State of Utah

Division of Medicaid and Health Financing

Bureau of Managed Health Care

Annual External Quality Review Report of Results

March 2023

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary 1-1
Introduction 1-1
The Utah Managed Care Delivery System 1-1
The State of Utah Managed Care Quality Strategy 1-3
Goals and Objectives 1-4
Purpose of the Report 1-6
Quality 1-6
Timeliness 1-7
Access 1-7
Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities 1-7
Validation of Performance Improvement Projects 1-9
Validation of Performance Measures 1-12
Compliance Monitoring 1-14
Validation of Network Adequacy 1-17
2. Evaluation of Utah Medicaid and CHIP Health Plans 2-1
Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—Medicaid 2-1
Medicaid ACOs Providing Only Physical Health Services 2-1
Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services 2-47
Medicaid PIHP PMHPs Providing Mental Health and Substance Use Disorder Services 2-110
Medicaid PAHPs Providing Dental Services 2-209
Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—CHIP 2-227
CHIP MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services 2-227
CHIP PAHP Providing Dental Services 2-249
Appendix A. Objectives and Methodology for External Quality Review by EQR Activity A-1
Appendix B. Statewide Comparative Results B-1
Appendix C. Assessment of Health Plan Follow-Up on Prior Year's Recommendations C-1
Appendix D. Summary of PIP Interventions by Health Plan Type and PIP Topic D-1

HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) require states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) ensure that a qualified external quality review organization (EQRO) conduct an annual external quality review (EQR) and prepare a detailed annual technical report of results that summarizes findings on the quality and timeliness of, and access to care. In May 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Medicaid 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 Code of Federal Regulations (CFR) §438.364 as articulated in the May 2016 regulations with revisions released in November 2020, effective December 2020. The Utah Department of Health and Human Service (DHHS), formerly the Utah Department of Health, is the Utah State agency responsible for the administration of Utah's Medicaid and CHIP programs. DHHS has contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare this report.

To provide medical services in calendar year (CY) 2022, DHHS contracted with accountable care organizations (ACOs) and prepaid mental health plans (PMHPs) that are PIHPs to serve the Medicaid population as well as Medicaid MCOs to serve the Medicaid and CHIP populations. To provide dental services, DHHS contracted with two dental PAHPs—one serving the Medicaid population and one serving both the Medicaid and CHIP populations. Throughout this report, these entities may be referred to as "health plans" unless there is a need to distinguish a particular health plan type. DHHS does not exempt any of its health plans from EQR.

The Utah Managed Care Delivery System

Table 1-1—Summary of Health Plans in CY 2022 by Type and Operating Authority

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

Four ACOs Operating Under the 1915(b) CHCD Waiver

DHHS has been operating the 1915(b) CHCD waiver program since 1982. Under this waiver, physical health care has been provided through MCOs. Since 1995, enrollment in an MCO has been mandatory for members living in Utah's urban counties. Effective January 1, 2013, the MCOs began administering the Medicaid pharmacy benefit for their members with the exception of mental health, substance use disorder (SUD), hemophilia, and transplant immunosuppressant drugs. In 2015, DHHS expanded mandatory ACO enrollment to include nine rural counties. During CY 2022, DHHS contracted with the following ACOs:

Health Choice Utah (Health Choice)

Healthy U

Molina Healthcare of Utah (Molina)

SelectHealth Community Care (SelectHealth CC)

One MCO Operating Under 1915(a) Contracting Authority

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

Four MCOs Operating Under an 1115 Demonstration Waiver

On January 1, 2020, DHHS launched its Utah Medicaid Integrated Care (UMIC) plans providing both physical health and behavioral health services to Utah's adult Medicaid expansion population in Davis, Salt Lake, Utah, Washington, and Weber counties. During CY 2022, DHHS continued to contract with four UMIC plans:

Health Choice Utah (Health Choice UMIC)

Healthy U (Healthy U Integrated)

Molina Healthcare of Utah (Molina UMIC)

SelectHealth Community Care (SelectHealth CC UMIC)

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

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

Bear River Mental Health (Bear River)

Central Utah Counseling Center (Central)

Davis Behavioral Health (Davis)

Four Corners Community Behavioral Health (Four Corners)

Healthy U Behavioral

Northeastern Counseling Center (Northeastern)

Optum (Optum/Tooele)

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

Southwest Behavioral Health Center (Southwest)

Wasatch Behavioral Health (Wasatch)

Weber Human Services (Weber)

Two MCOs Operating Under Title XXI Authority

Created in 1997 under Title XXI of the Social Security Act, CHIP provides low-cost health insurance coverage for children in working families who do not qualify for Medicaid. Utah began operating its CHIP program in 1997. In CY 2022, DHHS contracted with the following CHIP MCOs:

Molina Healthcare of Utah CHIP (Molina CHIP)

SelectHealth CHIP

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

Premier Access (Premier)

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

One CHIP Dental PAHP Operating Under Title XXI Authority

Premier Access

The State of Utah Managed Care Quality Strategy

Consistent with CMS recommendations, the DHHS Quality Strategy[1-1] provides a blueprint for advancing the State's commitment to improving quality health care delivered through the contracted

[1-1] Division of Medicaid and Health Financing: Bureau of Managed Health Care. State of Utah Managed Care Quality Strategy. Available at: Utah Managed Care Quality Strategy 2021.pdf. Accessed on: Dec 8, 2022.

health plans. Utah's primary system of health care delivery and payment is designed to improve the quality of care that Utah's Medicaid and CHIP members receive. The DHHS Quality Strategy outlines goals designated as the Triple Aim to achieve better care, better health, and better value for members enrolled in Utah's managed Medicaid and CHIP health plans. Based on results from CY EQR-related activities, HSAG offers observations and recommendations related to the following targeted goals.

Goals and Objectives

Goal 1: Improve the Quality of Care for Members

OBJECTIVES

- Evaluate health plan quality assessment and performance improvement program (QAPIP) impact

RECOMMENDATIONS

HSAG recommends that DHHS develop a forum for health plans to come together. This forum could be in coordination with the Quality Improvement Council (QIC) and/or Care Coordination Committee described in the Managed Care Quality Strategy. HSAG acknowledges that the ACOs currently meet quarterly. HSAG suggests that other health plan types such as PMHPs and PAHPs could benefit from participation. HSAG also recommends that the Division of Integrated Healthcare (DIH) medical director play an active role in the direction and implementation of this forum. This forum may achieve the following objectives:

- Discuss quality initiatives, best practices, and common barriers to improvement on measures.
- Support and encourage the health plans to continuously evaluate and improve quality programs.
- Promote collaboration between the health plans and DHHS and among health plans.
- Examine performance and collaboratively develop statewide initiatives.
- Evaluate and improve member experience of care.
- Effectively manage the oversight of contracted health plans.
- Leverage DHHS' EQRO to share and describe upcoming changes in regulations or requirements.

HSAG noted that the ACOs scored below the NCQA Quality Compass average for several measures related to health care for women and children, including *Breast Cancer Screening*, *Chlamydia Screening in Women—Total*, *Child and Adolescent Well-Care Visits—3–11 Years, Cervical Cancer Screening*, *Prenatal and Postpartum Care—Postpartum Care*, and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life*. The UMICs scored below the NCQA Quality Compass average for *Breast Cancer Screening* and *Cervical Cancer Screening*. HSAG recommends that DHHS perform a segmentation analysis of eligible populations for these measures and determine subgroups of members that represent the biggest areas of opportunity to improve performance. HSAG also

recommends focusing on health care for women and children in the forum for health plans to discuss and identify innovative approaches for improving these measures.

Goal 2: Improve the Health of Members

OBJECTIVES

- Improve statewide collaboration on quality measures
- Improve health plan performance on quality measures

RECOMMENDATIONS

Across all ACOs, in CY 2022, statewide average scores for Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems improved from 94 percent to 99 percent. For PMHPs in CY 2022, statewide average scores for Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems improved from 97 percent to 100 percent. Scores are based on whether health plans' QAPIPs include the contractually required elements. The health plans are not required to take the next step and assess whether the QAPIP activities and initiatives had an impact on member outcomes.

HSAG recommends that DHHS collaborate with the health plans to develop a quality program impact analysis format for health plans to use in determining achievement of goals set to improve performance on selected measures and other quality initiatives. This will help evaluate the impact and effectiveness of the QAPIP for each health plan. HSAG recommends that DHHS designate specific DHHS staff members to monitor the quality program impact analysis annually.

Goal 3: Improve the Value of Healthcare

OBJECTIVES

- Control health care costs while improving quality care through innovative strategies

RECOMMENDATIONS

HSAG has noted the low performance of the ACOs and UMICs for DHHS' statewide collaborative PIP, *Well-Child Visits in the First 30 Months of Life*. HSAG recommends that DHHS implement an incentive for ACOs, UMICs, and CHIP health plans by offering additional funding for achieving the NCQA 75th and 90th percentile for the *Well-Child Visits in the First 30 Months of Life* measure.

HSAG also noted low performance rates for the *Follow-Up After Hospitalization for Mental Illness* measure by the PMHPs and HOME. DHHS may also want to consider a value-based payment (VBP) program for the PMHPs and HOME based on improved performance on the *Follow-Up After*

Hospitalization for Mental Illness measure. DHHS could collaborate with the PMHPs and HOME to determine benchmark performance levels to be achieved.

Purpose of the Report

This report provides the results of the four mandatory EQR activities HSAG completed in CY 2022. DHHS contracted with HSAG to conduct validation of PIPs following CMS' *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 1)[1-2]; validation of performance measures following CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 2)[1-3]; an assessment of compliance with Medicaid managed care regulations following CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 3)[1-4] (i.e., compliance review); and validation of network adequacy (protocol not yet released) for all health plans. This report also presents health plan-specific and statewide assessments of strengths and weaknesses (listed as opportunities for improvement throughout this report) regarding health care quality and timeliness of, and access to care furnished by the health plans; conclusions drawn; and recommendations for performance improvement with statewide recommendations in this section (Section 1—Executive Summary) and health plan-specific recommendations in Section 2—Evaluation of Utah Medicaid and CHIP Health Plans.

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

Quality

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

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM [primary care case management] entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 2, 2022.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 2, 2022.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 2, 2022.

> characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and through interventions for performance improvement.[1-5]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-6]

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

Access

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

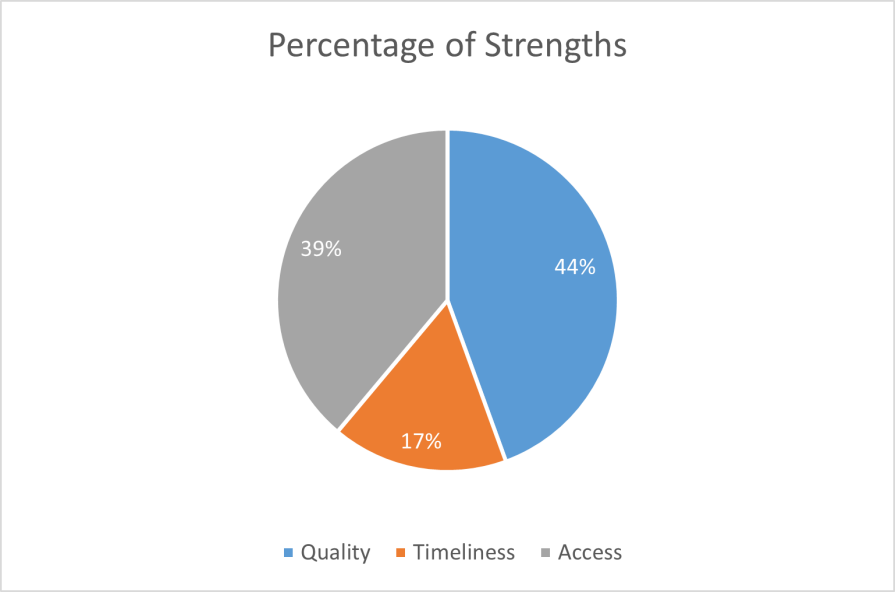
> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care health plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services).[1-7]

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

Figure 1-1 and Figure 1-2 provide an overall assessment of the percentages of strengths and weakness (opportunities for improvement) that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of all mandatory activities conducted during CY 2022.

