified members who were included in the measure calculation process improperly, as well as members who were excluded from the denominator when they should have been included.

SUD PAHP

For RY 2019, 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.

CHIP MCOs

Both CHIP MCOs exceeded the 2019 NCQA Quality Compass average on all but two measure rates, 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*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Both CHIP MCOs fell below the 2019 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 2019 NCQA Quality Compass average for both CHIP MCOs, improvement efforts could be focused on increasing required well-child visits for young children.

Dental PAHPs

Premier's performance for the Medicaid population exceeded the 2019 NCQA Quality Compass Average for the *Annual Dental Visit—2–3 Years of Age* and *Total* measure rates but fell below the average for the *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* measure rates. These results indicate opportunities for improvement for Premier.

Premier's performance for the CHIP population exceeded the 2019 NCQA Quality Compass average for four of the seven *Annual Dental Visit* measure rates, indicating overall strength for the CHIP PAHP.

Validation of Performance Improvement Projects

Statewide Results

For CY 2019, HSAG validated one PIP for each of the 11 PMHPs, five Medicaid MCOs, and two CHIP MCOs.

Table 4-8 lists the PIP topics and validation scores for each health plan.

Table 4-8—CY 2019 PIP Topics Selected by Health Plans
Summary of Each 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*	91%	100%	*Met*
Healthy U	*Asthma Medication Management*	95%	90%	*Not Met*
Molina	*Breast Cancer Screening for Women Ages 50–74*	95%	91%	*Not 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*
HOME	*Impact of clinical and educational interventions on progression of pre-diabetes to Type II Diabetes Mellitus*	100%	100%	*Met*
Bear River	*Suicide Prevention*	90%	100%	*Met*
Central	*Suicide Prevention*	95%	100%	*Met*
Davis	*Suicide Prevention*	95%	90%	*Partially Met*
Four Corners	*Suicide Prevention*	100%	100%	*Met*
Northeastern	*Suicide Prevention*	100%	100%	*Met*
Salt Lake	*Suicide Prevention*	95%	90%	*Partially Met*
Southwest	*Suicide Prevention*	100%	100%	*Met*
Utah County	*Suicide Prevention*	95%	90%	*Partially Met*
Valley	*Suicide Prevention*	95%	100%	*Met*
Wasatch	*Suicide Prevention*	89%	90%	*Partially Met*
Weber	*Suicide Prevention*	70%	73%	*Partially Met*
Molina CHIP	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	95%	90%	*Not 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 2019, HSAG validated one PIP for each of the two dental Medicaid PAHPs and the dental CHIP PAHP.

Table 4-9 lists the PIP topics and validation scores for each dental PAHP.

Table 4-9—CY 2019 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 Members Ages 6–9*	56%	50%	*Not Met*
Premier CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*	50%	50%	*Not Met*

Statewide Conclusions and Recommendations—Performance Improvement Projects

For CY 2019 the PMHPs continued the statewide *Suicide Prevention* PIP, and each ACO and MCO continued with its respective unique PIP topics. One health plan (Health Choice) and three dental PAHPS submitted a new PIP topic in CY 2019. Of the 21 PIPs validated, 11 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles, use of appropriate QI activities to support improvement of PIP outcomes, and achievement of statistically significant outcomes across all study indicators. Five PIPs received an overall *Partially Met* validation status, and the remaining five 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.

The PIPs validated in CY 2019 were in varying stages. One health plan (Healthy U) reported Remeasurement 4 results; seven health plans (Molina, Molina CHIP, Bear River, Central, Davis, Wasatch, and Weber) reported Remeasurement 3 results; seven health plans (SelectHealth, SelectHealth CHIP, Four Corners, Northeastern, Salt Lake, Southwest, and Valley) reported Remeasurement 2 results; and two health plans (HOME and Utah County) reported Remeasurement 1 results. These health plans were evaluated for achievement of statistically significant and sustained outcomes. The remaining health plan (Health Choice), the two Medicaid dental PAHPs (MCNA and Premier), and the one CHIP dental PAHP (Premier CHIP) started new PIP topics in CY 2019 and therefore were not assessed for improvement in outcomes. More specific information about each

health plan's and dental PAHPs' PIP validation results for CY 2019 are included in Section 3 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.
- When initiating a new PIP, the health plans must ensure that the PIP topic selection is supported by data with an opportunity for improvement, and the study population and study indicators are defined accurately.
- 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' 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 identify and document new barriers that have prevented improvement in PIP outcomes and must develop new or revised interventions to better address high-priority barriers associated with lack of improvement.
- The health plans must implement active, evidence-based, innovative interventions to improve study indicator outcomes.
- The health plans must evaluate the effectiveness of each intervention throughout the measurement period and document the findings in the PIP Submission Form. Additionally, rather than relying on study indicator data to determine effectiveness, the evaluation process for each intervention must identify the individual impact of that intervention on the study indicator rate. In addition to qualitative data, the health plans must provide quantitative data for intervention evaluation.
- The health plans must consider using QI science techniques such as Plan-Do-Study-Act (PDSA) as part of improvement strategies. Interventions may be tested on a small scale, evaluated, and then fully implemented if deemed successful.
- The health plans must address HSAG's feedback in next year's annual PIP submission.
- The health plans must request technical assistance from HSAG, as needed.
- The health plans should apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

Network Adequacy

Statewide Results

Table 4-10 and Table 4-11 display the number of provider categories meeting the time/distance standards by health plan statewide and by urbanicity, respectively.

Table 4-10—Statewide Compliance With Time/Distance Standards by Health Plan

Health Plan	Statewide		
	Number of Provider Categories	Within Time/Distance Standard*	Within Time/Distance Standard (%)
ACO			
Health Choice	56	29	51.8%
Healthy U	56	46	82.1%
Molina	56	35	62.5%
SelectHealth	56	37	66.1%
MCO			
HOME	62	52	83.9%
CHIP MCO			
Molina CHIP	60	35	58.3%
SelectHealth CHIP	60	38	63.3%
PMHP*			
Bear River	5	0	0.0%
Central	5	0	0.0%
Davis	5	0	0.0%
Four Corners	5	0	0.0%
Northeastern	5	0	0.0%
Salt Lake	5	0	0.0%
Southwest	5	0	0.0%
Utah County	5	0	0.0%
Valley	5	0	0.0%
Wasatch	5	0	0.0%
Weber	5	4	80.0%
Dental PAHPs			
MCNA	2	2	100.0%
Premier	2	0**	0.0%
CHIP Dental PAHP			
Premier CHIP	2	0**	0.0%

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

**The Premier PAHP contracts did not state a specific requirement for rural and frontier areas; the standard in the urban areas (i.e., at least two dental providers within 40 miles of each enrollee's residence) was assessed in this analysis.

Table 4-11—Compliance With Time/Distance Standards by Health Plan and Urbanicity

Health Plan	County Classification								
	Frontier			Rural			Urban		
	Number of Provider Categories	Within Time/ Distance Standard* (%)	Within Time/ Distance Standard (%)	Number of Provider Categories	Within Time/ Distance Standard*	Within Time/ Distance Standard (%)	Number of Provider Categories	Within Time/ Distance Standard*	Within Time/ Distance Standard (%)
ACO									
Health Choice	56	49	87.5%	56	34	60.7%	56	29	51.8%
Healthy U	56	49	87.5%	56	41	73.2%	56	48	85.7%
Molina	56	26	64.3%	56	37	66.1%	56	27	66.1%
SelectHealth	56	42	75.0%	56	38	67.9%	56	42	75.0%
MCO									
HOME	62	53	85.5%	62	38	61.3%	62	52	83.9%
CHIP MCO									
Molina CHIP	60	19	31.7%	60	36	60.0%	60	39	65.0%
SelectHealth CHIP	60	35	58.3%	60	39	65.0%	60	42	70.0%
PMHP									
Bear River	5	4	80.0%	5	4	80.0%	5	0	0.0%
Central	5	4	80.0%	5	4	80.0%	5	0	0.0%
Davis	5	4	80.0%	5	0	0.0%	5	0	0.0%
Four Corners	5	4	80.0%	5	4	80.0%	5	0	0.0%
Northeastern	5	4	80.0%	5	0	0.0%	5	0	0.0%
Salt Lake	5	2	40.0%	5	0	0.0%	5	4	80.0%
Southwest	5	2	40.0%	5	2	40.0%	5	0	0.0%
Utah County	5	0	0.0%	5	0	0.0%	5	0	0.0%
Valley	5	4	80.0%	5	4	80.0%	5	0	0.0%
Wasatch	5	0	0.0%	5	0	0.0%	5	0	0.0%
Weber	5	4	80.0%	5	4	80.0%	5	4	80.0%
Dental PAHPs									
MCNA	2	2	100.0%	2	2	100.0%	2	2	100.0%
Premier	2	0	0.0%	2	1	50.0%	2	2	100.0%
CHIP Dental PAHP									
Premier CHIP	2	0	0.0%	2	1	50.0%	2	2	100.0%

