

State of Utah

MANAGED CARE QUALITY STRATEGY

DIVISION OF MEDICAID AND HEALTH FINANCING
BUREAU OF MANAGED HEALTH CARE



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Section I: Introduction

Program Background, Overview, Goals and Objectives

Program Background

The Utah Department of Health (UDOH) includes the Division of Medicaid and Health Financing (DMHF). DMHF is the agency in UDOH responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP). Utah began operating its Medicaid program in 1966 under authority of Title XIX of the Social Security Act and entered into managed care in 1982. In 1995, enrollment in managed care plans became mandatory for members living in Utah's urban counties. Utah began operating the CHIP program in 1997.

The Bureau of Managed Health Care (BMHC) has been operating two separate 1915(b) freedom-of-choice waivers. The names of the waivers are the Prepaid Mental Health Plan (PMHP) waiver and the Choice of Health Care Delivery Program (CHCD) waiver. The CHCD waiver is for the physical health plans. Under the PMHP waiver, Medicaid recipients are enrolled in the PMHP contractor serving their county of residence. One PMHP is a Prepaid Ambulatory Health Plan (PAHP) under the 1915(b) PMHP waiver that provides substance abuse services.

With the exception of one Medicaid Mental and Physical Health Plan under 1915(a) contract authority, the Healthy Outcomes, Medical Excellence (H.O.M.E.) Program, Medicaid Managed Care Organizations (MCO) provide only physical health services. CHIP MCOs provide both physical and mental health services. Established in 2006, H.O.M.E. specializes in mental health and medical services for members who are dually diagnosed with a developmental disability and a mental illness.

In 2011, Senate Bill 180, Medicaid Reform, was passed during the General Legislative Session. In part, the bill requires that: "The Department shall develop a proposal to amend the State Plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models." To achieve these goals, effective January 2013, DMHF implemented Accountable Care Organizations (ACO). Currently, the State has contracts with four Medicaid ACOs providing physical health services: HealthChoice Utah (HCU), Healthy U (HU), Molina Healthcare of Utah (MHU), and Select Health Community Care (SHCC) all of which meet the CMS definition of an MCO. In addition, two of the Medicaid ACOs providing physical health services also have CHIP contracts. These are MHU and SHCC.

The goals of the ACOs are to maintain quality of care and improve health outcomes for Medicaid recipients and to control costs. All managed care contracts are full risk, capitated contracts and therefore assume the risk for all health care costs for their members. Members living in the urban counties of Salt Lake, Utah, Davis and Weber have a choice to enroll in any of the four ACOs. Members living outside of these urban counties have the option to choose an ACO, if any are available in their county of residence.

In September 2013, DMHF implemented capitated contracts with two dental plans, Premier Access and Delta Dental. Prior to these contracts, dental services were reimbursed on a fee-for-service (FFS) basis.

BMHC is responsible for oversight of the delivery of quality health care services provided by all of the ACOs, PMHPs, H.O.M.E. and dental plans.

Summary of MCOs by Type and Operating Authority	
MCO Type	Operating Authority
Ten Medicaid Prepaid Inpatient Health Plans (PIHP) ¹ , and one Prepaid Ambulatory Health Plan (PAHP)	1915(b) Prepaid Mental Health Plans (PMHPs) waiver
Four Medicaid ACOs ²	1915(b) Choice of Health Care Delivery (CHCD) waiver
One Medicaid Mental and Physical Health Plan, MCO (Healthy Outcomes, Medical Excellence-H.O.M.E.)	1915(a) contract authority
Two CHIP MCOs	CHIPRA authority
Two Capitated Medicaid Dental PAHPs	1915(b) Choice of Dental Care Delivery Program waiver
Two Capitated CHIP Dental PAHPs	CHIPRA authority

Overview

As part of quality management, BMHC established the State Quality Committee (SQC). The SQC consisted of internal and external stakeholders including ACO Quality Improvement Directors. At its inception, the SQC established certain performance targets to further drive quality improvement in Medicaid and CHIP managed care. The SQC recommended a set of 25 quality measures (including some HEDIS and CAHPS measures) to track and trend using performance benchmarks and scoring methodology adopted by the SQC (see page 9 for these measures listed in the ACO Quality Measures Table). These measures included some measures from the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). HEDIS measures performance on dimensions of care and service while CAHPS provides a report on consumer and patient experience with health care. The SQC has recently been renamed as the Quality Improvement Council (QIC).

¹ The eleven PMHPs include Bear River Mental Health, Central Utah Counseling Center, Davis Behavioral Health, Four Corners Community Behavioral Health, Northeastern Counseling Center, Salt Lake County, Southwest Behavioral Health Center, Valley Mental Health, Wasatch Mental Health, Weber Human Services and Utah County Department of Drug and Alcohol Prevention and Treatment.

² ACOs are considered MCOs for purposes of 42 CFR 438.

Goals and Objectives

DMHF’s mission is to “provide access to quality, cost effective health care for eligible Utahns.” The Quality Strategy will help accomplish this through the following goals and objectives which align with the priorities in the National Quality Strategy³.

The Quality Strategy will be implemented over a five year time period with an effective date of XX/XX/XXXX. A review will occur annually and updates will be made as needed during that review.

Quality Strategy Goals	Quality Strategy Objectives	Timeline
<p>1: Promote effective coordination of care between ACOs and PMHPs.</p>	<p>1.1 Implement semi-annual coordination meetings between ACO and PMHP staff to enhance coordination of care for members.</p> <p>1.2 Revise contract language for ACOs and PMHPs to solidify expected outcomes related to coordination of care.</p> <p>1.3 Develop rate setting methodologies that support contract language and coordination of care.</p> <p>1.4 Develop collaborative relationships with other state bureaus, agencies and/or external partners to improve coordination of care between ACOs and PMHPs.</p>	<p>1.1 2014-2019</p> <p>1.2 July 2015. Update accordingly.</p> <p>1.3 Ongoing effort.</p> <p>1.4 Ongoing effort.</p>
<p>2: Promote preventive care for women and children.</p>	<p>2.1 ACOs will perform at or above national average on the following 6 preventive HEDIS measures from the 25 QIC Recommended Quality Measures: Postpartum Care Rate, Childhood Immunizations, Well-Child Visits, Breast Cancer Screening, Cervical Cancer Screening and Chlamydia Screening in Women. ⁴</p>	<p>2.1 Performance improvement plan to be developed for 2015-2019 based on findings from the 2013 HEDIS baseline data reported in Fall 2014.</p>

³ <http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm>

⁴ Verification that each plan has sufficient enrollment to report these measures.