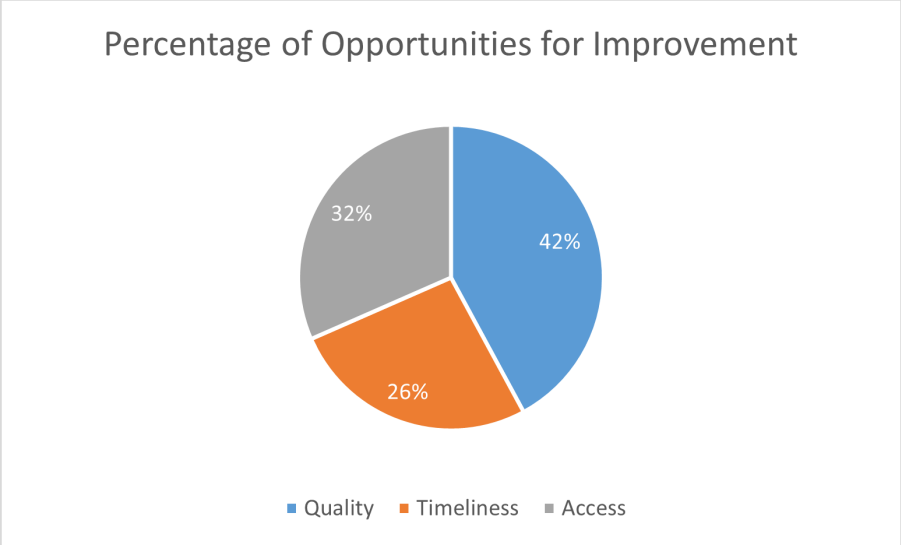
[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[1-6] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

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



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

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



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

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

Quality =

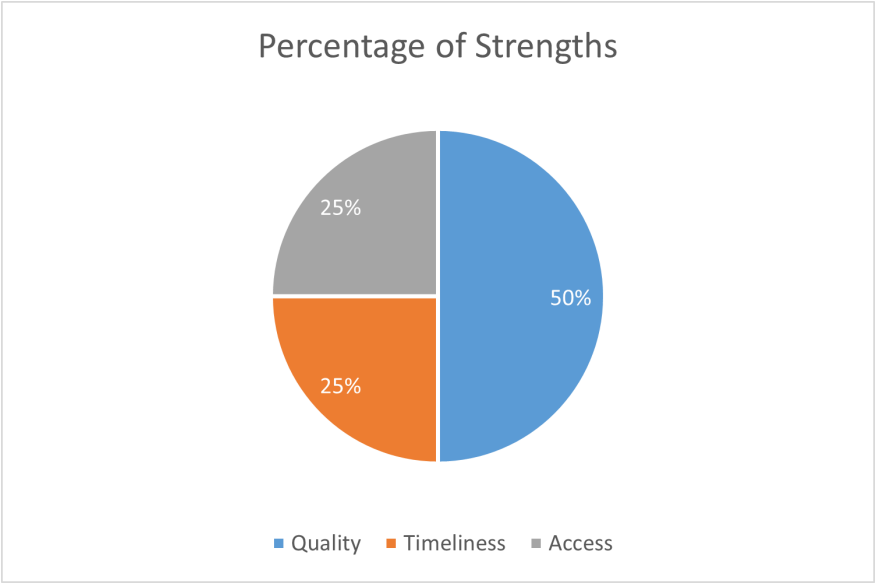
Timeliness =

Access =

Validation of Performance Improvement Projects

Figure 1-3 provides an overall assessment of the percentages of strengths and opportunities for improvement that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of PIP activities conducted during CY 2022. For plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

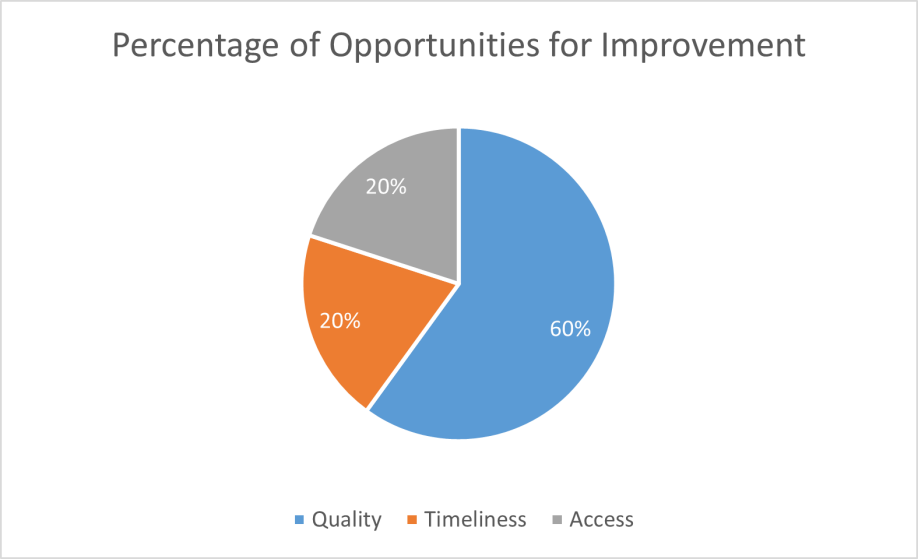
Figure 1-3—Percentage of Strengths by Care Domain for PIPs Statewide*



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

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

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



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

Statewide Strengths Related to Validation of PIPs

HSAG identified the following statewide strengths related to PIP validation:

- The health plans and dental PAHPs demonstrated a thorough application of the PIP design principles and the use of appropriate QI activities to support improvement of PIP outcomes.
- Nine (three UMIC plans and six PMHPs) of the 14 plans that reported remeasurement data demonstrated improvement in performance indicator rates over the baseline.

Statewide Opportunities for Improvement Related to Validation of PIPs

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

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

Statewide Recommendations Related to PIPs

For CY 2022, HSAG received 25 PIPs for validation. The PIPs were in varying stages. Six health plans (four ACOs , SelectHealth CHIP, and Southwest) reported PIP study design only; three health plans (Bear River, HOME, and Optum/Tooele) and two dental PAHPs (Premier Access and Premier CHIP) reported baseline results; seven health plans (Central, Four Corners, Health Choice UMIC, Healthy U Behavioral, Healthy U Integrated, Molina UMIC, and SelectHealth Integrated) reported Remeasurement 1 results; five health plans (Davis, Northeastern, Salt Lake, Wasatch, and Weber) and one dental PAHP (MCNA) submitted Remeasurement 2 results; and one health plan (Molina CHIP) reported Remeasurement 3 results. The health plans submitting remeasurement data were evaluated for achievement of statistically significant, significant clinical, and significant programmatic improvement in processes and outcomes.

Of the 25 PIPs HSAG validated, 20 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles and the use of appropriate QI activities to support improvement of PIP outcomes. The remaining five PIPs received an overall *Partially Met* validation status. The opportunities for improvement existed primarily in documentation of adequate details about the interventions, and evaluation of the effectiveness of each intervention and achievement of improvement in outcomes. More specific information about the PIP validation results for CY 2022 for each health plan and dental PAHP is included in Section 2 of this report.

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

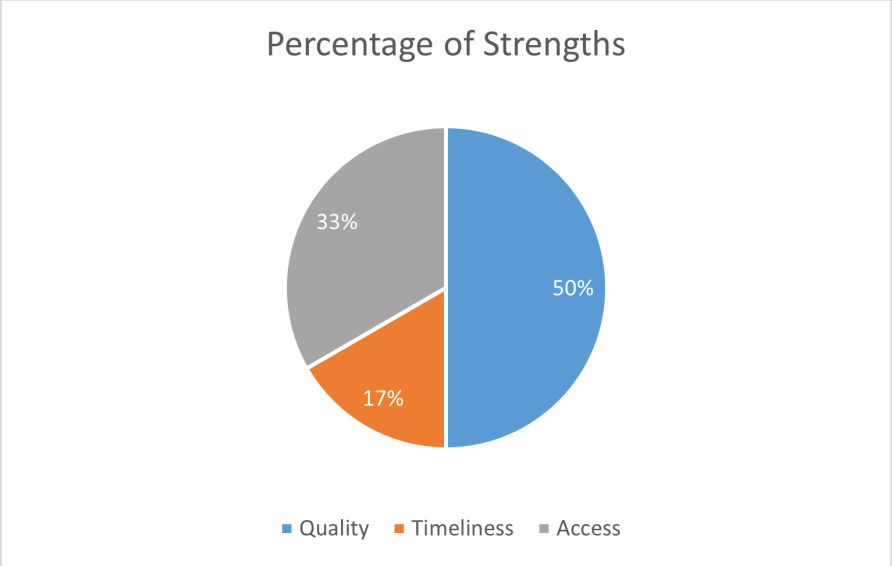
- Ensure that all documentation in the PIP Submission Form is documented correctly and completely to address each applicable evaluation element.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis during each measurement period.
- Consider using QI science-based tools, such as process mapping and failure modes and effects analysis (FMEA), for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care, in addition to other stakeholders' input.
- Implement interventions in a timely manner to impact the remeasurement rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
- Ramp up and adopt plan-wide interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles in order to impact the entire eligible population in the next measurement period.

- Include an executive sponsor (e.g., medical director, chief medical officer, or CEO) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.
- Seek technical assistance from HSAG, if needed.

Validation of Performance Measures

Figure 1-5 provides an overall assessment of the percentages of strengths and opportunities for improvement that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of performance measure activities conducted during CY 2022. For plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

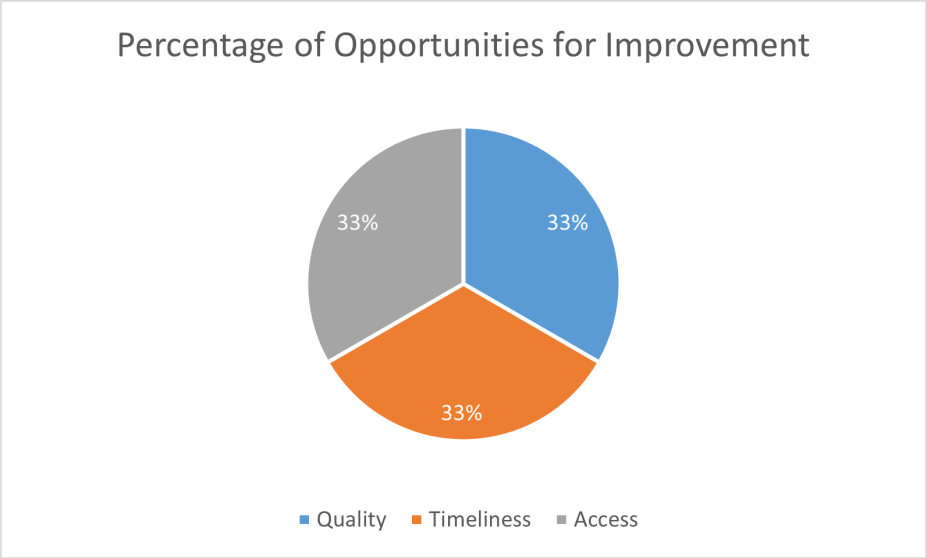
Figure 1-5—Percentage of Strengths by Care Domain for Performance Measures Statewide*



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

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

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



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

Statewide Strengths Related to Validation of Performance Measures

- The Utah ACO and CHIP plans are demonstrating strong performance in the areas of ensuring access to ambulatory care, childhood immunization, avoiding unnecessary medical treatment, and annual dental care.
- The Utah ACO plans are also displaying strong performance with regard to management of chronic medical conditions within the traditional Medicaid population.
- The majority of members enrolled in a Utah PMHP who were hospitalized for mental health treatment received outpatient follow-up care within 30 days of hospital discharge.