Overall time/distance results are summarized below:

- Statewide, the ACOs ranged from 51.8 percent (Health Choice) to 82.1 percent (Healthy U) of the assessed provider categories meeting the time/distance standards. The results for HOME were similar to the ACOs, with 61.3 percent of the assessed provider categories meeting the time/distance standards.
  - All ACOs encountered challenges in meeting the time/distance standards for the pediatric specialty providers.
  - Healthy U was the only ACO wherein members in every county had access to mammography providers within the time/distance standards.
- Statewide, Molina CHIP and SelectHealth CHIP met the time/distance standards for 58.3 percent and 63.3 percent of the provider categories, respectively.
  - Both Molina CHIP and SelectHealth CHIP had challenges meeting the time/distance standards for the pediatric specialty providers.
  - General hospitals with a psychiatric unit were not identifiable in the provider data for either Molina CHIP or SelectHealth CHIP, which could indicate either a lack of available providers or, more likely, an inability to consistently identify those providers in the submitted provider data.
- The PMHPs struggled to meet the statewide time/distance standards because in order to meet the standards, the plans had to meet the requirements for members residing in urban, rural, and frontier areas. While the health plans generally did well meeting the requirements in one or two urbanicities, they often struggled to maintain the standard in all three usually due to a low number of members in one urbanicity.
- MCNA maintained a network of providers that met the time/distance standards for the provider categories assessed. The provider networks for Premier and Premier CHIP met the time/distance standards in urban counties.

Statewide Conclusions and Recommendations—Network Adequacy

The development of the provider crosswalks and the baseline NAV are the first steps in preparing for future and continuing network adequacy analyses. As part of the process of conducting these baseline analyses, HSAG distributed the provider Data Structure Questionnaire to the health plans. The questionnaire highlighted differences in the methods being used to collect and store provider data. The findings from the provider Data Structure Questionnaire also highlighted the inconsistent collection and use of some crucial fields in the provider data (i.e., provider type and provider specialty). While the provider Data Structure Questionnaire identified some inconsistencies in data collection and storage, it also highlighted that all health plans are doing some monitoring and maintenance of the provider data regularly.

HSAG collaborated with UDOH to build provider crosswalks, which describe how to identify a variety of providers in the following categories: PCPs, specialists, behavioral health providers, healthcare

facilities, and dental providers. Provider categories were identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree. HSAG submitted the crosswalks to UDOH separately from this report.

In using the crosswalks to conduct the NAV, HSAG found that, in general, members had access to the provider categories within the time/distance standards. Across the health plans, access to pediatric specialty providers was limited, which may be due to an inability to identify pediatric providers in the selected data. Additionally, some provider categories were not noted in the provider data, such as general hospitals with a psychiatric unit in the MCO CHIP data. This may be due to the inability to confirm the presence of a psychiatric unit at the hospitals from the available data.

The first NAV analysis will set a baseline for future analyses to ensure that provider categories can be assigned consistently across UDOH and the health plans. As the first comprehensive investigation into the health plans' provider networks, the current study established a foundation on which UDOH can build robust managed care network adequacy expectations and processes for overseeing the health plans' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight based on the findings detailed in this report:

- To facilitate future network adequacy validation, UDOH should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the health plans.
- While developing the provider crosswalks, HSAG identified health plans' lack of consistent use of the provider type and provider specialty fields and UDOH's lack of consistent use of taxonomy codes. UDOH should collaborate with the health plans to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's provider crosswalk development identified numerous spelling variations and/or use of special characters for the health plans' data values for provider type, specialty, and credentials. The health plans should assess available data values in their provider data systems and standardize available data value options.
- UDOH should conduct an in-depth review of provider categories for which no health plans met the time/distance standards, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Future analyses should evaluate the extent to which health plans have requested exemptions from UDOH for provider categories for which providers may not be available or willing to contract with UDOH.
- As the time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, UDOH should consider using appointment availability surveys to evaluate providers' availability. HSAG also recommends incorporating encounter data to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.

5. Assessment of Health Plan Follow-up on Prior Year's Recommendations

Medicaid ACOs Providing Physical Health Services

Steward Health Choice Utah

Compliance Monitoring

In CY 2018, HSAG was on-site at Health Choice to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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 areas of coverage and authorization of services, access and availability, member rights and information, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based 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, HSAG identified ongoing required actions related to member information, which were not adequately addressed and required a continuing CAP. In 2019, HSAG also conducted a review of initial credentialing records for new providers and found Health Choice to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Health Choice focus improvement efforts on the following:

- Increasing screenings for women (breast cancer, cervical cancer, and chlamydia)
- Care for women following delivery
- Required well-care 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

In 2019, Health Choice reported that it implemented the following quality initiatives as a result of HSAG's CY 2018 recommendations:

Increasing screenings for women (breast cancer, cervical cancer, and chlamydia):

- Performance improvement coordinators (PICs) called all members with breast cancer and cervical cancer "gaps in care" and offered assistance to schedule an appointment for a mammogram/Pap.

- PICs educated providers on the importance of recommending cancer screenings.
- PICs delivered "gap lists" including breast cancer screening (BCS), cervical cancer screening (CCS), and chlamydia screening gaps to all participating providers every month.
- PICs recommended to providers that they implement a "urine catch" procedure that would include a chlamydia test as a standard part of well checks for adolescents and young adults.
- PICs set up a process with the Health Choice Clinical Services team in which PICs are notified when a member delivers a baby; the PIC then calls the member's OB/GYN 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.
- PICs coordinated a mobile mammogram event in St. George to provide mammograms for members in the southern part of the State.

Care for women following delivery:

- All members are contacted at two weeks postpartum by the maternity nurse case manager. Members are asked how they are feeling physically; about pain control; and about follow-up appointments, family planning, and postpartum depression. Members are asked how the baby is doing and if the member has attended follow-up appointments. Members are provided with resources and information as needed. Health Choice also follows up with the providers to ensure that a four-to-six-week postpartum visit has been completed and works with the member to schedule one if necessary.

Required well-care visits for infants and young children:

- PICs called the parents or guardians of all members without well-care visits and offered assistance to schedule an appointment for a well-care visit.
- PICs 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).
- PICs delivered "gap lists" that included infant and child well-care visit "gaps" to all participating providers every month.

Documentation of 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 electronic health records (EHRs) 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 EHR and provided the practice with information about compliant documentation.

Appropriate management of conditions for members with diabetes and high blood pressure:

- Health Choice reported actively developing a disease management program for various conditions including diabetes and high blood pressure. The diabetes program was scheduled to begin in January 2020. Members will be screened for risk level and receive interventions based on acuity, which may include education information, a tracking booklet, and personalized case management. Health Choice is using community resources such as chronic disease self-management programs. The Health Choice website will be updated to include disease management information with links to request a case manager.

Validation of Performance Improvement Projects

The health plan submitted a new PIP topic in CY 2019; therefore, HSAG could not determine whether the health plan addressed HSAG's recommendations based on the previous year's PIP topic.