	2.2 Develop a collaborative relationship with the UDOH Bureau of Health Promotion and ACOs to improve access to and implementation of prevention and treatment practices.	2.2 July 2014 ongoing
3: Improve the access to and quality of services provided to Medicaid members in ACOs, PMHPs, Dental Plans, H.O.M.E. and CHIP. ⁵	3.1 Develop an assessment of baseline performance by ACOs in the 25 QIC recommended quality measures (separate from the 6 preventive measures from 2.1).	3.1 2014
	3.2 In coordination with the QIC, develop performance improvement goals to enhance current performance in the 25 QIC recommended quality measures ⁶ .	3.2 2015
	3.3 Monitor plan performance related to the performance improvement goals for the 25 QIC recommended quality measures and evaluate progress on an annual basis.	3.3 2016-2019
	3.4 Perform a baseline assessment of the current HEDIS measure reported by PMHPs to determine potential improvement targets for this measure.	3.4 2015
	3.5 In coordination with QIC and other stakeholders, explore additional quality measures for the PMHPs to report.	3.5 2016
	3.6 Perform a baseline assessment of the current quality measures reported by Dental Plans to determine potential	3.6 2015

⁵ Maintenance of certain measures is acceptable if they are already at a level where improvement would not be reasonable but maintenance would be appropriate.

⁶ This will include posting results to the Managed Care website. May require that ACOs will perform at or above the national average on all HEDIS and CAHPS measures.

	<p>improvement targets.</p> <p>3.7 In coordination with QIC and other stakeholders, explore additional quality measures for the Dental Plans to report.</p> <p>3.8 In coordination with QIC develop an Oral Health Strategy for Medicaid and CHIP that reflects CMS standards.</p> <p>3.9 Perform a baseline assessment of the current quality measures reported by H.O.M.E. to determine potential improvement targets.</p> <p>3.10 In coordination with QIC and other stakeholders, explore additional quality measures for H.O.M.E. to report.</p> <p>3.11 Perform a baseline assessment of the current quality measures reported by the CHIP MCOs to determine potential improvement targets.</p> <p>3.12 Assess and improve BMHC's eligibility data sharing process with the plans.</p>	<p>3.7 2016</p> <p>3.8 2015</p> <p>3.9 2015</p> <p>3.10 2016</p> <p>3.11 2015</p> <p>3.12 2015</p>
<p>4: Control quality care costs through innovative strategies with ACOs, PMHPs and other stakeholders.</p>	<p>4.1 Evaluate incentive programs such as auto assignment and capitation withholding to drive cost-effective quality improvement in the ACOs.</p> <p>4.2 Develop and implement a plan to improve member access to ACO quality metrics in order to assist members in choosing the plan with the highest value.</p> <p>4.3 Collaborate with the ACOs and PMHPs to compile best practices about management of super-utilizer members and use this data to develop</p>	<p>4.1 2015-2016</p> <p>4.2 2015-2016</p> <p>4.3 Compile best practices from 2014 and begin to develop strategies based on these best practices in</p>

	<p>strategies that provide quality, cost-effective, coordinated care to these individuals.</p> <p>4.4 Work with the plans and DMHF’s contract actuarial firm to identify value based reimbursement methodologies and ways to incorporate these costs in the rate setting process.</p>	<p>2015. Assess the development and implementation of these strategies annually.</p> <p>4.4 January 2015</p>
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Goal 1: The National Quality Strategy prioritizes the need to promote effective coordination of care. Promoting effective coordination of care between ACOs and PMHPs will address a currently fragmented system between physical and behavioral health. Behavioral health services for Medicaid members in Utah are provided through PMHPs. Physical health services are provided to Medicaid members enrolled in managed care with Medicaid’s ACOs. The objectives for this goal in the Quality Strategy will effectively advance coordination of physical and behavioral health services for Medicaid members in Utah.

Goal 2: Utah is the state with the highest birth rate in the U.S.⁷ Preventive care for women and children is especially needed in this context. The Quality Strategy goal to promote preventive care for women and children will address this need through performance measures and collaboration with other partners to improve access to and implementation of prevention and treatment practices. This goal aligns with the National Quality Strategy priority to “promote the most effective prevention and treatment practices.”

Goal 3: Part of DMHF’s mission is to “provide access to quality health care for eligible Utahns.” This third goal in the Quality Strategy seeks to improve the access to and quality of health care services provided to Medicaid members in ACOs and PMHPs. The QIC and External Quality Review Organization (EQRO) will offer valuable input from our internal and external partners to improve in this important area. The EQRO conducts the federally required External Quality Review (EQR) for DMHF.

Goal 4: The National Quality Strategy seeks to “make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.” The final goal in the Quality Strategy recognizes the importance of delivering affordable quality care for Utah Medicaid members through innovative strategies with ACOs, PMHPs and other stakeholders. The evaluation of incentive programs like the auto assignment incentive program will explore new methods for providing affordable care to Utah Medicaid members. Improving member access to meaningful ACO quality metrics seeks to drive down

⁷ http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf

costs by helping members choose the plan with the highest value. This also aligns with the National Quality Strategy priority to ensure that patients are engaged in their care. The objective to study and develop strategies for management of super-utilizers also seeks to achieve more affordable care for members by addressing a significant cost driving issue.