Statewide Opportunities for Improvement Related to Validation of Performance Measures

- All Utah Medicaid plans demonstrated opportunities for improvement in the areas of preventive and follow-up care for women and children.
- Utah UMIC plans demonstrated additional opportunities for improvement in access to primary care, management of chronic medical conditions, and behavioral health follow-up care for Adult Medicaid Expansion members.

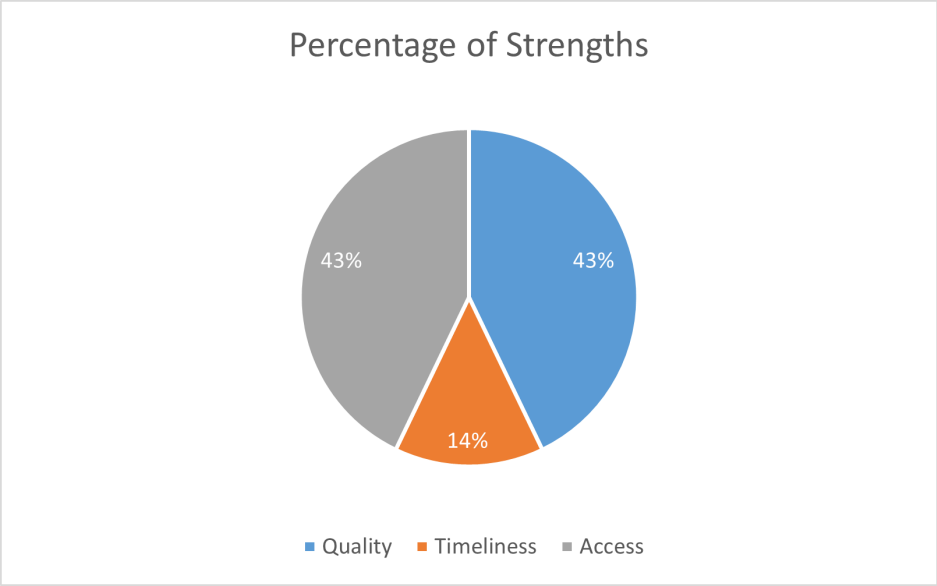
Statewide Recommendations Related to the Validation of Performance Measures

Based on measurement year (MY) 2021 performance, HSAG recommends that Medicaid ACOs, UMIC plans, and CHIP plans perform a segmentation analysis on the eligible populations for measures falling below the national average to determine subgroups of members that represent the biggest area of opportunity to improve performance. The health plans can tailor interventions that will meet the needs of noncompliant subgroups (e.g., by age, race, gender, geography, primary care provider [PCP]) once they understand the unique barriers and behavior patterns of these subgroups. It is also recommended that all Utah Medicaid plans focus on member programs that address the specific needs and barriers of women to health care since they are the key to performance across a large number of low-performing scoring indicators. HSAG recommends that the PMHPs and HOME ensure adequate validation against measure inclusion and exclusion criteria is performed prior to rate calculation and perform an analysis of noncompliant members to better understand the remaining barriers to follow-up care.

Compliance Monitoring

Figure 1-7 provides an overall assessment of the percentages of strengths and opportunities for improvement that HSAG assessed to likely impact each of the care domains of quality, timeliness, and access. These percentages were derived from the results of compliance activities conducted during CY 2022. For plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

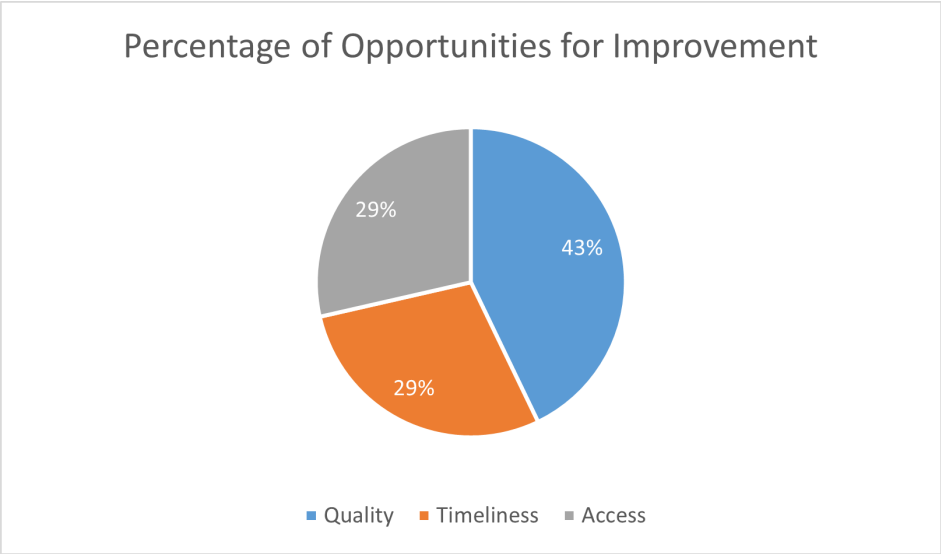
Figure 1-7—Percentage of Strengths by Care Domain for Compliance Monitoring Statewide*



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

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

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



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

Table 1-2 lists the number of health plans that had ongoing findings for each standard as a result of the CY 2022 follow-up corrective action plan (CAP) compliance review.

Table 1-2—Number of Health Plans (Statewide) With Ongoing Findings in CY 2022

Standard	Number of Health Plans (of 25 total) With Ongoing Findings
Standard I—Coverage and Authorization of Services	12
Standard II—Access and Availability	8
Standard III—Coordination and Continuity of Care	1
Standard IV—Member Rights and Information (Includes Confidentiality)	21
Standard V—Grievance and Appeal System	16
Standard VI—Provider Selection and Program Integrity	17
Standard VII—Subcontractual Relationships and Delegation	4
Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems	5
Standard IX—Enrollment and Disenrollment	0

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

HSAG identified the following statewide strengths related to compliance monitoring:

- Coordination and Continuity of Care
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Statewide Opportunities for Improvement Related to Compliance Monitoring

HSAG identified the following statewide opportunities for improvement related to compliance monitoring:

- Coverage and Authorization of Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Statewide Recommendations Related to Compliance Monitoring

HSAG offers the following statewide recommendations related to compliance monitoring:

- HSAG recommends that health plan leadership review policies, procedures, defined terms, and member- and provider-facing documents to ensure alignment with federal regulations and State contract requirements, and that any revisions identified are formally implemented within a reasonable time frame, including being made available to members and providers.
- HSAG recommends that health plans continue to refine processes to ensure that member-facing documents are written in easy-to-understand language, at or below a sixth-grade reading level, as required.
- During CY 2022, HSAG reviewed a sample of denial, appeal, grievance, credentialing, and recredentialing records from each health plan. HSAG recommends that health plan leadership review the record review findings and perform a root cause analysis to determine appropriate interventions.

Validation of Network Adequacy

While the network adequacy validation (NAV) process may be used to analyze different aspects of provider networks and members' access to care, the CY 2022 NAV focused on time/distance and provider capacity analyses for specified provider types using member enrollment and provider data files. DHHS and each respective health plan submitted these files to HSAG.

For services that require members to travel to the provider (e.g., dental care), each health plan must ensure that it contracts with an adequate number of providers to meet urbanicity-specific time or distance network requirements. However, a health plan's failure to meet a time/distance standard does not necessarily reflect a network concern, as the health plan may have DHHS' approval to use alternate methods to ensure members' access to care (e.g., community services). Additionally, a health plan's ability to meet the minimum network standard does not guarantee all facets of access to care for all members. Regardless of each health plan's ability to meet the established time/distance standards, the scope of the CY 2022 NAV did not analyze other potential barriers members may encounter when attempting to access Medicaid services. For example, factors such as members' access to transportation, health status and needs related to disability accommodations, and appointment/service availability could account for inadequate access to care despite the CY 2022 NAV results.

Overall, the Utah CY 2022 NAV results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider types (e.g., pediatric specialists). Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards. HSAG determined that all strengths and opportunities for improvement relate to the access domain and as such domain tables have not been presented for this activity. For plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

Statewide Strengths Related to NAV

- Overall, the Utah CY 2022 NAV results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider types (e.g., pediatric specialists). Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards.

Statewide Opportunities for Improvement Related to NAV

- For the provider categories for which the health plans did not meet the time/distance standard, the health plans should assess if this is due to a lack of providers available for contracting in the area,

providers who chose not to contract with the health plan, the inability to identify the providers in the data using the standard definitions, or other reasons. Each health plan can use its saturation analysis results to identify potential providers available for contracting to improve compliance with the time/distance standards.

Statewide Recommendations Related to Validation of Network Adequacy

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

- As the provider ratios and geographic distribution represent the potential capacity and distribution of contracted providers and may not directly reflect the availability of providers at any point in time, DHHS should use appointment availability and utilization analyses to evaluate providers' availability and members' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- For each health plan that did not meet either the time or the distance contract standard for a particular provider category, HSAG recommends that DHHS conduct or require the health plan to conduct an in-depth review of those provider categories, with the goal of determining whether or not the failure of the health plan to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area. Future analyses should evaluate the extent to which the health plans have requested exemptions from DHHS for provider categories in which providers may not be available or willing to contract with the health plan.
- In addition to assessing the number, distribution, and availability of providers, DHHS should review patient satisfaction survey results and grievance and appeal data to evaluate the degree to which members are satisfied with the care they have received.
- DHHS may consider collaborating with its EQRO to design and implement a focus study to investigate selected topics regarding access to care among Medicaid members by geographic region. Depending on available resources, study topics may include evaluating health disparities affecting access to care or the potential for providers in the network who are not providing services to Medicaid members (i.e., phantom provider network assessment).