Healthy U

Compliance Monitoring

In CY 2018, HSAG was on-site at Healthy U to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based 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 ongoing required actions related to coverage and authorization of services, access and availability, member information, and provider participation and program integrity, which were not adequately addressed and required a continuing CAP. In 2019, HSAG also conducted a review of initial credentialing records for new providers and found Healthy U to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Healthy U focused improvement efforts on increasing screenings for women (breast cancer, cervical cancer, and chlamydia); care for women following delivery; required well-care visits for infants and young children; eye exams for members with diabetes; and ensuring that members on antidepressant medications are compliant with their medications. In CY 2019, Healthy U reported the following initiatives to increase screenings for women.

Breast and Cervical Cancer Screening:

- Healthy U conducted outreach to members and providers to increase compliance rates with the HEDIS *BCS* and *CCS* measures. Using HEDIS prospective data, University of Utah (U of U) Health Plans identified women ages 21 through 74 years who were due for cervical cancer and/or breast cancer screening. Women in the 50 to 74 age range received reminder letters for both BCS and CCS. Women in the 21 to 49 age range received reminder letters for CCS. PCPs received a list of their patients who were overdue for these exams and were encouraged to contact these members to schedule appointments.

Diabetic Eye Exams:

- Healthy U also conducted 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 eyecare provider. The member letter also contained a Diabetic Eye Exam Communication Form that members could take to their eyecare provider. The form instructed the member and the eyecare 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.

Well-Care Visits:

- U of U Health Plans offered the parents/guardians of children turning 3, 4, 5, or 6 years of age a $25 Target gift card for receiving a well-child visit during 2019. Postcards were sent to members informing them of this initiative and encouraging them to schedule the exam. Providers received a list of their patients who had not yet had a well visit during 2019 and were encouraged to reach out to those members to schedule appointments.

Medication Compliance for Members on Antidepressants:

- U of U Health Plans is partnering with the University Health System to implement a pilot project aimed at improving care for high-risk members. Depression is one of the conditions included in the population health risk model. A central component of this pilot will be a pharmacist-led medication adherence initiative, with pharmacists providing direct outreach to patients.

Care for women following delivery:

- U of U Health Plans makes outreach calls to all pregnant Healthy U members to identify high-risk pregnancies for referral into our U Baby Care Management program. Women identified for the program are followed 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. Reminder letters were also mailed to all women who delivered while enrolled in Healthy U (regardless of risk status) to encourage postpartum visits.

Validation of Performance Improvement Projects

Healthy U's *Asthma Medication Management* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified the opportunity to improve study indicator outcomes. In the 2019 final PIP submission, Healthy U's study outcomes did not demonstrate statistically significant improvement over the baseline.

Molina Healthcare of Utah

Compliance Monitoring

In CY 2018, HSAG was on-site at Molina Healthcare of Utah to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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 of services, member information, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based 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, the grievance and appeal system, and provider participation and program integrity which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found Molina to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Molina focus improvement efforts on increasing required well-care visits for children ages 3 to 6; increasing screenings for women (breast cancer, cervical cancer, and chlamydia); care for women following delivery; required well-care visits for infants and young children; eye exams for members with diabetes; and appropriate management of low back pain. In 2019, Molina Healthcare reported the following initiatives to address these recommendations:

Pregnancy Rewards Program:

- Member Intervention:
  - Molina mailed members identified as pregnant a flyer to encourage a prenatal exam with a provider within the first trimester of pregnancy.
  - After members delivered, Molina sent them a flyer encouraging them to see their provider for a postpartum exam within one to 12 weeks following delivery. Members who submit a flyer signed by their provider are sent a $40 incentive.

- Program improvements:
  - Molina added interactive voice response (IVR) calls to inform members of the Pregnancy Rewards program and that they may now view and print flyers from Molina's website at their convenience.

Mothers of Molina Program:

- Member Intervention**:**
  - A nurse practitioner now completes in-home postpartum visits. The visit also includes an educational packet.
- Program improvements:
  - Molina now provides members with a diaper voucher and a copy of the $40 Pregnancy Reward flyer to mail in for redemption.

Well-Child Visits in the First 15 months of Life (W15) Well-Child Check Incentive Mailing:

- Member intervention:
  - Molina sent incentive flyers monthly to all members ages 10 and 11 months of age to encourage well-child checks. Molina offered a $40 gift card to complete all six well-child exams by 15 months of age.
- Program improvements:
  - Molina began the *W15* member-focused incentive program in 2019. Providers also supported and executed this intervention through the Medicaid Pediatric Quality Partner Bonus Program.

BCS Incentive Mailing:

- Member Intervention:
  - Molina mailed incentive flyers to members to encourage completion of their mammogram and offered a $40 incentive.
- Program improvements:
  - In addition to offering the mailing, Molina called members to inform them of the incentive and to assist with scheduling if needed. Providers also supported and executed this intervention through the Provider Engagement: Value Based Contracting (VBC) Program.

Comprehensive Diabetes Care (CDC) Eye Incentive Mailing:

- Member Intervention:
  - Molina mailed incentive flyers to members with diabetes to encourage a dilated eye exam and offered a $40 incentive.
- Program Improvements:

- Providers also supported and executed this intervention through the Provider Engagement: VBC Program.

Case Management—Pain Management Program:

- Member Intervention:
  - Molina administers an annual health risk assessment to members once they are engaged in Molina's Case Management program, and the HRA includes a question regarding pain. If members mention during the HRA that they are experiencing pain, Molina administers an additional subset of questions related to pain (rating, location, etc.). Molina supports members experiencing low back pain issues through this program.
- Program Improvements:
  - Molina provides members identified with pain issues (including low back pain) during the HRA or other case management activities a separate assessment focused specifically on pain, which Molina uses to develop an individualized care plan to address pain management.

Molina Healthcare Inc. Corporate Incentives/Opioid Use Disorders:

- Member intervention: Molina's Opioid Use Disorder Program focuses on:
  - Identifying where member groups access opioid use disorder care and why/why not.
  - Locating gaps in access to care.
  - Strengthening relationships with providers by offering additional coordination support.
  - Adding specialty network providers.
  - Partnering with community groups or other stakeholders to strengthen community initiatives to address substance abuse and misuse.
- Molina uses opioid use disorder criteria to determine program eligibility. Members must opt into the program. Screening and case management tools, member-driven interventions, as well as an assigned SUD navigator/case manager are all components of the program. Both the provider network and the community offer resources to members.
- Program Improvements:
  - This program was introduced in mid-2019 and thus far has been successful in managing members with pain (low back pain) and opioid use disorders. The program supports the pain management program listed above by monitoring those at risk for opioid use disorder.

Care Connections:

- Member Intervention:
  - Care Connections nurse practitioners perform in-home assessments for HEDIS "gap" closures on CDC, which includes a diabetic eye exam.

- Program Incentives: This intervention is also supported and executed through the CDC Eye Incentive program.

Validation of Performance Improvement Projects

Molina's *Breast Cancer Screening for Women Ages 50–74* PIP received a *Met* score for 91 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified the opportunity to improve study indicator outcomes. In the 2019 final PIP submission, Molina's study outcomes did not indicate sustained improvement over the baseline.

SelectHealth Community Care

Compliance Monitoring

In CY 2018, HSAG was on-site at SelectHealth Community Care to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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 coverage and authorization of services, access and availability, member information, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based 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 ongoing required actions related to member information, the grievance and appeal system, and provider participation and program integrity, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found SelectHealth to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In 2018 HSAG recommended targeted improvement efforts focused on increasing screenings for women (breast cancer, cervical cancer, and chlamydia) and well-care visits for children ages 3 to 6. In CY 2019, SelectHealth reported having implemented the following quality initiatives:

Well-care visits for children ages 3 to 6 years:

- SelectHealth used a vendor that conducted IVR calls to remind parents of children on Medicaid who are ages 3 to 6 that their child was due for an annual well-exam with their PCP. This outreach included an appointment-scheduling reminder call for those members who had a well exam in the prior year, a well exam education call for those who did not have a visit in the prior year, and an end of the year "gap-in-care" call for those who had not yet had a visit in the measurement year.