In addition, Section 26-18-405 (2) Utah Code Annotated directs the state to modify provider reimbursement methodologies as follows:

- “(a) restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the proposal, maintain or improve recipient health status;
- (b) restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to:
 - (i) maintain or improve their health status; and
 - (ii) use providers that deliver the most appropriate services at the lowest cost;
- (c) identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that:
 - (i) pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter; and
 - (ii) reward providers for delivering services that make the most positive contribution to a recipient's health status;”

The result of this effort should have an impact on reducing costs of care and improving health outcomes. However, rate setting methodologies must be able to account for this change in direction to assure capitation rates are not affected prematurely or unfairly which will discourage innovation in this area.

Development and Review of Quality Strategy

Development Process

DMHF has implemented previous quality strategies since it began managed care. In 1995 Utah's Quality Assurance Monitoring Plan was developed for MCOs providing physical health services. In 2003, the UQAMP was refined and became Utah's Quality Assessment and Performance Improvement Plan. A separate strategy, the PMHP Quality Strategy, existed for the PMHPs providing mental health services. The current Quality Strategy brings strategies for the ACOs, PMHPs, Dental Plans and H.O.M.E. for further quality improvement of quality within all of these managed care plans.

In accordance with 42 CFR 438.202, BMHC seeks input from stakeholders for the Quality Strategy. These include internal bureaus such as the Division of Community and Family Health Services (Bureaus of Maternal Child Health, Bureau of Children with Special Health Care Needs,

and Bureau of Health Promotion), and the Center for Health Data and Informatics Office of Health Care Statistics (OHCS).

Other stakeholders include the Department of Human Services, including the Division of Substance Abuse and Mental Health, Division of Aging, Division of Child and Family Services, Division of Juvenile Justice Services, and the Division of Services for People with Disabilities; the State Office of Education, family advocacy groups, compliance officers and quality improvement managers from contracted ACOs; bureau and division management staff, Medicaid's Medical Care Advisory Committee (MCAC), CHIP Advisory Committee, the Utah Hospital Association, Utah Medical Association and other provider groups.

Public Comment

The Quality Strategy was first reviewed internally with DMHF staff and then shared with the managed care plans and the Quality Improvement Council (QIC) for review. Other stakeholders as mentioned above were consulted and the Quality Strategy was made available for public comment through UDOH's website, and public stakeholder meetings.

Feedback was obtained from CMS and approval was granted on XX/XX/XXXX.

Timeline for Assessing the Effectiveness of the Quality Strategy

BMHC will engage in regular activities for assessing the effectiveness of the Quality Strategy. They are as follows:

- BMHC will engage in an annual review and updating process with internal and external stakeholders to update and modify the Quality Strategy as needed (see Timeline for Modifying or Updating the Quality Strategy).
- BMHC will review the annual External Quality Review (EQR) report to assess the effectiveness of the ACOs, PMHPs, Dental Plans and H.O.M.E. in providing accessible, quality services. The annual EQR is designed in accordance with federal requirements.
- As part of the EQR, Individual Plan Reports (IPR) will also be reviewed by BMHC. The IPRs provide individual plan level information for each ACO, PMHP, Dental Plan and H.O.M.E. as well as information to assist in the development of any Corrective Action Plans (CAP) as needed.
- BMHC uses a number of contractually required reports in addition to IPRs to assist in evaluating ACO, PMHP, Dental Plan and H.O.M.E. performance and care provided to Medicaid and CHIP members. BMHC will review these to aid in assessing the effectiveness of the Quality Strategy.

Timeline for Modifying or Updating the Quality Strategy

A Quality Strategy report will be updated on an annual basis. Modifications to the Quality Strategy will be made as needed. The Quality Strategy may also be modified or updated more frequently if significant changes arise that need to be included in the Quality Strategy. A significant change is defined as any change to the Quality Strategy that may be foreseen to

materially affect the delivery or measurement of the quality of health care services. Steps for updating the Quality Strategy include:

- The BMHC director will collaborate with the DMHF director to ensure the goals and objectives of the Quality Strategy are consistent with the goals and objectives of DMHF.
- During the updating process, BMHC seeks input from DMHF staff about areas that the Quality Strategy should focus on which will help guide the revision of the strategy.
- BMHC will share the final revised Quality Strategy with the QIC and post it on the UDOH Medicaid website for public review and comment.
- BMHC will share the Quality Strategy with members, requesting their input and comments via a special email inbox.
- BMHC will submit the updated Quality Strategy to CMS for approval and make it available to the public via the UDOH Medicaid website.

Section II: Assessment

Quality and Appropriateness of Care

In accordance with 42 CFR 438.200, BMHC has quality assessment and performance improvement strategies to ensure the delivery of quality health care by all ACOs, PMHPs, Dental Plans and H.O.M.E. These strategies assist BMHC in assessing the quality and appropriateness of care furnished to all Medicaid members under ACO, PMHP, Dental and H.O.M.E. contracts. These strategies include the EQR by the EQRO. Information from all State and EQR related activities is used to assess the performance of its ACOs and PMHPs and Dental Plans.

42 CFR 438.240 requires that all MCOs and PIHPs have ongoing quality assessment and performance improvement programs. These programs must comply with the following requirements:

- Conduct Performance Improvement Projects (PIP)⁸
- Submit performance measurement data
- Detect underutilization and overutilization of services
- Assess the quality and appropriateness of care for members with special health care needs
- Maintain a health information system that collects, analyzes, integrates, and reports data

⁸ Performance Improvement Projects (PIP): designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on the health outcomes and Enrollee satisfaction.

Special Health Care Needs

Enrollees with ‘special health care needs’ means members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

A ‘child with special health care needs’ means a child under 21 years of age who has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions and requires health and related services of a type or amount beyond that required by children generally, including a child who, consistent with Section 1932(a) (2) (A) of the Social Security Act, 42 U.S.C. 1396u-2(a) (2) (A):

- is blind or disabled or in a related population (eligible for SSI under title XVI of the Social Security Act);
- is in Foster Care or other out-of-H.O.M.E. placement;
- is receiving Foster Care or adoption assistance; or
- is receiving services through a family-centered, community-based coordinated care system that receives grant funds described in Section 501(a) (1)(D) of Title V of the Social Security Act.