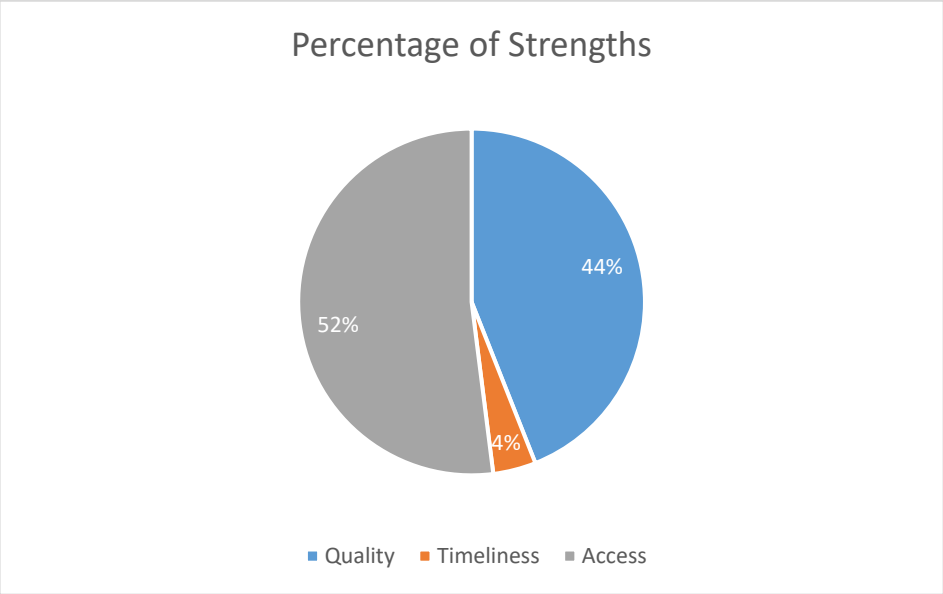
2. Evaluation of Utah Medicaid and CHIP Health Plans

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

Medicaid ACOs Providing Only Physical Health Services

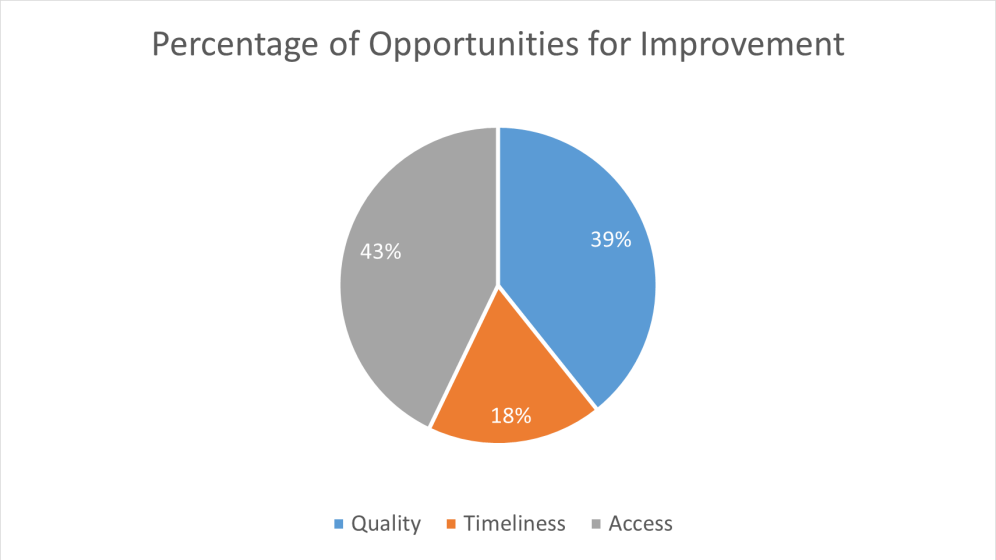
Health Choice Utah (Health Choice)

Figure 2-1—Percentage of Strengths by Care Domain for Health Choice*



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

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



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Health Choice submitted a new PIP topic: *Well-Child Visits in the First 30 Months of Life.* This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-1 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-1—CY 2022 Performance Improvement Project Validation Results for Health Choice (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**7/7**	**0/7**	**0/7**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		
	8. Assess the Improvement Strategies			
	Implementation Total			
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred			
	Outcomes Total			
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For CY 2022, Health Choice submitted the PIP design only. Health Choice had not progressed to the point of reporting data and outcomes during this validation cycle.

Barriers

Health Choice had not progressed to the point of identifying barriers during this validation cycle.

Interventions

Health Choice had not progressed to the point of determining or implementing interventions during this validation cycle.

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

Strengths

HSAG identified the following strengths:

- Health Choice received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Health Choice designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Health Choice:

- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the final audit report (FAR) for the Healthcare Effectiveness Data and Information Set (HEDIS)[2-1] MY 2021 showed that Health Choice's HEDIS compliance auditor found Health Choice's information systems (IS) and processes to be compliant with the applicable IS standards and reporting requirements for HEDIS MY 2021. Health Choice contracted with an external software vendor with

[2-1] HEDIS® is a registered trademark of the NCQA.

HEDIS Certified Measures℠,[2-2] for measure production and rate calculation. HSAG's review of Health Choice's FAR revealed that Health Choice's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to performance measure validation (PMV) results.

Performance Measure Outcomes

Table 2-2 shows Health Choice's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass[2-3] average rates.

Table 2-2—Health Choice HEDIS MY 2021 Results

HEDIS Measure	Health Choice MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	**73.81%**	75.81%
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)	69.09%	60.80%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	95.63%	93.22%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**36.88%**	51.00%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**41.61%**	56.26%
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)	63.26%	63.03%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	**80.54%**	85.28%

[2-2] HEDIS Certified Measures℠ is a service mark of the NCQA.
[2-3] Quality Compass® is a registered trademark of the NCQA.

HEDIS Measure	Health Choice MY 2021 Rate	MY 2021 NCQA Quality Compass Average
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**44.04%**	50.81%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	68.80%	58.63%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**26.76%**	36.11%
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	**62.78%**	83.53%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**64.30%**	76.18%
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.	78.02%	74.53%
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)	**57.18%**	76.11%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**48.15%**	54.10%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**44.47%**	57.13%

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

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

Strengths

Health Choice exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Upper Respiratory Infection (URI)—3 Months–17 Years*
- *Childhood Immunization Status—Combination 3*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 2*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Health Choice fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care— HbA1c Testing* and *Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life*
- *Child and Adolescent Well-Care Visits—3–11 Years*

Recommendations

Health Choice fell below the MY 2021 NCQA Quality Compass average for 10 of the 16 performance indicators (62.50 percent), indicating significant areas of opportunity. HSAG recommends improvement efforts focused on the following:

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

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

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

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-3 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Health Choice's total weighted compliance score was 85 percent. Following the CY 2022 CAP review, Health Choice improved its cumulative weighted score to 96 percent.

Table 2-3—Summary of Scores for the Standards for Health Choice ACO

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	25	23	2	0	0	96%
II	Access and Availability	14	14	13	1	0	0	96%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	28	0	0	0	100%
V	Grievance and Appeal System	28	28	21	7	0	0	88%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	14	2	0	0	94%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**152**	**139**	**13**	**0**	**0**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coordination and Continuity of Care
- Member Rights and Information (Includes Confidentiality)
- Subcontractual Relationships and Delegation
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability

- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that all Health Choice denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Health Choice UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- During the CY 2022 record review, HSAG found that almost all Health Choice grievance and appeal records lacked full compliance. For example, some records lacked evidence of Health Choice's acknowledgement of the appeal to the member, and some records lacked required information in the resolution letter to the member. HSAG recommends that Health Choice appeals leadership review the findings and perform a root cause analysis to determine appropriate interventions.
- HSAG found that some notice of adverse benefit determination (NABD) letters and member letters pertaining to appeals were not written at or below a sixth-grade reading level, as required. HSAG recommends that Health Choice UM and appeals managers develop a process to ensure that member correspondence is written in easy-to-understand language.
- HSAG recommends that Health Choice review pertinent member- and provider-facing documents to ensure the accurate and consistent use of definitions, timelines, and training for terms, including "urgent" and "grievance."

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-4 displays the number and percentage of provider categories by provider domain wherein Health Choice met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-4—Compliance With Time/Distance Standards by Provider Domain—Health Choice

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	1	50.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	13	76.5%	
Specialists—Pediatric	17	2	11.8%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	5	71.4%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

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

Opportunities for Improvement

Table 2-5 displays the provider domains and categories wherein Health Choice failed to meet the time/distance standards at the statewide level.

Table 2-5—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Outpatient Dialysis; Outpatient Infusion/ Chemotherapy	
Hospitals	Hospital—Pediatric	
PCP—Pediatric	PCP—Midlevel—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric;	

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
	Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	
Specialists—Adult	Endocrinology; Gastroenterology; Infectious Disease; Pulmonology	

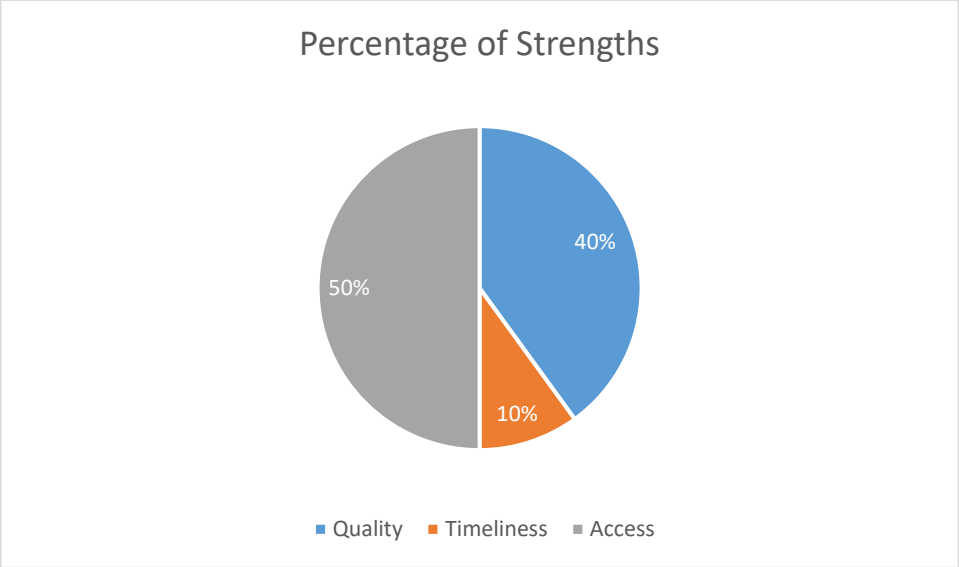
*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

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

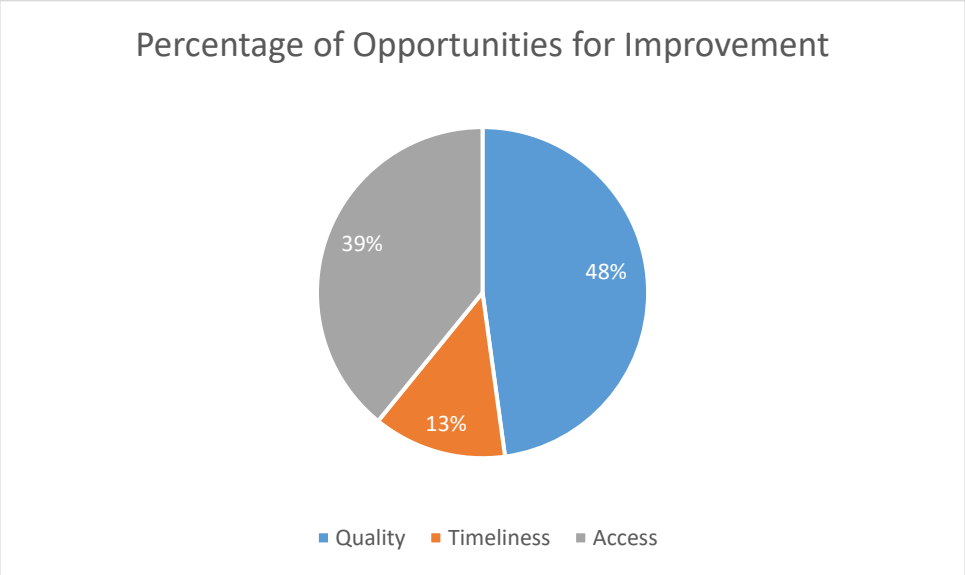
Healthy U

Figure 2-3—Percentage of Strengths by Care Domain for Healthy U*



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

Figure 2-4—Percentage of Opportunities for Improvement by Care Domain for Healthy U*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Healthy U submitted its new PIP topic: *Well-Child Visits in the First 30 Months of Life*. This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-6 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-6—CY 2022 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**7/7**	**0/7**	**0/7**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		
	8. Assess the Improvement Strategies			
	Implementation Total			
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred			
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2022, Healthy U submitted the PIP design only. Healthy U had not progressed to the point of reporting data and outcomes during this validation cycle.