- In 2019, SelectHealth's IVR vendor added a digital consent capability to allow SelectHealth to collect member phone numbers and email addresses for those who opt in to receiving digital reminders. This gave members the option to receive future reminders in their preferred mode of communication.
- In CY 2019, SelectHealth reported that it was creating a well-child exam schedule that includes tests and vaccines that will be used in a reminder mailing in 2020.

Cervical Cancer and Chlamydia Screenings:

- SelectHealth conducted outreach mailings to women who had "gaps" in care that included a Women's Health Brochure. Outreach also included IVR reminder calls, prevention education calls, and "gap in care" calls. The provider outreach program provided monthly Women's Preventive Health Reports. It included the women for each of the providers who have "gaps" in breast cancer screening, cervical cancer screening, chlamydia screening, or colorectal cancer screening and have a birthday coming up the following month.

Breast Cancer Screening:

- SelectHealth's outreach mailings to members included a brochure that includes phone numbers for all contracted imaging centers and research-based information about why it was important to get screened.
- SelectHealth coordinated live outbound calls to all members who were due for a mammogram.
- SelectHealth provided OB/GYN providers with a monthly cancer screening report that told them which patients were due for a mammogram.
- SelectHealth's Medical Home department performed provider outreach to those providers enrolled in SelectHealth to offer reimbursement rates and intervention suggestions for patient outreach.

Validation of Performance Improvement Projects

SelectHealth' s *Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the study outcomes. In the 2019 final PIP submission, the health plan addressed HSAG's recommendation and documented a statistically significant improvement over the baseline in the study indicator outcome.

MCO Providing Both Physical and Mental Health Services for Individuals With Developmental Disabilities and a Mental Illness

Healthy Outcomes Medical Excellence (HOME)

Compliance Monitoring

In CY 2018, HSAG was on-site at HOME to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. HOME scored well in many standard areas. Following the review, HOME 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 information, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based follow-up review of HOME's CAP during which HOME 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, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found HOME to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that HOME outline and clearly define the parameters used for reporting performance measures to ensure compliance with each component of the measure specifications. HSAG also recommended that HOME perform comprehensive data validation activities internally to confirm that all issues are corrected prior to submitting data to the State. In CY 2019, HOME reported the following improvement initiatives:

- HOME has introduced comprehensive internal audits of collected data between its case management team (who collect and document data) and its data team who check, validate, and manage reporting.
- HOME verified the data entered in the "Hospital Tracking" spreadsheet with medical records in EPIC (HOME's EHR) System. HOME matched the admit, discharge, and follow-up dates entered into the spreadsheet with information documented in EPIC.
- HOME confirmed member demographic information and eligibility for qualifying follow-up visits in EPIC.
- In addition, HOME reported that it cross-checked the collected data with submitted claims. HOME further matched all documented follow-up visits with Current Procedural Terminology (CPT) codes and dates of service on the claims for accuracy, which facilitated that only qualifying events within specified time parameters for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure

indicators were reported. The final spreadsheet submitted for review included associated CPT codes and claims IDs.

Validation of Performance Improvement Projects

HOME's *Impact of clinical and educational interventions 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 2018 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

PMHPs Providing Mental Health Services

Bear River Mental Health Services

Compliance Monitoring

In CY 2018, HSAG was on-site at Bear River Mental Health Services to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based 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 identified ongoing required actions related to coverage and authorization, member information, and provider participation and program integrity, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Bear River focus improvement efforts on ensuring that members receive a Bear River-furnished service within 30 days following discharge from a hospitalization. Additionally, HSAG recommended that Bear River create a member-level detail file for each reporting period that contains a snapshot of the data used for performance indicator reporting. In 2019, Bear River Mental Health (BRMH) reported the following improvement initiatives:

- Implementing programming changes based on the change to the required specifications and automating retrieval of the data.

- The HEDIS report being reviewed monthly by the BRMH Executive Committee, clinical supervisors, and IT.
- Clients being scheduled for an appointment with BRMH before or during hospital discharge. The appointment information in the system indicates that the client was a hospital discharge. If the client failed to make the appointment, support staff notified the case manager assigned to hospital discharges. The case manager attempts to engage the client within 24 hours. The case manager keeps the client's treatment team informed of client contact information.
- If the case manager could not contact the client or the client's therapist, the case manager would go to the client's residence and would make every effort to engage the client in BRMH's 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 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the narrative interpretation of results. In the final 2019 PIP submission, the health plan continued to have deficiencies in the narrative interpretation of the data.

Central Utah Counseling Center

Compliance Monitoring

In CY 2018, HSAG was on-site at Central Utah Counseling Center to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Central scored well in many standard areas. Following the review, Central completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and the grievance and appeals system. In CY 2019, HSAG conducted a webinar-based follow-up review of Central's CAP during which Central demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. HSAG found that Central had successfully implemented its required actions and did not have any further required corrective actions. In CY 2019 HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In 2018 HSAG recommended that Central implement additional automated functions in the measure calculation and reporting process (e.g., conditional formatting in the MS Excel spreadsheet) to ensure the accuracy for measure rate reporting. In CY 2019, Central reported the following improvement initiatives:

- Central added a formula to calculate the number of days from *Discharge* to the *Date Appointment Kept*.
- Central also added conditional formatting to color-code the time frame results: green for 0–7 days, yellow for 8–29 days, and red if the value was more than 30 days. The changes have assisted Central to clearly identify and calculate the HEDIS performance measure.

Validation of Performance Improvement Projects

Central's *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the study outcomes. In the 2019 final PIP submission, the health plan addressed HSAG's recommendation and sustained a statistically significant improvement over the baseline in the study indicator outcomes.

Davis Behavioral Health

Compliance Monitoring

In CY 2018, HSAG was on-site at Davis Behavioral Health to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Davis scored well in many standard areas. Following the review, Davis completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and the grievance and appeal system. In CY 2019, HSAG conducted a webinar-based follow-up review of Davis' CAP during which Davis 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, which were not adequately addressed and required a continuing CAP. In CY 2019 HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Davis implement additional quality checks and create a detailed procedure document to ensure that all performance measure calculation steps are followed to comply with required specifications for measure reporting. In CY 2019, Davis reported the following improvement initiatives:

- Changing Davis' PMV process from a manual calculation to an automated report generated directly from the EHR to include the following features:
  - The EHR generates data based on PMV specifications received from HSAG using data available and integrated in the EHR.
  - Data are then reviewed by Davis' staff for accuracy prior to submission.

- The EHR report is called "HSAG Dashboard," and it consists of four components to calculate the numerator and denominator.
- The dashboard shows both the aggregate numbers as well as the details that verify the episodes of care and clients.
- The numerator shows follow-up visits within seven and 30 days grouped by age.
- The denominator shows the number of total episodes also grouped by age.
- All reports are written in SQL.

Validation of Performance Improvement Projects

Davis' *Suicide Prevention* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified an opportunity to improve study indicator outcomes for Study Indicator 2. In the 2019 final PIP submission, Davis did not demonstrate statistically significant improvement over the baseline for Study Indicator2.