Each ACO is required to have policies and procedures to identify adults and children with special health care needs. ACOs provide information about primary care providers with training for members with special health care needs. They also ensure that there is access to appropriate specialty providers and assist with case management and coordination of care for members with special health care needs.

The Healthy Outcomes Medical Excellence Program (H.O.M.E.) is another example of how DMHF serves members with special health care needs. H.O.M.E. provides physical and mental health services for members with developmental disabilities and mental illness. There is no age limit for participation in the H.O.M.E. program. H.O.M.E. uses a “medical H.O.M.E.” model and emphasizes coordination of care between mental and physical health care in the same setting. The program provides primary care, referrals to specialty care, psychiatric evaluations, psychotherapy, psychosocial rehabilitation, care coordination, and other needed services.

Procedure for Identifying Race, Ethnicity, and Primary Language

BMHC utilizes the Medicaid application process to identify race, ethnicity, and primary language. The Utah Department of Workforce Services (DWS) processes Medicaid applications in Utah. The information from the application is entered into the DWS database which is then shared with BMHC. BMHC sends ACOs, PMHPs, Dental Plans and H.O.M.E. an eligibility file with information regarding the primary language, race and ethnicity of each Medicaid member.

National Performance Measures

All ACOs report HEDIS and CAHPS measures to the OHCS at UDOH. The QIC has selected 25 measures for the ACOs to report on annually to BMHC. These include HEDIS, CAHPS and other

nationally qualified measures. 2014 will serve as a baseline year for collecting data for these performance measures from the ACOs. Subsequent years will provide comparison data to drive quality improvement.

PMHPs report to BMHC on timely access to services. This includes a measure which assesses initial outpatient follow-up and scheduling. As part of Goal 3 in the Quality Strategy, BMHC and QIC will be considering additional quality measures to be reported by PMHPs for continuing quality improvement.

The dental plans are required to report HEDIS and CAHPS measures. They are also required to submit service performance measures for children that have received preventive dental services, dental treatment services and sealants on a permanent molar. CMS 416 reporting for the dental plans includes the total numbers of members receiving any dental service, a dental diagnostic service and any dental and oral health service. Per Goal 3 in the Quality Strategy, BMHC and QIC may develop additional performance and quality measures for the dental plans to report.

H.O.M.E. currently reports performance measures to UDOH which include readmission rate, availability of appointments, care coverage, hospital follow-up and a performance improvement project to analyze the metabolic monitoring rates of H.O.M.E. members prescribed antipsychotic drugs. Per Goal 3 in the Quality Strategy, BMHC and QIC may develop additional performance and quality measures for H.O.M.E. to report.

The following is a table of the 25 quality measures selected by the QIC for ACOs to report on annually.

ACO Quality Measures Table

Population/Condition	Preventive Services	Chronic Care	Acute Care	Access	Satisfaction
Maternity Care	NQF 1391/HEDIS-PPC: Postpartum Care Rate*	N/A	NQF 0471: PC-02: Caesarean Rate for Nulliparous Singleton Vertex NQF 1392: Percentage of Live Births less than 2,500 Grams*	CAHPS	CAHPS
Newborn/Infant Care	NQF 0038/HEDIS-CIS: Childhood Immunization Status: Combo 3* NQF 1392/HEDIS-W15/EPST: Well-Child Visits in the First 15 Months of Life*	N/A	N/A	N/A	N/A
Pediatric Care	NQF 1407/HEDIS-IMA: Immunizations for Adolescents* NQF 1516/HEDIS-W34/EPST: Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life*	NQF 0036/HEDIS-ASM: Use of Appropriate Meds for Asthma	NQF 1789: Hospital-Wide All-Cause Readmission Measure NQF 0002/HEDIS-CWP: Appropriate Testing for Children with Pharyngitis NQF 0069/HEDIS-URI: Appropriate Treatment for Children with URI	CAHPS	CAHPS
Adult Care	NQF 0031/HEDIS-BCS: Breast Cancer Screening* NQF 0032/HEDIS-CCS: Cervical Cancer Screening* NQF 0033/HEDIS-CHL: Chlamydia Screening in Women*	NQF 0057/HEDIS-CDC-D: Diabetes: A1c Testing* NQF 0055/HEDIS-CDC-G: Diabetes: Eye Exam NQF 0018/HEDIS-CBP: Controlling High Blood Pressure*	NQF 1789 Hospital-Wide All-Cause Readmission Measure NQF 0052/ HEDIS-LBP: Use of Imaging for Low Back Pain	CAHPS	CAHPS

*Indicates a CMS core performance measure. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care---Performance-Measurement.html>.

The collection of the six preventive HEDIS measures of Postpartum Care Rate, Childhood Immunizations, Well-Child Visits, Breast Cancer Screening, Cervical Cancer Screening and Chlamydia Screening in Women will assist BMHC in measuring the achievement of Goal 2 in the Quality Strategy, “promote preventive care for women and children.” Objective 2.1 states that ACOs will perform at or above the national average on these measures and that will ensure that Goal 2 in the Quality Strategy is effectively met.

The other ACO quality measures (Immunizations for Adolescents, Use of Appropriate Meds for Asthma, Diabetes: A1c Testing, Diabetes: Eye Exam, Controlling High Blood Pressure, Caesarean Rate for Nulliparous Singleton Vertex, Percentage of Live Births less than 2,500 Grams, Hospital-Wide All-Cause Readmission Measure for Adults and Children, Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with URI, Use of Imaging for Low Back Pain and CAHPS survey for each population served) will assist the BMHC in determining the achievement of Goal 3 in the Quality Strategy, “Improve the access to and quality of services provided to Medicaid members in ACOs...”

Monitoring and Compliance

42 CFR 438.204(g) details access, structure and operations, and measurement and improvement standards for MCOs and PIHPs. Each ACO and PMHP is responsible for compliance with all of these standards as specified in contract.