Barriers

Healthy U had not progressed to the point of identifying barriers during this validation cycle.

Interventions

Healthy U had not progressed to the point of determining interventions during this validation cycle.

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

Strengths

HSAG identified the following strengths:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Healthy U designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Healthy U:

- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input, in addition to other stakeholder feedback, during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and

determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Healthy U's HEDIS compliance auditor found Healthy U's IS and processes to be partially compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Healthy U contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

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

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

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

Performance Measure Outcomes

Table 2-7 shows Healthy U's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-7—Healthy U HEDIS MY 2021 Results

HEDIS Measure	Healthy U MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	77.46%	75.81%
Antidepressant Medication Management		

HEDIS Measure	Healthy U MY 2021 Rate	MY 2021 NCQA Quality Compass Average
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	**59.86%**	60.80%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	95.71%	93.22%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**38.30%**	51.00%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**48.66%**	56.26%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	66.18%	63.03%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	86.37%	85.28%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**50.12%**	50.81%
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.	71.05%	58.63%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	37.23%	36.11%
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	84.97%	83.53%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**71.31%**	76.18%

HEDIS Measure	Healthy U MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**70.34%**	74.53%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	80.40%	76.11%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**42.57%**	54.10%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**48.77%**	57.13%

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

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

Strengths

Healthy U exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Appropriate Treatment for URI—3 Months–17 Years*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

Opportunities for Improvement

Healthy U fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life*
- *Child and Adolescent Well-Care Visits—3–11 Years*

Recommendations

Healthy U fell below the MY 2021 NCQA Quality Compass average for nine of the 16 performance indicators (56.25 percent), indicating significant areas of opportunity. Improvement efforts could be focused on the following:

- Consider a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are showing up for care, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health Plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and

providers, and whether the health plan is collecting and using data to focus efforts and drive performance.

  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the quality strategy is aligned with performance goals.

- Consider a focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Healthy U measures falling below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-8 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Healthy U's total weighted compliance score was 92 percent. Following the CY 2022 CAP review, Healthy U improved its cumulative weighted score to 96 percent.

Table 2-8—Summary of Scores for the Standards for Healthy U ACO

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	30	30	26	4	0	0	93%
II	Access and Availability	14	14	14	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	27	25	2	0	1	96%
V	Grievance and Appeal System	28	28	23	5	0	0	91%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**157**	**156**	**144**	**12**	**0**	**1**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- Coordination and Continuity of Care
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that all Healthy U denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Healthy U UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- HSAG found that some NABD letters and member letters pertaining to appeals and grievances were not written at or below a sixth-grade reading level, as required. HSAG recommends that Healthy U UM managers and grievance and appeals managers develop a process to ensure that member correspondence is written in easy-to-understand language.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-9 displays the number and percentage of provider categories by provider domain wherein Healthy U met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-9—Compliance With Time/Distance Standards by Provider Domain—Healthy U

Provider Domain	Number of Provider Categories in the Domain	Number of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	1	50.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Specialists—Pediatric	17	6	35.3%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	6	85.7%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

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

Opportunities for Improvement

Table 2-10 displays the provider domains and categories wherein Healthy U failed to meet the time/distance standards at the statewide level.

Table 2-10—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U*

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

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

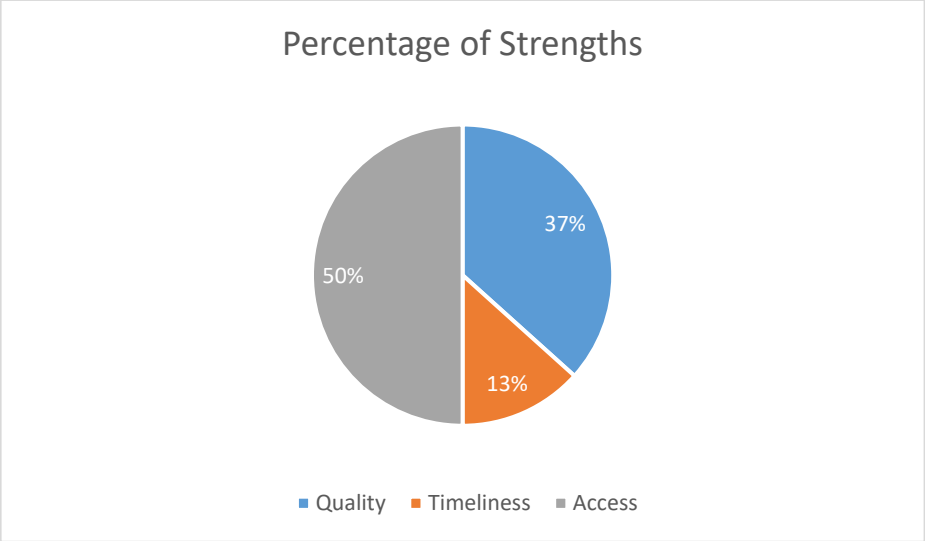
** No data were submitted for the provider category.

Recommendations

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

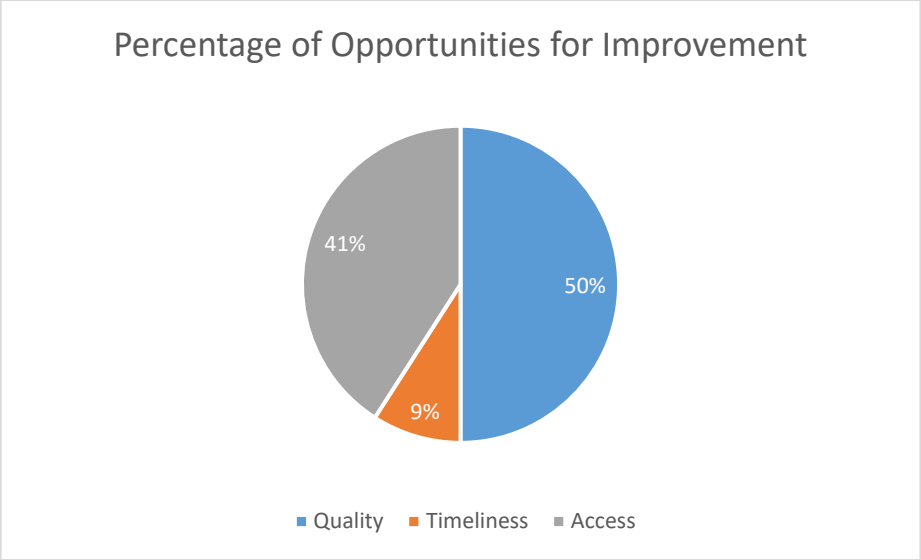
Molina Healthcare of Utah (Molina)

Figure 2-5—Percentage of Strengths by Care Domain for Molina*



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

Figure 2-6—Percentage of Opportunities for Improvement by Care Domain for Molina*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Molina submitted its new PIP topic: *Well-Child Visits in the First 30 Months of Life.* This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-11 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-11—CY 2022 Performance Improvement Project Validation Results for Molina (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**7/7**	**0/7**	**0/7**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		
	8. Assess the Improvement Strategies			
	Implementation Total			
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred			
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2022, Molina submitted the PIP design only. Molina had not progressed to the point of reporting data and outcomes during this validation cycle.

Barriers

Molina had not progressed to the point of identifying barriers during this validation cycle.

Interventions

Molina had not progressed to the point of determining interventions during this validation cycle.

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

Strengths

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Molina designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Molina:

- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input, in addition to other stakeholder feedback, during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Molina contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

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

Performance Measure Outcomes

Table 2-12 shows Molina's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-12—Molina HEDIS MY 2021 Results

HEDIS Measure	Molina MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	75.89%	75.81%
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	60.80%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	94.62%	93.22%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**35.60%**	51.00%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**46.47%**	56.26%
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	**56.45%**	63.03%

HEDIS Measure	Molina MY 2021 Rate	MY 2021 NCQA Quality Compass Average
chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)		
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	86.37%	85.28%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**47.45%**	50.81%
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.	**48.91%**	58.63%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**26.28%**	36.11%
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	**66.91%**	83.53%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**69.59%**	76.18%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	75.23%	74.53%
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)	**57.42%**	76.11%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**44.72%**	54.10%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**46.90%**	57.13%

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

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

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

Strengths

Molina exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Appropriate Treatment for URI—3 Months–17 Years*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Immunizations for Adolescents—Combination 2*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Molina fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

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

Recommendations

Molina fell below the MY 2021 NCQA Quality Compass average for 10 of the 16 performance indicators (62.50 percent), indicating significant areas of opportunity. Improvement efforts could be focused on the following:

- Consider a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are showing up for care, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health Plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the quality strategy is aligned with performance goals.
- Consider a focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Health Choice measures falling below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-13 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Molina's total weighted compliance score was 96 percent. Following the CY 2022 CAP review, Molina improved its cumulative weighted score to 99 percent.

Table 2-13—Summary of Scores for the Standards for Molina ACO

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	25	23	2	0	0	96%
II	Access and Availability	14	14	14	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	27	1	0	0	98%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**152**	**148**	**4**	**0**	**0**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- Coordination and Continuity of Care
- Grievance and Appeal System
- Subcontractual Relationships and Delegation

- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information (Includes Confidentiality)
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that all Molina denial records lacked compliance. For example, some standard authorization decisions were not made in a timely manner, and all letters were missing content as required at 42 CFR §438.404(b). HSAG recommends that Molina UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment, timely, and include complete information.
- HSAG found that some member letters pertaining to appeals were not written at or below a sixth-grade reading level, as required. HSAG recommends that Molina UM managers develop a process to ensure that member correspondence is written in easy-to-understand language.
- HSAG recommends that Molina review pertinent provider-facing documents to ensure accurate and consistent time frames related to appeals and State fair hearings.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-14 displays the number and percentage of provider categories by provider domain wherein Molina met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-14—Compliance With Time/Distance Standards by Provider Domain—Molina

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	1	50.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Specialists—Pediatric	17	6	35.3%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

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

Opportunities for Improvement

Table 2-15 displays the provider domains and categories wherein Molina failed to meet the time/distance standards at the statewide level.