Four Corners Community Behavioral Health

Compliance Monitoring

In CY 2018, HSAG was on-site at Four Corners Community Behavioral Health to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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 coverage and authorization of services, access and availability, member information, and the grievance and appeal system. In CY 2019, HSAG conducted a webinar-based follow-up review of Four Corners' CAP during which Four Corners 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 access and availability, and member information, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found Four Corners to be fully compliant related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Four Corners focus improvement efforts on ensuring that members receive a Four Corners-furnished service within seven days and 30 days following discharge from a hospitalization. With regard to measure calculations, HSAG recommended that Four Corners consider using a single tracking mechanism to avoid possible data entry errors or missing data and to ensure appropriate reconciliation. HSAG also recommended that Four Corners cross train additional

staff to perform measure calculation to ensure that appropriate oversight and quality checks are in place. In CY 2019, Four Corners reported the following improvement initiatives:

- Four Corners evaluated the hospital discharge process in use during the reporting time frame. Four Corners retains a Hospital Liaison position who is responsible for the admission and discharge of all members assigned to Four Corners' coverage area. One of the functions of the Hospital Liaison position is to ensure timely access to services that meet the HEDIS standard of seven- and 30-day follow-up care. This evaluation concluded that some discharges were occurring without the involvement of the Four Corners Hospital Liaison. Four Corners formalized the process for discharging clients from the hospital and began to require that all hospital discharges involve the Four Corners hospital liaison, to ensure that all necessary requirements relating to discharges are met.
- Prior to 2018, Four Corners used two separate spreadsheets for tracking hospitalization admission and discharge information for performance measure calculation. Beginning in reporting year 2018, Four Corners used a single tracking spreadsheet for measure calculation as recommended in the prior year's recommendations.
- Four Corners added a column to the tracking spreadsheet to monitor a service provided within the seven-day as well as the 30-day time frame.
- Four Corners uses the tracking spreadsheet on Mondays and Thursdays to monitor discharges and services rendered and contacts hospitals to get pending discharge dates and request discharge paperwork.
- Four Corners monitors treatment schedules of those providers assigned to specific members to see if a service was provided as scheduled. If not, Four Corners emails the clinic director, provider, and front office staff to request that the client be contacted, and status confirmed.
- As part of the 2018 measurement calculation, Four Corners began to cross train an additional staff member on the process for measure calculation. After the initial staff member completed the measure calculation, the newly trained staff member replicated the same measure calculation procedure using the Four Corners hospitalization/discharge tracking spreadsheet.

Validation of Performance Improvement Projects

Four Corners' *Suicide Prevention* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the narrative interpretation of results, evaluation of interventions, and Study Indicator 2 outcomes. In the final 2019 PIP submission, Four Corners addressed all of HSAG's recommendations and documented achievement of statistically significant improvement over the baseline for both study indicators.

Northeastern Counseling Center

Compliance Monitoring

In CY 2018, HSAG was on-site at Northeastern Counseling Center to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Northeastern scored well in many standard areas. Following the review, Northeastern completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and the grievance and appeal system. In CY 2019, HSAG conducted a webinar-based follow-up review of Northeastern's CAP during which Northeastern demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. HSAG found that Northeastern had successfully implemented its required actions and did not have any further required corrective actions. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Northeastern implement additional quality checks to ensure that all discharge dates are captured according to the measure specification criteria. Additionally, HSAG did not find evidence that members under the age of 6 were included in Northeastern' s reported rates; therefore, HSAG also recommended that Northeastern update its *Follow-Up After Hospitalization for Mental Illness (FUH)* reporting spreadsheet to include a date of birth column to ensure the appropriate member population is captured. Finally, to further ensure accuracy of reported rates, HSAG recommended that Northeastern implement a final verification step to its process wherein a designated staff member initials/approves the calculated rates prior to submission. In CY 2019, Northeastern reported the following improvement initiatives:

- The spreadsheet used to generate the measures had an age column and formula that used the enrollee's birth date and discharge date to determine age at discharge. If a child was to be included at age 4 or 5 at the time of discharge, Northeastern changed the field to show the member excluded and removed from the eligible population.
- For many years, Northeastern has had a two-step verification process in which the clinical director performs the final check and submits the report. This included double checking each data field used for calculations prior to submission. Support staff completed the first stage and then submitted the data to the clinical director to complete final checks and submission. Northeastern agreed to add a documentation process to demonstration performance of its two-step process.

Validation of Performance Improvement Projects

Northeastern' s *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified an opportunity to improve study indicator outcomes. In the final 2019 PIP submission, Northeastern documented achievement of statistically significant improvement for both study indicators.

Salt Lake County Division of Mental Health

Compliance Monitoring

In CY 2018, HSAG was on-site at Salt Lake County Division of Mental Health to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Salt Lake scored well in many standard areas. Following the review, Salt Lake 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 information, grievance and appeal system, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based follow-up review of Salt Lake's CAP during which Salt Lake demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. HSAG found that Salt Lake had successfully implemented its required actions and did not have any further required corrective actions. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found Salt Lake to be fully compliant related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Salt Lake focus improvement efforts designed to ensure that members receive a Salt Lake-furnished service within seven days and 30 days following discharge from a hospitalization. With regard to measure calculations, HSAG recommended that Salt Lake implement additional quality checks to ensure that all measure calculation steps are followed to comply with specifications for measure reporting. HSAG also recommended that Salt Lake and Optum increase oversight of Valley Behavioral Health (VBH)—a contracted provider of services—in the future to ensure that Valley monitors its providers for timely provider registration with the State. In CY 2019, Salt Lake reported the following improvement initiatives:

- On July 8, 2019, Optum/Salt Lake created a new Care Coordination Specialist position to promote communication between Optum/Salt Lake and its provider network to enhance the clinical experience of Optum/Salt Lake Medicaid members. The program worked within current organizational processes to ensure optimal collaboration between Optum/Salt Lake, the provider network, Accountable Care Organizations, other community stakeholders, and Optum/Salt Lake Medicaid members. The goal was to ensure adequate linkage to the most appropriate resources

available to members in support of their behavioral health recovery and engagement in treatment. The Care Coordination Specialist position can manage concerns related to inpatient discharge and disposition planning by performing outreach to members and/or providers to facilitate linkage to appropriate resources within clinically appropriate guidelines, which may be needed sooner than seven days after hospitalization.

- Since July, the care coordination specialist and Optum/Salt Lake leadership have met with all inpatient providers to outline the expectations of the new role and identified opportunities for enhanced collaboration.
- The care coordination specialist has also attended meetings to initiate connections with the following groups or entities: Optum/Salt Lake Provider Advisory Committee, Optum/Salt Lake/VBH Leadership Meeting, Mental Health Court Advisory Committee, UNI Crisis Team, Salt Lake County Mental Health Commitment Court, Crisis Response Services with Salt Lake City Police Department, Volunteers of America Assertive Community Treatment (ACT) Advisory Group, Salt Lake County Coordinating Council for Substance Use Treatment Providers, Wasatch Pediatrics Behavioral Health Integration Community Collaborative, Alliance House, Optum/Salt Lake, School Districts Collaboration Meeting, 4th Street Clinic, and specific in-network providers.
- An additional initiative of the care coordination specialist in fiscal year (FY) 2020 has been working with larger providers to implement Critical Time Intervention (CTI), a person-centered case management model that initiates linkage with Optum/Salt Lake members while in a hospital setting. At the time of Salt Lake reporting on this initiative, one provider had adopted this program, and three others were scheduled to be trained in January 2020. This model has been shown to be superior to other case management models in reducing recidivism and helping members moving from an institutional setting back into community settings.
- The Reporting/Analytics Team has reviewed all criteria applied to the performance measurements and created checks on each data element and calculation.

To increase oversight of Valley Behavioral Health to ensure timely provider registrations with the State, Salt Lake reported the following improvement initiatives:

- IT/Claims and Network departments met with the VBH Billing Team in January 2019 to set up a fixed schedule of roster updates.
- VBH agreed to send weekly updates on new employees with approved Provider Reimbursement Information System for Medicaid (PRISM) (Medicaid) registrations.
- The Optum/Salt Lake Network Team agreed to review these employees within MMCS and DOPL. If the employee is current and the file has been updated, the Network Team would update within MyAvatar within five working days of the submission.
- The Optum/Salt Lake Network Team would then notify the VBH Billing department of the update or provide feedback as to why the employee's information was not able to be updated (i.e., PRISM not matching MMCS).

Validation of Performance Improvement Projects

Salt Lake' s *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the study indicator outcomes. In the final 2019 PIP submission, Salt Lake did not demonstrate statistically significant improvement for Study Indicator 2.