BMHC also has contractual requirements with the ACOs which are overseen through the following programs/methods:

- Semi-Annual Reports
 - Includes report on organ transplants, obstetrical information, grievance and appeals report and corrective actions
- Reporting of Abortions, Sterilizations, and Hysterectomies
- Provider Network Reports
- Case Management Reports
- Provider Statistical and Reimbursement Reporting
- Report of HEDIS Results
- Report of CAHPS Results
- Report of Performance Measures
- PIPs

Contractual requirements between BMHC and the PMHPs include that the PMHPs submit the following reports to BMHC:

- Annual Independent Financial Audit
- Annual PMHP Financial Report
- Semi-Annual Grievances and Appeals Reports
- Performance Standards Report

- Reports of Potential Provider-Related Fraud, Waste or Abuse
- Reports of Prohibited Affiliations with Individuals Debarred by Federal Agencies
- Reports of Excluded Providers

The dental plans are required to submit the following reports to BMHC:

- Semi-Annual and Annual Enrollment, Cost and Utilization Reports
- Monthly Encounter Data Reports
- Monthly Income Statements
- Semi-Annual Summary of Complaints and Formal Grievances
- Semi-Annual Summary of Corrective Actions on Participating Providers
- Semi-Annual Cost and Utilization Report
- Semi-Annual Claims Data
- Semi-Annual Description of Subcontractor Claims Processing Times
- Annual Dental Plan Disclosure File
- Provider Network Reports
- Quarterly Service Performance Measures Reports,
- Quarterly CMS 416 Report
- HEDIS and CAHPS reports

DMHF's contracts with the ACOs, PMHPs, Dental Plans and H.O.M.E. also allow for additional audits of financial records and inspections. BMHC may request other reports as necessary to continue to assess quality improvement within ACOs, PMHPs and dental plans.

The Utah State Medical Care Advisory Committee (MCAC) serves as an advisory committee to UDOH and DMHF on health and medical care services within the Medicaid program. The committee advises and makes recommendations about the Medicaid program to UDOH as requested. This assists UDOH and DMHF in monitoring and ensuring compliance for ACOs, PMHPs and the dental plans.

The Utah CHIP Advisory Committee also serves as an advisory committee to DMHF on health and medical care services within the CHIP program. The committee advises and makes recommendations about the CHIP program to DMHF as requested.

External Quality Review

Following a competitive bidding process, BMHC will contract with Health Services Advisory Group (HSAG) in the fall of 2014 to conduct the External Quality Review (EQR) as described in 42 CFR 438.358(b)(3). HSAG will be the External Quality Review Organization (EQRO) and have responsibility for the mandatory review that must be conducted every three years to determine that the MCOs and PIHPs are in compliance with federal managed care standards that are related to access to care, structure and operations, and quality measurement and improvement. HSAG will produce an Individual Plan Report (IPR) for each managed care plan. Even though federal regulations do not require an EQRO to conduct compliance reviews for

PAHPs, the contract with HSAG includes conducting compliance reviews of the PAHPS and producing IPRs for each PAHP. Based on the information from the IPRs, managed care plans will develop Corrective Action Plans (CAP) as needed. The EQRO will not use information from Medicare or private accreditation reviews for any standards.

OHCS will be responsible for the other two mandatory EQR activities as described in 42 CFR 438.358(b) (1) and (2) which are as follows:

- Validation of PIPs required by the State to comply with requirements that were underway during the preceding 12 months; and
- Validation of performance measures reported to the State or performance measures calculated by the State during the preceding 12 months to comply with requirements.

BMHC will review the EQR reports and analyses from the EQRO and OHCS and review their recommended corrective actions and determine if BMHC concurs. If CAPs are needed, the EQRO and OHCS along with BMHC will review the CAPs to ensure the plans have identified appropriate corrective actions. The following is a tentative initial compliance review schedule for the managed care plans.

Managed Care Entity	Dates
1. Molina Healthcare of Utah (CHIP & Medicaid)	March 2015
2. Healthy U	March 2015
3. SelectHealth (CHIP & Medicaid)	March 2015
4. Health Choice Utah	March 2015
5. Bear River Mental Health	April 2015
6. Weber Human Services	April 2015
7. Northeastern Counseling Center	May 2015
8. Davis Behavioral Health	May 2015
9. Wasatch Mental Health	May 2015
10. Utah County Department of Drug and Alcohol Prevention and Treatment	May 2015
11. Salt Lake County Division of Mental Health	June 2015
12. Valley Mental Health	June 2015
13. Northeastern Counseling Center	June 2015
14. Four Corners Community Behavioral Health	June 2015
15. Central Utah Counseling Center	June 2015
16. H.O.M.E.	July 2015
17. Southwest Behavioral Health Center	July 2015
18. Delta Dental (Medicaid)	March 2016

19. DentaQuest (Medicaid)	April 20016
20. Premier Access (CHIP & Medicaid)	May 2016

Section III: State Standards

DMHF’s contracts with the ACOs, PMHPs and dental plans include the standards for access, structure and operations, and quality measurement and improvement as specified in 42 CFR Part 438 Subpart D. The standards incorporated into ACO, PMHP and dental plan contracts include the following Subpart D provisions:

- a. **Access** (availability of services, assurance of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services),
 - a. All standards for ACOs related to access can be found in Article 5, Delivery Network, of the ACO contract.
 - b. All standards for PMHPs related to access can be found in Article 7, Delivery Network, of the PMHP contract.
 - c. All standards for the Dental Plans related to access can be found in Article 5, Delivery Network of the Dental contract.
 - d. All standards for H.O.M.E. related to access can be found in Article 9, Contractor Assurances and Article 6, Authorization of Services and Notices of Action, of the H.O.M.E. Contract.
- b. **Structure and operations** (provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems and sub-contractual relationships and delegation), and
 - a. All standards for ACOs related to structure and operations can be found in Article 6, Program Integrity Requirements, and Article 8, Grievance and Appeals Systems, of the ACO contract.
 - b. All standards for PMHPs related to structure and operations can be found in Article 6, Enrollee Rights and Protections, Article 7, Grievance System, and Article 8, Program Integrity Requirements, of the PMHP contract.
 - c. All standards for the Dental Plans related to structure and operations can be found in Article 5, Delivery Network, and Article 8, Grievance and Appeals Systems, of the Dental contract.
 - d. All standards for H.O.M.E. related to structure and operations can be found in Article 3, Marketing, Enrollment, Orientation, and Disenrollment, Article 4, Benefits, Article 5, Delivery Network, and Article 7, Grievance Systems, of the H.O.M.E. contract.
- c. **Measurement and improvement** (practice guidelines, quality assessment and performance improvement program and health information systems).
 - a. All standards for ACOs related to measurement and improvement can be found in Article 14, Compliance and Monitoring, of the ACO contract.