Table 2-15—Provider Categories That Failed to Meet Time/Distance Standards—Molina*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology; Mammography; Outpatient Infusion/Chemotherapy**	
Hospitals	Hospital—Pediatric	
PCP—Pediatric	PCP—Midlevel—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric**; Endocrinology, Pediatric; Gastroenterology, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric**; Otolaryngology, Pediatric; Physical	

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
	Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric	

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

** No data were submitted for the provider category.

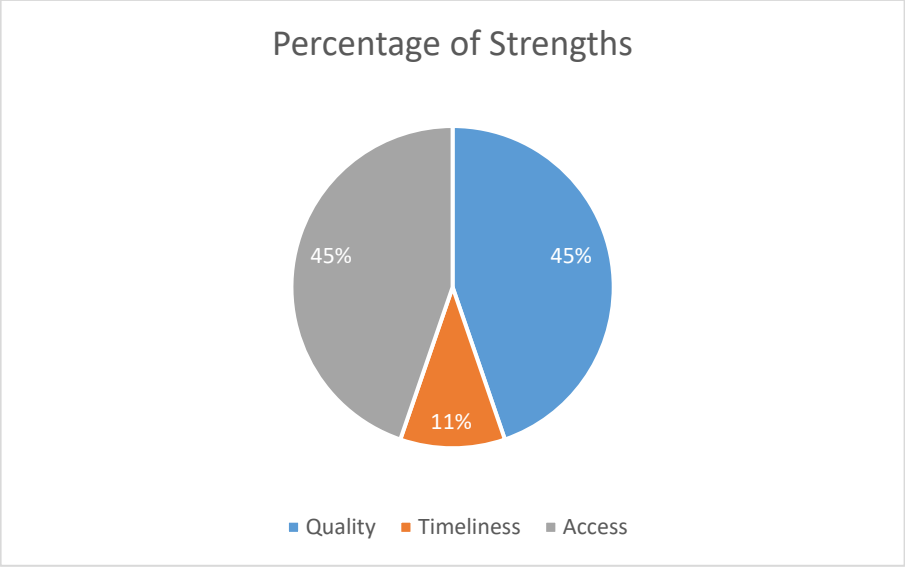
Recommendations

HSAG offers the following recommendations:

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

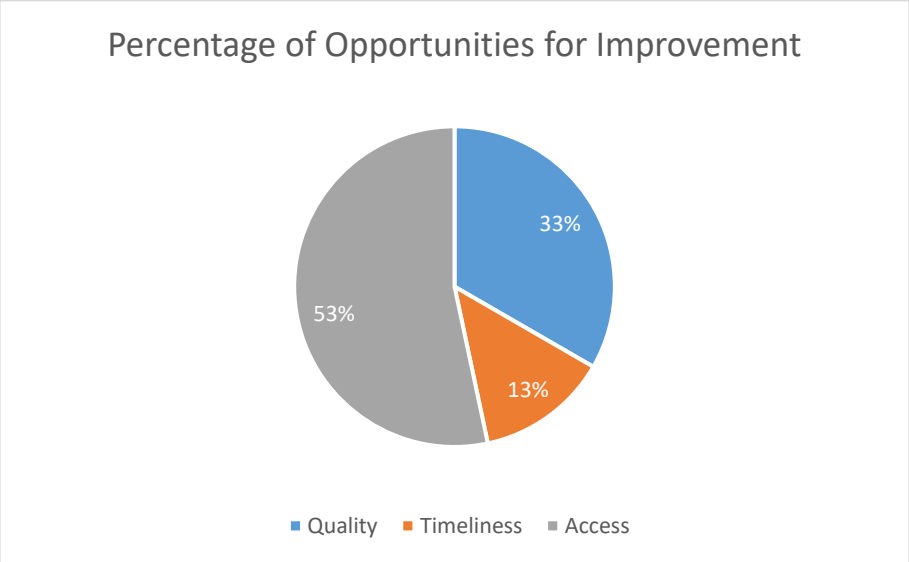
SelectHealth Community Care (SelectHealth CC)

Figure 2-7—Percentage of Strengths by Care Domain for SelectHealth CC*



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

Figure 2-8—Percentage of Opportunities for Improvement by Care Domain for SelectHealth CC*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, SelectHealth CC submitted a new PIP topic: *Well-Child Visits in the First 30 Months of Life.* This PIP is a collaborative approach with DHHS and other health plans in order to affect quality performance improvement on a broader scale for children in Utah.

Validation Results and Interventions

Table 2-16 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-16—CY 2022 Performance Improvement Project Validation Results for SelectHealth CC (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**7/7**	**0/7**	**0/7**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		
	8. Assess the Improvement Strategies			
	Implementation Total			
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred			
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2022, SelectHealth CC submitted the PIP design only. SelectHealth CC had not progressed to the point of reporting data and outcomes during this validation cycle.

Barriers

SelectHealth CC had not progressed to the point of identifying barriers during this validation cycle.

Interventions

SelectHealth CC had not progressed to the point of determining interventions during this validation cycle.

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

Strengths

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- SelectHealth CC designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that SelectHealth CC:

- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input, in addition to other stakeholder feedback, during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and

determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that SelectHealth CC's HEDIS compliance auditor found SelectHealth CC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. SelectHealth CC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

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

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

Performance Measure Outcomes

Table 2-17 shows SelectHealth CC's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-17—SelectHealth CC HEDIS MY 2021 Results

HEDIS Measure	SelectHealth CC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	81.03%	75.81%
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)	70.18%	60.80%
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	96.91%	93.22%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**47.76%**	51.00%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	60.80%	56.26%
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)	71.78%	63.03%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	92.53%	85.28%
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)	64.18%	50.81%
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.	66.77%	58.63%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	36.63%	36.11%

HEDIS Measure	SelectHealth CC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Prenatal and Postpartum Care		
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	94.27%	83.53%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	86.02%	76.18%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	75.27%	74.53%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	86.61%	76.11%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	58.07%	54.10%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**52.05%**	57.13%

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

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

Strengths

SelectHealth CC exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for URI—3 Months–17 Years*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*

- *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 2*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *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—Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement

SelectHealth CC fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Child and Adolescent Well-Care Visits—3–11 Years*

Recommendations

SelectHealth CC fell below the 2021 NCQA Quality Compass average for two of the 16 performance indicators (12.5 percent), indicating a few areas of opportunity. Targeted improvement efforts could be focused on the following:

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

  - Health Plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the quality strategy is aligned with performance goals.
- Consider a focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since all of the SelectHealth CC measures falling below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-18 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, SelectHealth CC's total weighted compliance score was 94 percent. Following the CY 2022 CAP review, SelectHealth CC improved its cumulative weighted score to 99 percent.

Table 2-18—Summary of Scores for the Standards for SelectHealth CC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	25	25	0	0	0	100%
II	Access and Availability	14	14	13	1	0	0	96%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	27	1	0	0	98%
V	Grievance and Appeal System	28	28	27	1	0	0	98%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VI	Provider Selection and Program Integrity	20	20	20	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	4	3	1	0	0	88%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**152**	**148**	**4**	**0**	**0**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Subcontractual Relationships and Delegation

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that SelectHealth CC implement a process to ensure updated member documents are made available to members on its website.
- During the CY 2022 record review, HSAG found that SelectHealth CC sent grievance acknowledgement letters with incorrect information to members. HSAG recommends that SelectHealth CC develop a process to ensure letters being sent to members contain accurate information.
- HSAG recommends that SelectHealth CC leadership review grievance policies and processes to identify any issues and implement appropriate corrections.
- HSAG recommends that SelectHealth CC review delegated agreements related to administrative services to ensure subcontractor agreement to comply with applicable Medicaid laws, regulations, and contract provisions.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-19 displays the number and percentage of provider categories by provider domain wherein SelectHealth CC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and SelectHealth CC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-19—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CC

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	🔑
PCP—Pediatric	2	1	50.0%	🔑
Prenatal Care and Women's Health Providers	2	1	50.0%	🔑
Specialists—Adult	17	17	100.0%	🔑
Specialists—Pediatric	17	4	23.5%	🔑

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	

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

Opportunities for Improvement

Table 2-20 displays the provider domains and categories wherein SelectHealth CC failed to meet the time/distance standards at the statewide level.

Table 2-20—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CC*

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

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

Recommendations

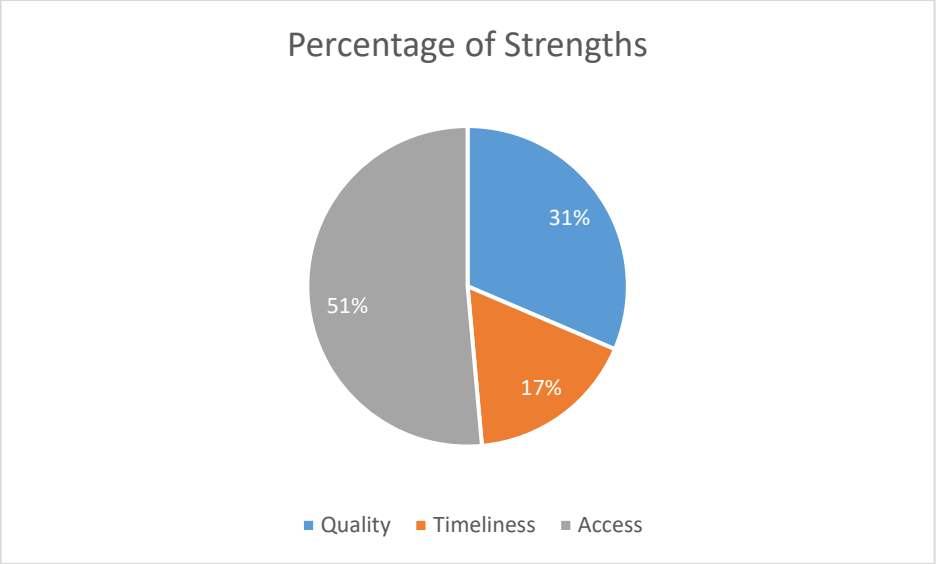
HSAG offers the following recommendations:

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

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

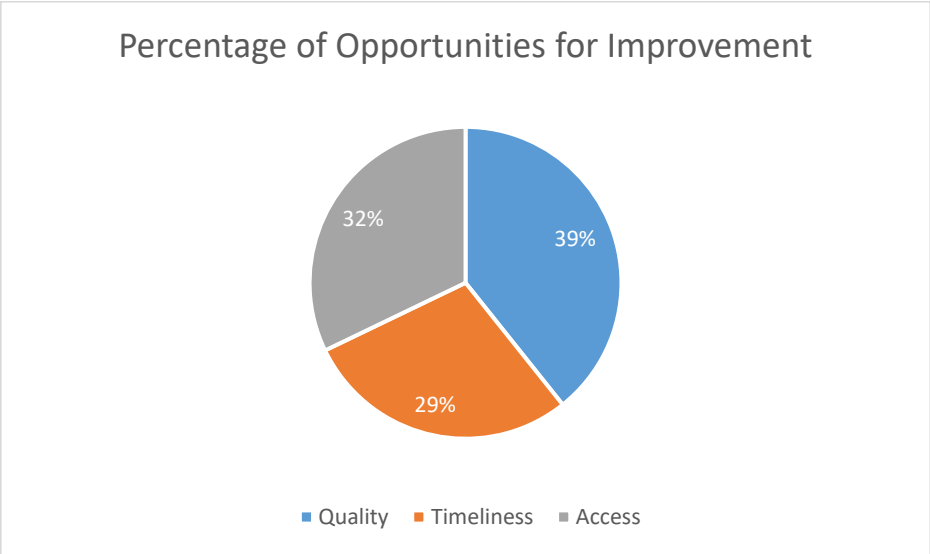
Health Choice Utah (Health Choice UMIC)

Figure 2-9—Percentage of Strengths by Care Domain for Health Choice UMIC*



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

Figure 2-10—Percentage of Opportunities for Improvement by Care Domain for Health Choice UMIC*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Health Choice UMIC continued its clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness.* This PIP aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Validation Results and Interventions

Table 2-21 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-21—PIP—*Follow-Up After Hospitalization for Mental Illness*
Health Choice UMIC

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**100% (9/9)**	**0%**	**0%**

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

Indicator Outcomes

Health Choice UMIC reported Remeasurement 1 data in the CY 2022 submission. Health Choice UMIC achieved statistically significant improvement in the Remeasurement 1 rates of both performance indicators over the baseline.