Southwest Behavioral Health Center

Compliance Monitoring

In CY 2018, HSAG was on-site at Southwest Behavioral Health Center to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Southwest scored well in many standard areas. Following the review, Southwest 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 information, grievance and appeal system, and provider participation and program integrity. In CY 2019, HSAG conducted a webinar-based follow-up review of Southwest's CAP during which Southwest 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, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Southwest assess its process for documenting eligibility begin and end dates in its transactional system and develop a protocol for ensuring that members' actual Medicaid enrollment dates are used for reporting. Additionally, HSAG recommended that Southwest create written procedures to define this process for all staff involved with documenting and editing enrollment dates in the PMHP's system of record (i.e., Credible). HSAG also recommended that Southwest modify the process for collecting the reported data to align exactly with each component of the measure specifications and criteria and provide additional training to staff members who record data for reporting. In CY 2019, Southwest reported the following initiatives:

- To ensure the highest level of accuracy in eligibility documentation within its EHR, Southwest's engagement and eligibility staff regularly reviewed client Medicaid eligibility and ensured that the Medicaid eligibility of all newly opened clients is recorded within the EHR, with a start date noted as the first day of admission or the first date of the retroactive month for pre-admission services.

- Southwest reported this to be the new standard practice and that it is outlined in staff training materials. While the revised process differs slightly from the recommendation of the prior year, in CY 2019 HSAG found this documentation process to be in line with contractual expectations.

Validation of Performance Improvement Projects

Southwest' s *Suicide Prevention* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Valley Behavioral Health

Compliance Monitoring

In CY 2018, HSAG was on-site at Valley Behavioral Health to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Valley scored well in many standard areas. Following the review, Valley 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 information, grievance and appeals system, program integrity, delegation subcontracts, and quality assessment and performance improvement (QAPI). In CY 2019, HSAG conducted a webinar-based follow-up review of Valley's CAP during which Valley 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. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found Valley to be fully compliant related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Valley implement more rigorous quality checks for performance measure reporting to the State beyond the built-in system validation. This would help ensure that staff members at different locations follow processes consistently and increase communication of potential data errors between staff to ensure accuracy of final reporting to the State. HSAG also recommended that Valley ensure that all providers be appropriately registered with the State to ensure that encounters are accepted and members receive services from registered providers. In CY 2019, Valley reported the following initiatives:

- Valley created tracking sheets which monitored the utilization management/utilization review (UMUR) activities and subcontractors to make sure Valley had the information and chart updates in line with regulations.

- Valley held weekly UMUR meetings. Valley created a new UMUR channel in the organization's *Slack* messaging system, which keeps Valley apprised regarding Tooele County UMUR issues.
- Valley ensured that all providers were enrolled in Medicaid internally through the credentialing process. This process was reviewed several times per year and annually with the credentialing audit of Valley's credentialing delegate, Precision Credentialing.
- Valley implemented an annual internal audit of the Human Resources (HR) department, and the audit contained a credentialing component.
- The Revenue Cycle department completed checks to ensure that subcontractors were enrolled as Medicaid providers, and if not, the claims submitted were not adjudicated.

Validation of Performance Improvement Projects

Valley' s *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities to improve study outcomes. In the final 2019 PIP submission, Valley achieved study outcomes for all the applicable study indicators in both Tooele and Summit counties.

Wasatch Mental Health

Compliance Monitoring

In CY 2018, HSAG was on-site at Wasatch Mental Health to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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 coverage and authorization of services, member information, grievance and appeal system, and provider participation and program integrity. In CY 2019, HSAG conducted a webinar-based 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 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. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Wasatch apply any readmission filtering prior to reviewing cases for diagnosis and eligibility to ensure accuracy of performance measure rate reporting. In CY 2019, Wasatch reported the following improvement initiative:

- Wasatch applied readmission filtering to SQL queries to exclude readmissions that occurred within the time limit indicated in the performance measure. Subsequent performance measure data were included in this filtering.

Validation of Performance Improvement Projects

Wasatch' s *Suicide Prevention* PIP received a *Met* score for 65 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the documentation of measurement periods, narrative interpretation of data, factors affecting comparability of data, description of the team's causal/barrier analysis process and QI tools used to identify causes and barriers, prioritization of barriers, and improvement in Study Indicator 2 outcomes. In the final 2019 PIP submission, Wasatch addressed most of the prior years' recommendations; provided an accurate narrative interpretation of results, comparability of data, and completion of an annual causal barrier process; and processes for evaluation of interventions for effectiveness. The PIP documentation, however, continued to have deficiencies in documentation of the barrier prioritization process. Additionally, Wasatch achieved statistically significant improvement in Study Indicator 1 but did not demonstrate statistically significant improvement in Study Indicator 2.

Weber Human Services

Compliance Monitoring

In CY 2018, HSAG was on-site at Weber Human Services to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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 areas of coverage and authorization of services, member information, grievance and appeal system, program integrity, and QAPI. In CY 2019, HSAG conducted a webinar-based 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 follow-up review, HSAG identified ongoing required actions related to member information, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2018, HSAG recommended that Weber focus improvement efforts designed to ensure that members receive a Weber-furnished service within 30 days following discharge from a hospitalization. In CY 2019, Weber reported the following improvement initiatives:

- Weber implemented a Same Day Access model. Any Medicaid member needing outpatient services, including those discharging from the hospital, could call or present in person and be scheduled with a same-day appointment for a mental health outpatient evaluation.
- In addition, Weber had a case manager assigned to the psychiatric unit of the hospital to help follow up with clients who were scheduled to seek services at Weber, post hospitalization.
- Weber also hired and trained an engagement specialist whose role is to contact all clients who do not attend their scheduled outpatient appointments.

Validation of Performance Improvement Projects

Weber's *Suicide Prevention* PIP received a *Met* score for 81 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the documentation of narrative interpretation of results, statistical analysis of data, and description of the team's causal/barrier analysis process and QI tools used to identify causes and barriers to desired outcomes. In the final 2019 PIP submission, Weber did not address prior years' recommendations, and the deficiencies in the PIP documentation continued.

PAHP Providing Substance Use Disorder Services

Utah County Department of Drug and Alcohol Prevention and Treatment

Compliance Monitoring

In CY 2018, HSAG was on-site at Utah County to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Utah County scored well in many standard areas. Following the review, Utah County 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 information, grievance and appeal system, provider participation and program integrity, and QAPI. In CY 2019, HSAG conducted a webinar-based follow-up review of Utah County's CAP during which Utah County demonstrated improvement in the 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 coverage and authorization of services, member information, provider participation and program integrity, and QAPI, which were not adequately addressed and required a continuing CAP. In CY 2019 HSAG also conducted a review of initial credentialing records for new providers and identified opportunities for improvement that prevented full compliance related to the timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In 2018, HSAG recommended that for future reporting, Utah County obtain a better understanding of the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* measure specification requirements and ensure that Utah County staff are following the State's performance measure reporting requirements and using allowable CPT codes, to be confident the performance measure rates are accurate. During 2019, Utah County reported the following improvement initiatives designed to help staff members gain a better understanding of the *IET* measure specification requirements and allowable CPT codes:

- The staff was trained to record the correct Medicaid start date in the EHR system.
- Utah County purchased and used an updated CPT code manual and trained staff on the proper CPT codes that must be used.
- Utah County defined and trained on peer support and targeted care management.
- Specialized personnel attended Utah Health Information Network (UHIN) provider training to learn correct reporting requirements.
- All newly hired staff were trained in all of the above-mentioned areas.