- b. All standards for PMHPs related to measurement and improvement can be found in Article 9, Quality Assessment and Performance Improvement, of the PMHP contract.
- c. All standards for the Dental Contracts related to measurement and improvement can be found in Article 11, Measurement and Improvement Standards, of the Dental contract.
- d. All standards for the H.O.M.E. contract related to measurement and improvement standards can be found in Article 10, Measurement and Improvement Standards, of the H.O.M.E. contract.

All contract provisions can be found at the following link:

[Insert Contract link here](#)

Section IV: Improvement and Interventions

BMHC has implemented a number of interventions to support the four goals of the Quality Strategy: promote effective coordination of care between ACOs and PMHPs, promote preventive care for women and children, improve the quality of services provided to Medicaid members, and deliver more affordable care through innovative strategies in partnership with ACOs and other stakeholders. The following are key projects and interventions related to improvement.

Restriction Program

BMHC manages the Restriction Program which safeguards against inappropriate and excessive use of Medicaid services. Members meeting one or more of the following criteria may be referred to and enrolled in the Restriction Program.

- Four or more Primary Care Providers (PCPs), non-affiliated, in a maximum of twelve eligible months, and/or four or more specialists seen outside a normal range of utilization.
- Four or more pharmacies in a maximum of twelve eligible months.
- Three or more providers (non-affiliated) prescribing abuse potential medications in a two month period.
- Six or more prescriptions filled for abuse potential medications in a two month period.
- Five or more non-emergent Emergency Department visits in twelve months.

ACOs must take into account other considerations when determining placement in the Restriction Program such as member diagnosis, concurrent prescribers, PCP and other utilization patterns, and limited access to care in rural areas. Members on the Restriction Program are restricted to one PCP and one pharmacy. Emergency services are not restricted but members receive education about how urgent care is an available alternative to care in the Emergency Room. ACOs review member placement on the Restriction Program on an annual basis and provide a contact person for Restriction Program members to call with any questions

or problems. PCPs participating in the Restriction Program manage all of the member's medical care, education regarding appropriate use of medical services, referrals, telephonically available 24/7 for emergencies, management of acute and/or chronic long term pain, and work with other providers to share pertinent information about the member.

The Restriction Program effectively implements the Quality Strategy goal to “deliver more affordable care through innovative strategies in partnership with ACOs and other stakeholders.” It does this by managing high cost members and assisting them in more effectively managing their own health care by decreasing excessive use of Medicaid services. This subsequently drives down costs of care.

Mental Health Surveys

In order to review quality issues such as performance and timely access, PMHPs administer satisfaction surveys under the direction of the Division of Substance Abuse and Mental Health. These include the Mental Health Statistics Improvement Program, Youth Services Survey and Youth Services Survey-Family. The data gathered from these surveys provides valuable information to assist PMHPs in delivering the most effective care.

Outcomes Project

The Utah Public Mental Health system participates in a state-of-the-art initiative designed to assess the outcomes of mental health treatment to improve the care provided. The State adopted the use of nationally recognized outcomes questionnaires, the Outcomes Questionnaire© (OQ) for adults and the Youth Outcomes Questionnaire© (YOQ) for youth. These tools provide mental health clinicians immediate feedback on the effectiveness of the treatment provided. These tools also provide clinical guidance to improve care, when needed.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant

In 2010, Utah and Idaho Medicaid were awarded a five-year CHIPRA Quality Demonstration grant that has allowed both states to collaboratively develop a regional quality system, guided by the Medical H.O.M.E. model, to enable and assure ongoing improvement in the healthcare of children enrolled in Medicaid/CHIP programs.

The Children's Health Care Improvement Collaborative (CHIC) project has focused its attention on improving care and outcomes for children and youth with special health care needs. Meaningful use and robust integration of electronic health records, health information exchanges (HIE), and other health information technology (HIT) and informatics tools have been integrated into existing and new quality improvement and care coordination programs, leveraging regional and national expertise in chronic care, quality improvement, HIT, and informatics.

Specific projects and accomplishments include but are not limited to:

1. Expansion of the Medical H.O.M.E. Portal to better support clinicians and families with information and resources to improve care and access to services,
2. A Pediatric Patient Summary tool that collects, filters and collates clinical data to assist clinicians in maintaining up-to-date patient information to guide clinical decision-making focused on children with special health care needs,
3. A successful provider based care coordination model whereby embedded Medical H.O.M.E. Coordinators in primary and sub-specialty care practices have supported coordination of care and quality improvement for twelve practices in Utah and three practices in Idaho, and
4. An interstate health information exchange of immunization from Utah's Immunization Registry (USIIS) to Idaho's immunization Registry (IRIS).

State Innovation Models (SIM) Grant

The SIM Grant provides funding to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation. The grant aims to improve health system performance for residents in participating states and particularly focuses on Medicare, Medicaid and CHIP members. The first round of SIM funding supported the creation of the Utah Health Innovation Plan. Utah is applying for second round SIM funding to support the implementation of the Utah Health Innovation Plan.