Table 2-22 displays the data for Health Choice UMIC's PIP.

Table 2-22—PIP—*Follow-Up After Hospitalization for Mental Illness*
Health Choice UMIC

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2020–12/31/2020)**		**Remeasurement 1 (01/01/2021-12/31/2021)**		**Sustained Improvement**
1. Follow-Up After Hospitalization for Mental Illness within 7 Days	N: 22	12.0%	N: 55	24.4%*	*Not Assessed*
	D: 184		D: 225		
2. Follow-Up After Hospitalization for Mental Illness within 30 Days	N: 44	23.9%	N: 91	40.4%*	
	D: 184		D: 225		

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

The baseline rate for the percentage of eligible members 6 years of age and older who had a follow-up visit with a mental health provider within seven days after discharge was 12.0 percent. For Remeasurement 1, Health Choice UMIC reported a Performance Indicator 1 rate of 24.4 percent, which represents a statistically significant improvement ($p < 0.05$) of 12.4 percentage points over the baseline.

The baseline rate for the percentage of members 6 years of age and older who had a follow-up visit with a mental health provider within 30 days after discharge was 23.9 percent. For Remeasurement 1, Health Choice UMIC reported a Performance Indicator 2 rate of 40.4 percent, which represents a statistically significant improvement ($p < 0.05$) of 16.5 percentage points over the baseline.

Health Choice UMIC will be assessed for sustained improvement in the next validation cycle.

Barriers

The identification of barriers to achieving the desired PIP outcomes through barrier analysis, and the subsequent selection of appropriate interventions to address these barriers, are necessary steps to improve outcomes. Each health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

For the *Follow-Up After Hospitalization for Mental Illness* PIP, Health Choice UMIC documented the following barriers to achieving desired PIP outcomes:

- Inability to reach members due to poor contact information.
- Lack of member engagement and follow-through on appointment attendance.
- Inability to receive timely notification for measure-eligible discharges to identify members for necessary case management outreach.

Interventions

To address the identified barriers, Health Choice UMIC implemented the following interventions:

- The behavioral health case manager used discharge documents with face sheets and the clinical health information exchange (cHIE) to find better contact information for the member and made three attempts to reach out and encourage follow-up care.
- The performance improvement coordinator (PIC) team works with the case management team to encourage outreach to the member or member's inpatient case manager prior to discharge to ensure a discharge plan is in place and also to update member contact information.
- Obtaining admit, discharge, and transfer alerts from the cHIE will help identify measure-eligible discharges. A process flow will be created for review and execution of outreach based on these new data.

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

Strengths

- The PIP received an overall *Met* validation status with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Health Choice UMIC achieved statistically significant improvement in performance indicators' rates over the baseline.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Health Choice UMIC:

- Continue with its improvement efforts to sustain the improvement achieved in PIP outcomes.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Have a process in place for evaluating each PIP intervention and its impact on the performance indicators. For example, Health Choice UMIC should track the number of measure-eligible discharges for which timely information was received using the Utah cHIE and whether the health plan was successful in conducting timely outreach after receiving the discharge information. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.
- Address any validation feedback comments associated with a *Met* score in the next annual submission. If the validation feedback is not addressed, the corresponding evaluation element's score in the PIP Validation Tool may be impacted.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Health Choice UMIC's HEDIS compliance auditor found Health Choice UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Health Choice UMIC contracted with an

external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Health Choice UMIC's FAR revealed that Health Choice UMIC's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-23 shows Health Choice UMIC's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-23—Health Choice UMIC HEDIS MY 2021 Results

HEDIS Measure	Health Choice UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**59.90%**	75.81%
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	60.80%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	NA	51.00%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	74.92%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**31.39%**	56.26%
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)	**74.70%**	85.28%
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)	**31.14%**	50.81%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	60.10%	58.63%

HEDIS Measure	Health Choice UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	**71.33%**	79.20%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.13%
Follow-Up After Emergency Department Visit for Mental Illness		
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up–Total)	**14.89%**	40.08%
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up–Total)	**24.47%**	53.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence		
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up–Total)	22.81%	13.35%
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up–Total)	28.90%	19.79%
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up–Total)	**24.44%**	38.44%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up–Total)	**40.44%**	58.73%
Initiation and Engagement of AOD Dependence Treatment		
Initiation of AOD Treatment: Adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. (Initiation of AOD Treatment–Total)	45.86%	44.16%

HEDIS Measure	Health Choice UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Engagement of AOD Treatment: Adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. (Engagement of AOD Treatment–Total)	14.55%	13.87%
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.	76.52%	74.53%

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

Strengths

Health Choice UMIC exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Controlling High Blood Pressure*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Health Choice UMIC fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

Recommendations

Health Choice UMIC fell below the MY 2021 NCQA Quality Compass average for eight of the 19 performance indicators (42.11 percent), indicating significant areas of opportunity. Improvement efforts could be focused on the following:

- Consider a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are showing up for care, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health Plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.

  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the quality strategy is aligned with performance goals.
- Establish partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and Value-Based Reimbursement [VBR] contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Consider providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Health Choice UMIC care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-24 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Health Choice UMIC's total weighted compliance score was 85 percent. Following the CY 2022 CAP review, Health Choice UMIC improved its cumulative weighted score to 96 percent.

Table 2-24—Summary of Scores for the Standards for Health Choice UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	25	23	2	0	0	96%
II	Access and Availability	14	14	13	1	0	0	96%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	28	0	0	0	100%
V	Grievance and Appeal System	28	28	21	7	0	0	88%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	14	2	0	0	94%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**152**	**139**	**13**	**0**	**0**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coordination and Continuity of Care
- Member Rights and Information (Includes Confidentiality)
- Subcontractual Relationships and Delegation
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that all Health Choice UMIC denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Health Choice UMIC UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- During the CY 2022 record review, HSAG found that almost all Health Choice UMIC grievance and appeal records lacked full compliance. For example, some records lacked evidence of Health Choice UMIC's acknowledgement of the appeal to the member, and some records lacked required information in the resolution letter to the member. HSAG recommends that Health Choice UMIC grievance and appeals leadership review the findings and perform a root cause analysis to determine appropriate interventions.
- HSAG found that some NABD letters and member letters pertaining to appeals were not written at or below a sixth-grade reading level, as required. HSAG recommends that Health Choice UMIC UM and appeals managers develop a process to ensure that member correspondence is written in easy-to-understand language.
- HSAG recommends that Health Choice UMIC review pertinent member- and provider-facing documents to ensure the accurate and consistent use of definitions, timelines, and training for terms, including "urgent" and "grievance."

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-25 displays the number and percentage of provider categories by provider domain wherein Health Choice UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Health Choice UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-25—Compliance With Time/Distance Standards by Provider Domain—Health Choice UMIC

Provider Domain	Number of Provider Categories	Count of provider Categories Within Time Distance Standard*	Percent of Provider Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	3	100.0%	
Behavioral Health—Facilities	4	2	50.0%	

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

Opportunities for Improvement

Table 2-26 displays the provider domains and categories wherein Health Choice UMIC failed to meet the time/distance standards at the statewide level.

Table 2-26—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice UMIC*

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

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

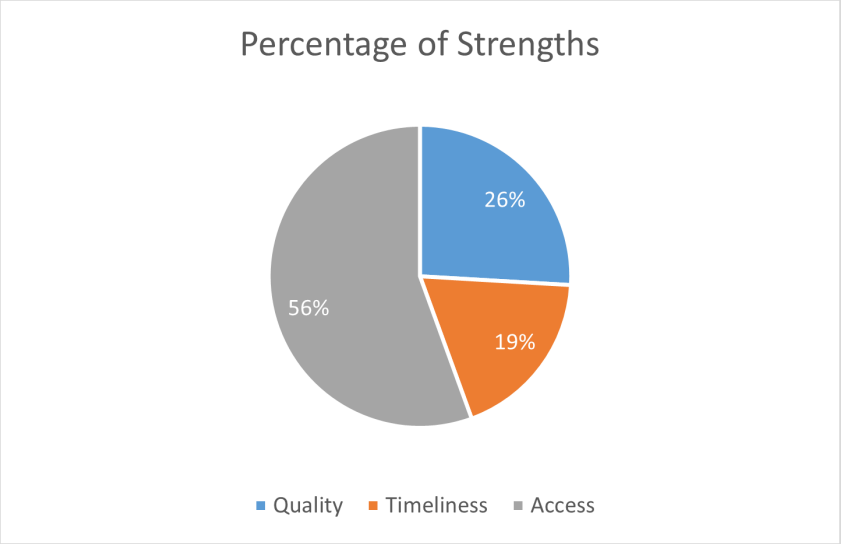
Recommendations

HSAG offers the following recommendations:

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

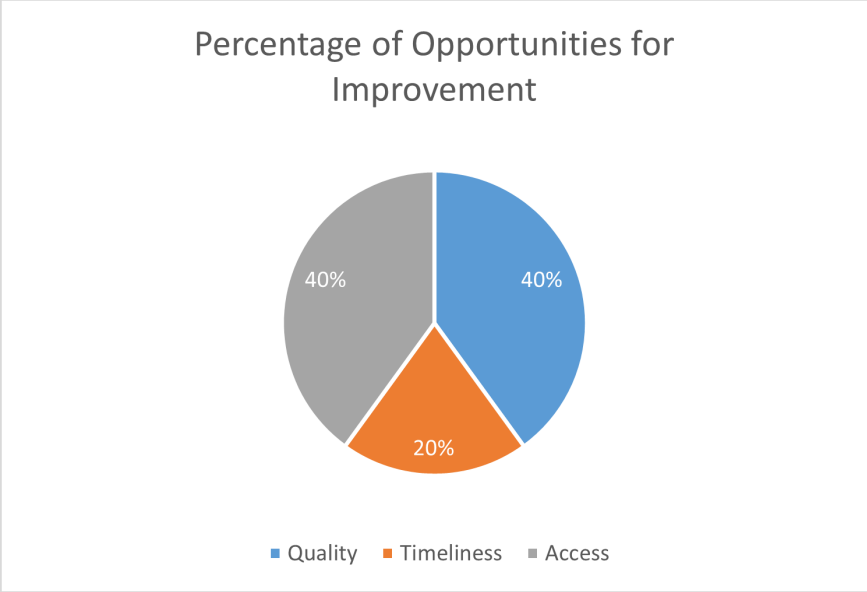
Healthy Outcomes Medical Excellence (HOME)

Figure 2-11—Percentage of Strengths by Care Domain for HOME*



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

Figure 2-12—Percentage of Opportunities for Improvement by Care Domain for HOME*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, HOME submitted its new PIP topic: *Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic.* The goal of this PIP is to improve outcomes of members' health through focus on increasing the percentage of members receiving at least one preventive annual physical examination.