Validation of Performance Improvement Projects

Utah County's *Suicide Prevention* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

CHIP MCOs Providing Both Physical and Mental Health Services

Molina Healthcare of Utah

Compliance Monitoring

In CY 2018, HSAG was on-site at Molina Healthcare of Utah to conduct a full compliance review of the CHIP program, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Molina CHIP scored well in many standard areas. Following the review, Molina CHIP completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based follow-up review of Molina CHIP's CAP during which Molina CHIP 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, the grievance and appeal system,

and provider participation and program integrity, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found Molina CHIP to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In 2018, HSAG recommended for Molina CHIP to focus improvement efforts on increasing well-care visits for infants and children ages 3 to 6. During 2019, Molina CHIP reported the following improvement initiatives related to HEDIS measures:

Well-Child Visits in the First 15 months of Life (W15) Well-Child Check Incentive Mailing:

- Member intervention:
  - Molina CHIP sent monthly incentive flyers to all members ages 10 and 11 months of age to encourage their well-child checks. Molina CHIP offered a $40 gift card is offered to complete all six well-child exams by 15 months of age.
- Program improvements:
  - Molina CHIP began the *W15* member-focused incentive program in 2019. Providers also supported and executed this intervention through the Medicaid Pediatric Quality Partner Bonus Program.

Validation of Performance Improvement Projects

Molina CHIP's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the study indicator outcomes. In the final 2019 PIP submission, the study indicator rate continued to remain below the baseline.

SelectHealth CHIP

Compliance Monitoring

In CY 2018, HSAG was on-site at SelectHealth to conduct a full compliance review of its CHIP program, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. SelectHealth CHIP scored well in many standard areas. Following the review, SelectHealth CHIP 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 information, grievance and appeal system, provider participation and program integrity, and delegation subcontracts. In CY 2019, HSAG conducted a webinar-based follow-up review of SelectHealth CHIP's CAP during which SelectHealth CHIP demonstrated improvement in the 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, the grievance and appeal system, and provider participation and program integrity, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and found SelectHealth CHIP to be fully compliant for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In 2018 HSAG recommended targeted improvement efforts focused on increasing well-care visits for children ages 3 to 6. In CY 2019, SelectHealth CHIP reported having implemented the following quality initiatives:

Well-care visits for children age 3 to 6 years:

- SelectHealth CHIP used a vendor that conducted IVR calls to remind parents of children on Medicaid who are ages 3 to 6 that their child was due for an annual well-exam with their PCP. This outreach included an appointment scheduling reminder call for those members who had a well exam in the prior year, a well exam education call for those who did not have a visit in the prior year, and an end of the year "gap-in-care" call for those who had not yet had a visit in the measurement year.
- In 2019, SelectHealth CHIP's IVR vendor added a digital consent capability to allow SelectHealth CHIP to collect member phone numbers and email addresses for those who opt in to receiving digital reminders. This gave members the option to receive future reminders in their preferred mode of communication.
- In CY 2019, SelectHealth CHIP reported that it was creating a well-child exam schedule that includes tests and vaccines that will be used in a reminder mailing in 2020.

Validation of Performance Improvement Projects

SelectHealth CHIP's *Improving the Percentage of 13-year-old Female CHIP Members who had 2 Doses of Human Papillomavirus (HPV) Vaccine Prior to Their 13th Birthday* PIP received a *Met* score for 85 percent of the applicable evaluation elements in the 2018 PIP Validation Tool. HSAG identified opportunities for improvement in the study outcomes. In the 2019 final PIP submission, the health plan addressed HSAG's recommendation and documented a statistically significant improvement over the baseline in the study indicator outcome.

PAHP Providing Medicaid Dental Services

Premier Access

Compliance Monitoring

In CY 2018, HSAG was on-site at Premier Access (Premier) to conduct a full compliance review, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. 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, access and availability, member information, grievance and appeal system, provider participation and program integrity, and QAPI. In CY 2019, HSAG conducted a webinar-based follow-up review of Premier's CAP during which Premier demonstrated improvement in the standard areas that had been less than fully compliant in the previous review year. HSAG identified ongoing required actions related to coverage and authorization of services, member information, and the grievance and appeal system during the follow-up review which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified areas for improvement preventing full compliance for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In 2018, HSAG recommended that Premier arrange for an NCQA HEDIS Compliance Audit for submission of HEDIS 2019 measure rates to comply with Medicaid managed care regulations released May 2016 and effective July 1, 2017, for Medicaid managed care entities. In CY 2019, Premier Medicaid completed an NCQA HEDIS Compliance Audit conducted by Advent Advisory Group for measurement year 2018 and reported that a subsequent NCQA HEDIS Compliance Audit is scheduled for CY 2019.

Validation of Performance Improvement Projects

CY 2019 is the first year for Premier's PIP. Therefore, this section is *Not Applicable* for this PIP.

MCNA

Compliance Monitoring

In CY 2018, HSAG was on-site at MCNA to conduct a full compliance review, which included a review of all standard requirements as well as a review of prior authorization denials, appeals, grievances, and credentialing. MCNA scored well in many standard areas. Following the review, MCNA completed a CAP for requirements found to be out of compliance in the areas of coordination and continuity of

care, member information, grievance and appeals system, and program integrity. In CY 2019, HSAG conducted a webinar-based follow-up review of MCNA's CAP during which MCNA evidenced full compliance in standard areas that had been less than fully compliant in the previous review year. MCNA successfully implemented its required actions and did not have any further required corrective actions. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified full compliance for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

MCNA was not contracted with UDOH in CY 2018; therefore, this section is *Not Applicable* for MCNA.

Validation of Performance Improvement Projects

CY 2019 is the first year for MCNA's PIP. Therefore, this section is *Not Applicable* for this PIP.

PAHP Providing CHIP Dental Services

Premier Access—CHIP

Compliance Monitoring

In CY 2018, HSAG was on-site at Premier Access to conduct a full compliance review of the CHIP program, which included a review of all standard requirements as well as a review of administrative records related to prior authorization denials, appeals, grievances, and credentialing. Premier CHIP scored well in many standard areas. Following the review, Premier CHIP 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 information, grievance and appeal system, provider participation and program integrity, and QAPI. In CY 2019, HSAG conducted a webinar-based follow-up review of Premier CHIP's CAP during which Premier CHIP demonstrated improvement in the 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 coverage and authorization, member information, and the grievance and appeal system, which were not adequately addressed and required a continuing CAP. In CY 2019, HSAG also conducted a review of initial credentialing records for new providers and identified areas for improvement preventing full compliance for timeliness of acquiring required information prior to granting providers clinical privileges.

Validation of Performance Measures

In CY 2019, HSAG recommended that Premier CHIP arrange for an NCQA HEDIS Compliance Audit for submission of HEDIS 2019 measure rates to comply with CHIP managed care regulations released May 2016 and effective July 1, 2018, for CHIP managed care entities. Premier CHIP is scheduled to have an NCQA HEDIS Compliance Audit completed by Advent Advisory Group, for CHIP managed care entities for measurement year 2019.

Validation of Performance Improvement Projects

CY 2019 is the first year for Premier CHIP's PIP. Therefore, this section is *Not Applicable* for this PIP.

Appendix A. Summary of PIP Interventions by Plan Type and PIP Topic

Table A-1 on the following page includes information about interventions each health plan implemented for PIP topics submitted for validation in CY 2019.