The four primary aims of the Utah Health Innovation Plan are:

- behavioral health integration
- geriatric advance care planning
- diabetes and obesity reduction
- value-based care financing strategies

In addition to provider training and technical assistance in all four aims, learning collaboratives will be established to provide a forum for participants in each aim to share their insights and outcomes, which will allow best practices to disseminate more rapidly across Utah. Medicaid ACOs and PMHPs will be encouraged to participate in these learning collaboratives. CMS will announce SIM grant recipients in October 2014. BMHC will work with SIM grant partners to identify and develop areas of coordination between SIM efforts and the Quality Strategy.

Intermediate Sanctions

In accordance with 42 CFR 438.700 BMHC may impose intermediate sanctions to address quality of care problems when an ACO, PMHP or Dental Plan fails to comply with contract and/or federal requirements. BMHC will provide written notice before imposing any intermediate sanction. The plan may request a pre-termination hearing if they disagree with the sanction.

BMHC may impose the following intermediate sanctions for ACOs and Dental Plans:

- Civil monetary penalties in the amounts specified in 42 CFR 438.704.
- Appointment of temporary management of the Contractor as provided in 42 CFR 438.706 and the Contract.
- Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- Suspension of all new enrollment, including default enrollment, after the effective date of sanction.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

BMHC may impose the following sanctions for a PMHP:

- Requiring the PMHP to meet the terms of a corrective action plan as directed by BMHC.
- Withholding capitation payments.
- Any other remedy as allowed by law.

The inclusion of these intermediate sanctions in BMHC contracts assists in addressing any identified quality of care problems.

BMHC may also utilize liquidated damages if an ACO or dental plan fails to perform or does not perform in a timely manner provisions under their contract. The liquidated damages that may be imposed are as follows:

- \$300 per calendar day that the Contractor fails to submit documents to the Department as required under this Contract;
- \$400 per calendar day the Contractor fails to submit required reports to the Department as required under this Contract;
- \$1,000 per calendar day the Contractor fails to submit Encounter Data (as required by Article 13.3) or the Post Adjudication Pharmacy file (as required by Article 4.14.8);
- \$1,000 per calendar day the Contractor fails to submit accurate or complete Encounter Data (as required by Article 13.3) or Post Adjudication History file (as required under Article 4.14.8);
- \$2,500 per calendar day the Contractor fails to submit HEDIS and CAHPS results in the time frames established under Article 11.2.5.
- \$500 per calendar day the Contractor fails to submit or comply with corrective action plan;
- \$500 per calendar day that the Contractor fails to provide audit access as required by Article 14.1;

- \$1,000 per calendar day for each day that the Contractor does not comply with the fraud and abuse provision found in Article 6 and such failure requires Department interventions;
- \$5,000 per calendar day that the contractor fails to maintain a complaint and appeal system as required by this Contract and such failure requires Department intervention;
- \$500 per calendar day for other violation of 42 CFR 438 which requires Department intervention or supervision.

Health Information Technology (HIT)

BMHC uses a variety of informatics sources and systems to conduct managed care operations and evaluate the effectiveness of care and services provided to Medicaid and CHIP members. UDOH has requirements to ensure that contracted entities also have effective information systems, data gathering and integration processes to conduct ongoing and annual self-evaluation activities.

The Medicaid Managed Care System (MMCS) supports the administration of all Medicaid and CHIP plans. This includes enrollment, disenrollment, capitations, encounter processing, contract management, EPSDT support, etc. All plans have access to MMCS so that they can produce their own reports on their members. Data from the MMCS is also shared in the State's Data Warehouse. The State's Data Warehouse holds information about encounters from managed care plans, fee-for-service claims and provider and recipient information.

The All Payer Claims Database (APCD) provides another source of data review. Payers submit claims data to OHCS which is then kept in the APCD. The APCD enables the calculation of a patient's total cost of care, which is a key metric in the evaluation of most healthcare reform pilots, including those that will be funded by the SIM grant. BMHC is also able to produce a variety of quality-related reports that will assist in the ongoing operation and review of the Quality Strategy. This will further enhance the use of this database in assisting with quality improvement for Medicaid's managed care plans and the health care system throughout Utah.

UDOH also has the Indicator-Based Information System for Public Health (IBIS-PH) to integrate public health data from across the Department. IBIS-PH includes 180+ indicator reports which are continuously updated to provide information on important public health measures. UDOH and other public health partners regularly analyze these measures to track and evaluate their progress towards goals. IBIS-PH will serve to enhance the Quality Strategy by providing important information about public health measures that will assist BMHC in the Quality Strategy goals of coordination of care, preventive care and improved quality of services.

Medicaid Electronic Health Records Incentive Payment Program

In addition to utilizing current data systems, DMHF is engaged in innovative HIT initiatives that will support the objectives of the Quality Strategy and ensure BMHC is progressing towards the Quality Strategy goals. DMHF is participating in the Medicaid Electronic Health Records (EHR) Incentive Payment Program through CMS and the Office of the National Coordinator for Health Information Technology. The program aims to improve quality of patient care, patient safety

and patient involvement in treatment options by using certified EHR technology. In October 2011 Utah received approval from CMS to make EHR incentive payments to eligible Medicaid providers as they adopt, implement, upgrade or demonstrate meaningful use of EHR technology. Meaningful use includes electronically capturing health information and using it to track conditions and communicate information for care coordination. At the end of 2013, more than 600 distinct providers and 34 hospitals have participated in the program. Utah's participation in EHR Incentive Program helps BMHC progress towards the Quality Strategy goal of improving the quality of services provided to members by ensuring timely and accurate data through EHRs.

Transition to PRISM (Provider Reimbursement Information System for Medicaid)

DMHF selected Client Network Solutions, Inc. (CNSI) through a competitive procurement process to provide technical and business services to transfer, design, develop and implement an existing state-of-the-art Medicaid Management Information System (MMIS), PRISM, to support functional requirements for the Medicaid and CHIP programs and help maximize its efficiency and cost effectiveness.

CNSI's work to implement PRISM is currently underway and is expected to be fully operational in 2018. The fully operational system will include the capacity for BMHC to produce quality measures which will support continued quality improvement for the managed care plans. In the interim, Medicaid and CHIP programs use the existing MMIS to monitor and drive improvement in the managed care plans.