Table A-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 plan had not progressed to developing and implementing improvement strategies.
Healthy U	*Asthma Medication Management*	1. The percentage of members 5 to 11 years old who have persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	• Member outreach: Care managers provide outreach to high-risk members for asthma education and self-management support through enrollment into the asthma care management program. • Asthma Care Management Registry: A system to track members who may benefit from asthma care management. This registry also helps staff prioritize members for intervention based on their asthma risk score (high, medium, low) and tracks the care management interventions and services received by these members. • Use of HEDIS asthma medication data: Developed a reporting process and format for providing care managers with a list of members from the HEDIS asthma cohort who may benefit from care management intervention. • PCP outreach letters: Developed outreach letters to notify providers of their members who had an asthma medication ratio <0.5 and could benefit from additional follow-up to improve asthma management. • Partnership with Salt Lake County Asthma: Signed a contract with the Salt Lake County Asthma Healthy Homes program in February 2019. This program will replace the Green and Healthy Homes

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
			Initiative, offering home-based environmental remediation and asthma education to members. • E-Asthma Tracker Pilot: Entered into a partnership with the developers of the e-Asthma Tracker Tool and will begin a pilot project. The e-Asthma Tracker is a web- and application-based tool designed to support ongoing monitoring and self-management of children with asthma. Parents complete a weekly five-question asthma control test online which populates a run chart that documents asthma control. Parents and care coordinators are automatically alerted to early signs of asthma attacks to promote timely interventions to improve control and prevent attacks.
Molina	*Breast Cancer Screening for Women Ages 50–74*	1. The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer during the measurement period.	• Continue mobile mammogram events to provide members an option to receive a mammogram closer to their home. • Contracted with seven provider groups to participate in the Value Based Care (VBC) program that is designed to encourage providers to manage all aspects of member care, including missing service gaps in a timely manner, to be eligible for a portion of the shared savings. • Partnered with VBC providers with an imaging center on-site to improve timely scheduling and completion of mammograms. • Provided training to VBC medical groups on using the secure registry/site for submitting and receiving documents such as the Missing Services List (MSL). • Monitor “no shows” for both standing imaging center and mobile appointments, and follow up to reschedule.
SelectHealth	*HPV Vaccine Prior to 13th Birthday for Female Medicaid Members*	1. The percentage of 13-year-old female Medicaid members who had at least	• Meet with Utah Statewide Immunization Information System (USIIS) staff to improve the immunization data exchange process,

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		2 doses of Human Papilloma Virus (HPV) vaccine prior to their 13th birthday.	and then standardize internal processes to make data availability consistent. • Update programming and member communications to reflect changes to the recommended dosing schedule and the measure. • Revise the reward program. Conduct a member mailing to clarify what is required to receive the gift cards. • Create a control group to assess the impact of interventions.
Medicaid MCO Providing Both Physical Health and Mental Health Services for Individuals with Developmental Disabilities and a Mental Illness			
Healthy Outcomes Medical Excellence (HOME)	*Impact of clinical and educational interventions on progression of pre-diabetes to Type II Diabetes Mellitus*	1. Percentage of HOME enrollees in the identified pre-diabetic study cohort, who had a most recent HbA1c < 5.7 in the measurement period.	• Dedicated nurse case manager to educate patients and caregivers on the importance of regular monitoring, lifestyle modification, and regular clinic visits. • The medical team and nutritionist collaborate on planning individualized Medical Nutrition Therapy (MNT) to serve patients' needs. • Retrained providers to prescribe metformin to the identified cohort. • Adjusted the provider schedule to increase availability.
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	• Trained staff on how to use the new system. • Monitored staff performance requirements that all new admissions receive a C-SSRS screening and same-day safety plan, if indicated. • Trained staff to conduct and record the same-day safety plans.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		or higher and received a same-day safety plan.	
Central	*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.	• Added the C-SSRS to the individual therapy note to simplify the process of completing the screener. • Implemented training around the Center's new Suicide Prevention Policy and addressed the expectations around "Zero Suicide." • Provided staff training on the C-SSRS and safety plan administration requirements. • Added a system reminder to prompt staff when the C-SSRS screening should be administered. • Identified long-term members without a C-SSRS in the EHR. Results are shared with staff training on the need to assess all members for suicide risk.
Davis	*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.	• Contacted and reminded providers of the administration requirements of the C-SSRS and safety plan. • Within each department, the staff member with the highest rate of same-day safety planning received a gift card. • The C-SSRS was added and made mandatory to the Stabilization and Mobile Response documentation in Credible. • Supervisors reminded therapists that the C-SSRS needs to be updated with current information when they update the evaluations. • Supervisors meet with their teams to discuss how to make safety plans a meaningful tool. • Improved the systems so staff cannot submit an assessment until all portions are completed. • Provide program-level data to directors each month to review and discuss outcomes with their staff.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Four Corners	*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 C-SSRS training online and as part of the new employee training requirement. • Provided training at each clinic staff meeting on how to develop a safety plan. • Provided training on the frequency of when the C-SSRS should be administered.
Northeastern	*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.	• Training will be provided to all clinical staff responsible for C-SSRS and safety plan completion. • Added a new prompt and date field into the clinical service note to assist providers in ensuring that a C-SSRS is completed every year. • Required nurses to complete the C-SSRS as part of the pre-visit contact for “medication only” members. Nurses will subsequently notify the prescriber and therapist if a safety plan is needed. • Added a monthly report to the process that includes members who required a safety plan but did not have one completed on the same day that the suicide risk was identified.
Salt Lake	*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	• Trained providers and administrators on the C-SSRS and steps to accurately submit data. • Trained providers on the importance of a same-day clinical review of the C-SSRS. • Continued to notify providers that their data have not been submitted into Optum’s electronic system. Nonresponsive providers would be required to attend a mandatory training.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		or higher and received a same-day safety plan.	• Continued to provide annual clinical provider trainings on C-SSRS usage, safety planning, and data submission. • Optum provided assistance to providers who are encountering technical issues when entering the CSSRS and safety plan data into Optum's system.
Southwest	*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.	• Program managers trained staff to check the appropriate box on cloned safety plans. • Program managers trained staff to document accurately the same day the safety plan was completed. • Program managers trained all clinicians on the process and importance of revisiting and completing the safety plan form. • The screening form will be modified so that clinicians can indicate that a safety plan is not needed.
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 or higher and received a same-day safety plan.	• Removed the C-SSRS short version from the EHR and replaced it with the full version. • The Stanley-Brown Safety Plan has been added in the EHR as a new tool. • Trained clinicians on how to use the SBSP if the C-SSRS result was 2 or higher. • Trained new staff to use the C-SSRS followed by the SBSP.
Valley	*Suicide Prevention*	1. The percentage of members who received a C-SSRS screening during a face-to-face outpatient visit.	• 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.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		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.	• 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	*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 staff training on the importance of completing the C-SSRS and safety plan. • Staff work with members to create the safety plan in the member's cell phone application (app). • Worked with providers to document in the clinical notes that the safety plan was created in the member's app, with the member's input.
Weber	*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.	• Trained clinicians to copy/update the safety plan in the electronic chart upon completion of a new CSSRS. • Trained clinicians on proper use of the C-SSRS and safety plan. • Provided training including motivational speakers to emphasize consistency in completion of C-SSRS and safety plans.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
CHIP MCOs Providing Both Physical Health and Mental Health Services			
Molina—CHIP	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	1. The percentage of members 3–6 years of age who had one or more well-child visits with a primary care provider during the measurement year.	• Contracted with seven provider groups to participate in the VBC program. The VBC program is a shared-savings program designed to encourage providers to manage all aspects of member care, including closing missing service gaps in a timely manner, to be eligible for a portion of the shared savings. • Hired a QI manager to focus on developing a robust strategy to launch meetings with VBC providers. • Educated providers on Molina CHIP's provider portal to obtain MSLs as well as directly engage with providers to facilitate provider outreach to members. • Provided training to VBC medical groups on using the secure registry/site for submitting supplemental data reports so that all components of well-child checks can be captured. • Mailed a member incentive flyer to all Molina CHIP members ages 3 to 6 years who needed a well-child check. Molina CHIP offered a $40 gift card to Walmart for completing the screening by December 31, 2018.
SelectHealth—CHIP	*HPV Vaccine Prior to 13th Birthday for Female CHIP Members*	1. The percentage of 13-year-old female CHIP members who had at least 2 doses of Human Papilloma Virus (HPV) vaccine prior to their 13th birthday.	• Meet with USIIS staff to improve the immunization data exchange process, and then standardize the internal process to make data availability consistent. • Update programming and member communications to reflect changes to the recommended dosing schedule and the measure. • Revise the reward program. Conduct a member mailing to clarify what is required to receive the gift cards. • Create a control group to assess the impact of interventions.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
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 compelling, wafer-sealed member communication.
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. 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.	• The plan had not progressed to developing and implementing improvement strategies.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
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 compelling, wafer-sealed member communication.