Utah Health Information Exchange (UHIN) and Clinical Health Information Exchange (cHIE)

cHIE is Utah's electronic health information exchange and is operated by Utah's Health Information Network (UHIN). In September of 2012, as the result of House Bill 46, Medicaid and CHIP members are automatically enrolled in the cHIE. These families are notified about how to opt-out if they do not wish to participate during their application/renewal process for benefits.

The four major Utah healthcare systems, a number of large clinics, rural hospitals and many independent practices are in various stages of joining the cHIE effort to exchange shared information for shared patients to improve quality of care and reduce costs. Utah's SIM grant will provide technical assistance to increase provider connection to and use of the cHIE, making it a statewide platform for providers' to share clinical data and report on quality metrics and community quality metrics benchmarks. Subsequent updates to the Quality Strategy will include an update on enrollment and progress with the cHIE.

Section V: Delivery System Reforms

The managed care delivery system in Utah is inclusive of many populations as well as quality services for them. Populations served through managed care in the Utah Medicaid program include the aged, blind, and disabled population, children with special health care needs, foster care children, and dual eligibles. Services include dental services, behavioral health, and

substance abuse services. The Utah Medicaid program does not currently include long-term care services and supports.

Another delivery system reform will occur through expanding mandatory enrollment in an ACO in the rural areas of the state in the future. A stakeholder process will be used to obtain feedback on this proposed expansion.

Section VI: Conclusions and Opportunities

Successes

- The establishment of ACOs as part of the Utah Medicaid program was a successful decision by lawmakers, UDOH and other stakeholders to reform the fee-for-service delivery model with one that would maintain and improve quality of care for Medicaid members and control costs. The coming years will provide important information to continue to improve the ACOs and their services to Medicaid members.
- The establishment of Utah Medicaid's ACOs in 2013 was quickly followed by the development of 25 quality measures to be tracked on an annual basis. Utah's managed care plans have performed well on these measures in the past. Plans to enhance performance of these measures through the ACOs will serve to further improve the quality of services provided to Medicaid members.
- DMHF's transition to a new information management system presents a great opportunity to implement and utilize a new data system that will enhance the implementation and review of the Quality Strategy goals.
- The HIT Incentive provides another avenue to help achieve Quality Strategy goals by improving the quality of services provided to members through ensuring timely and accurate data through EHRs.
- The continued development of the cHIE will allow BMHC and its ACOs and PMHPs to continue to exchange valuable information related to quality improvement activities which will fulfill the Quality Strategy goals.

Ongoing Challenges

- Fragmented care between physical and mental health continues to be a challenge for BMHC and its managed care plans. Mental health services for Medicaid members in Utah are primarily provided through mental health plans under the supervision of individual counties. Physical health services for Utah Medicaid members enrolled in managed care are received through the ACOs. The separation of these two services presents ongoing challenges in providing seamless and coordinated care to Medicaid members. BMHC sees several opportunities for improved integration of physical and mental health services and has included these opportunities in the Quality Strategy through different objectives and interventions. Review and analysis of these will reflect the success of BMHC and the ACOs and PMHPs in addressing this important challenge.
- As DMHF continues to manage a number of major initiatives including continued oversight of the ACOs, PRISM development and implementation, and health care

reform, organizational resources will be used at full capacity. BMHC will have to continue to prioritize the goals and objectives of the Quality Strategy in order to continue to move the work of quality improvement forward. This will ensure improved care for members through higher value managed care plans.

Recommendations

- Recommendations for ongoing quality improvement activities for Medicaid and CHIP in the State include each of the goals, objectives and interventions outlined in the Quality Strategy. Specifically, Utah Medicaid will improve in the areas of care coordination, preventive care for women and children, access to and quality of services provided, and innovative strategies for controlling quality care costs.
- It is also recommended that BMHC continue to partner with other state bureaus, external stakeholders and the SIM grant in order to most effectively and collaboratively achieve the goals and objectives outlined in the Quality Strategy.

Section VII: Appendix

Appendix: Glossary of Acronyms

ACO-Accountable Care Organization

APCD-All Payer Claims Database

BMHC-Bureau of Managed Health Care

CAHPS- Consumer Assessment of Healthcare Providers and Systems

CAP-Corrective Action Plan

CHCD-Choice of Health Care Delivery Waiver

CHIC-Children's Health Care Improvement Collaborative

cHIE-Clinical Health Information Exchange

CHIP-Children's Health Insurance Program

CHIPRA-Children's Health Insurance Program Reauthorization Act

CNSI-Client Network Solutions, Inc.

DMHF-Division of Medicaid and Health Financing

DWS-Department of Workforce Services

EHR-Electronic Health Record

EQR-External Quality Review

EQRO-External Quality Review Organization

FFS-Fee-for-Service

HCU-Health Choice Utah

HEDIS- Healthcare Effectiveness Data and Information Set

HIE-Health Information Exchange

HIT-Health Information Technology

H.O.M.E.-Health Outcomes Medical Excellence Program

HSAG-Health Services Advisory Group

HU-Healthy U

IBIS-PH-Indicator-Based Information System for Public Health

IPR-Individual Plan Report

IRIS-Idaho's Immunization Registry

MCAC-Medicaid Medical Care Advisory Committee

MCO-Managed Care Organization

MHU-Molina Healthcare of Utah

MMCS-Medicaid Managed Care System

MMIS-Medicaid Management Information System

OHCS-Office of Health Care Statistics

OQ-Outcomes Questionnaire

PAHP-Prepaid Ambulatory Health Plan

PCP-Primary Care Provider

PIHP-Prepaid Inpatient Health Plan

PIP-Performance Improvement Project

PMHP-Prepaid Mental Health Plan

SHCC-Select Health Community Care

SIM-State Innovation Models

QIC-Quality Improvement Council

UUDOH-Utah Department of Health

UHIN-Utah Health Information Network

USIS-Utah's Immunization Registry

YOQ-Youth Outcomes Questionnaire