Validation Results and Interventions

Table 2-27 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-27—CY 2022 Performance Improvement Project Validation Results for HOME (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**7/7**	**0/7**	**0/7**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	*Not Assessed*		
	Implementation Total	**3/3**	**0/3**	**0/3**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Validation Status	***Met***		

Indicator Outcomes

For this year's validation, HOME reported baseline results. HOME will be assessed for improvement in outcomes in next year's annual validation.

Table 2-28 displays data for HOME's *Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic*.

Table 2-28—PIP—*Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic*
HOME

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2021–12/31/2021)**		**Remeasurement 1 (01/01/2022–12/31/2022)**		**Remeasurement 2 (01/01/2023–12/31/2023)**		**Sustained Improvement**
Percentage of HOME enrollees (4 years and older) who received at least one annual physical examination during measurement year.	N: 624	51.1%					
	D: 1,222						

N–Numerator D–Denominator

The baseline rate for the percentage of eligible members who received at least one annual physical examination during CY 2021 was 51.1 percent.

Barriers

HOME had not progressed to the point of identifying barriers during this validation cycle.

Interventions

HOME had not progressed to the point of implementing interventions during this validation cycle.

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

Strengths

HSAG identified the following strengths:

- The PIP received an overall *Met* validation status with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- HOME designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that HOME:

- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2021 PMV Report indicated that HSAG found HOME's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up* should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-29 presents HOME's MY 2021 performance measure results.

Table 2-29—HOME MY 2021 *FUH* Results

Indicator	HOME Rate*
Follow-Up Within 7 Days	36.67%
Follow-Up Within 30 Days	90.00%

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

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

Strengths

- HOME demonstrated commitment to address the medical and behavioral health needs of its Medicaid members internally. HOME made improvements to its leadership structure and expanded its internal provider network to cover services that were previously conducted by external providers, such as occupational and speech therapy.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during this year's PMV activity.

Recommendations

HSAG did not identified any recommendation related to PMV.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-30 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, HOME's total weighted compliance score was 91 percent. Following the CY 2022 CAP review, HOME improved its cumulative weighted score to 98 percent.

Table 2-30—Summary of Scores for the Standards for HOME

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	28	28	28	0	0	0	100%
II	Access and Availability	14	14	14	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	27	1	0	0	98%
V	Grievance and Appeal System	28	28	23	5	0	0	91%
VI	Provider Selection and Program Integrity	20	20	20	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	7	7	7	0	0	0	100%
	Totals	**154**	**154**	**148**	**6**	**0**	**0**	**98%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care

- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified strengths within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that HOME implement a process to ensure updated member-facing documents are made available to members on its website.
- HSAG recommends that HOME leadership review grievance and appeals policies, processes, and member-facing documents to identify any issues related to grievance and appeal requirements and implement appropriate corrections.
- During the CY 2022 record review, HSAG found that all appeals acknowledgement letters contained incorrect information. HSAG recommends that HOME develop a process to ensure appeal letters being sent to members contain accurate information.
- HSAG found that some appeal resolution letters were not written at or below a sixth-grade reading level, as required. HSAG recommends that HOME appeals managers develop a process to ensure that member correspondence is written in easy-to-understand language.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-31 displays the number and percentage of provider categories by provider domain wherein HOME met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and HOME in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-31—Compliance With Time/Distance Standards by Provider Domain—HOME

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
PCP—Pediatric	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Specialists—Pediatric	17	14	82.4%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	7	100.0%	
Hospitals	2	2	100.0%	

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

Opportunities for Improvement

Table 2-32 displays the provider domains and categories wherein HOME failed to meet the time/distance standards at the statewide level.

Table 2-32—Provider Categories That Failed to Meet Time/Distance Standards—HOME*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Allergy & Immunology, Pediatric**; Ophthalmology, Pediatric**; Orthopedic Surgery, Pediatric**	

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

** No data were submitted for the provider category.

Recommendations

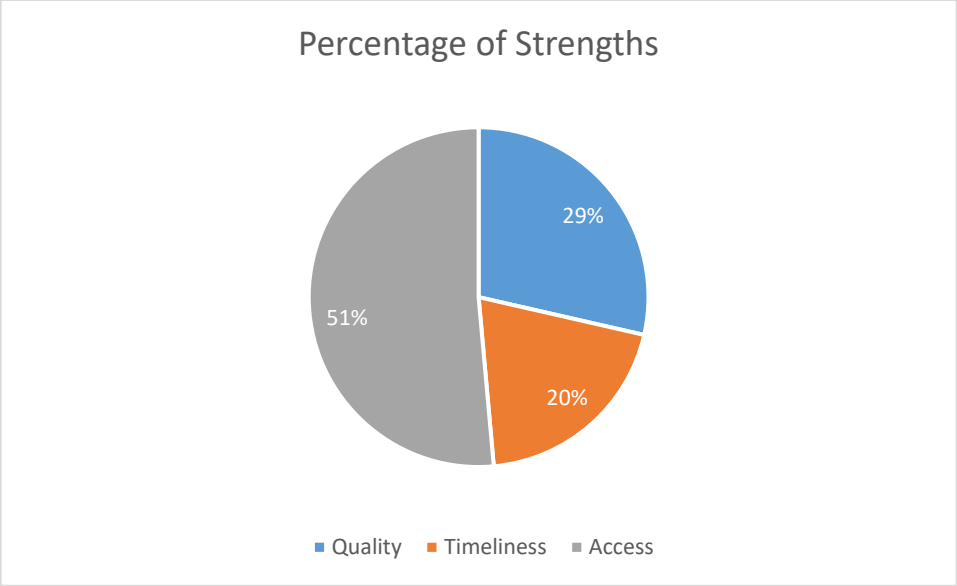
HSAG offers the following recommendation:

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

to data concerns, HOME should ensure all providers are appropriately identified in future data submissions.

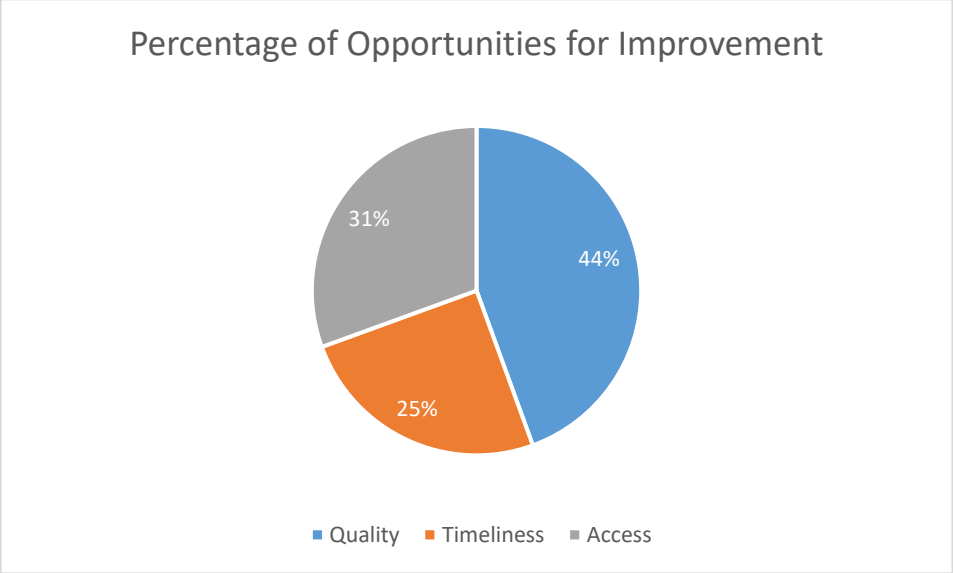
Healthy U Integrated

Figure 2-13—Percentage of Strengths by Care Domain for Healthy U Integrated*



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

Figure 2-14—Percentage of Opportunities for Improvement by Care Domain for Healthy U Integrated*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Healthy U Integrated continued its clinical PIP topic: *Improving Adults' Access to Preventive/Ambulatory Care Services*. The PIP submitted by Healthy U Integrated aims to increase the percentage of adult members receiving annual ambulatory or preventive care visits with a physician.

Validation Results and Interventions

Table 2-33 summarizes the validation findings for the PIP validated for CY 2022. Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-33—CY 2022 Performance Improvement Project Validation Results for Healthy U Integrated (N=1 PIP)

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

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Evaluation Elements *Met*		**95%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

Healthy U Integrated reported Remeasurement 1 data in this validation cycle. There was a decline in the performance indicator rate, and Healthy U Integrated did not show evidence of achieving significant clinical or programmatic improvement during Remeasurement 1.

Table 2-34 displays data for Healthy U Integrated's *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP.

Table 2-34—PIP—*Improving Adults' Access to Preventive/Ambulatory Care Services*
Healthy U Integrated

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

N–Numerator D–Denominator

The baseline rate for the percentage of eligible members 20 years of age and older who received one or more ambulatory or preventive care visits during the measurement year was 71.3 percent. For Remeasurement 1, Healthy U Integrated documented a 2.8 percentage point decrease in the performance over the baseline for a Remeasurement 1 rate of 68.5 percent. Healthy U Integrated noted an increase in its Integrated Care membership and the Delta and Omicron surges of the coronavirus disease 2019 (COVID-19) pandemic in 2021 as the likely reasons for the negative impact on members seeking nonurgent primary or ambulatory care visits.

Barriers

For the *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP, Healthy U Integrated used a fishbone diagram to identify the following barriers to achieving desired PIP outcomes:

- The Medicaid expansion population may be new to health insurance and unsure of how to navigate the health system or find a PCP.
- Due to the large increase in the Medicaid membership coupled with limited resources in staffing, Healthy U Integrated does not have the capability to conduct personalized outreach calls to each member via text or interactive voice response (IVR).

Interventions

To address the identified barriers, Healthy U Integrated implemented the following interventions:

- Healthy U Integrated is conducting a phone and letter member outreach campaign to educate members on the importance of identifying a PCP and making an appointment to see that provider annually. Members who do not have an attributed PCP are the target of both the letter and phone outreach.
  - Letters will be mailed to active Healthy U Integrated Care members who do not have an attributed PCP in two phases. Phase 1 letters are to be mailed in March of the measurement year. Phase 2 letters are to be mailed in August/September of the measurement year.
  - Phone calls to active members who do not have an attributed PCP are ongoing throughout the year.
- Healthy U Integrated has signed a contract with a new member engagement vendor that has the capability to conduct text messaging and IVR campaigns. Healthy U Integrated planned to launch the first text messaging campaign in third quarter of CY 2022. The campaign will serve two purposes:
  - Gain members' consent to contact them via text messaging
  - Assist members in finding a PCP

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

Strengths

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- Healthy U Integrated conducted appropriate processes to identify the barriers, and it implemented interventions that were logically linked to the barriers.

Opportunities for Improvement

- Healthy U Integrated reported a decline in the performance indicator rate

- Within the PIP tool, Healthy U Integrated did not document achievement in significant clinical or programmatic improvement during Remeasurement 1.

Recommendations

Related to the identified opportunities for improvement as the PIP continues, HSAG recommends that Healthy U Integrated:

- Develop an evaluation process to determine the performance of each intervention and its impact on the performance indicator. For example, for the text message outreach intervention, the intervention evaluation plan should include collection of data for members having a compliant provider visit after receiving the outreach texts. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.
- Continually work on the PIP throughout the year.
- 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. Healthy U should consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Healthy U Integrated's HEDIS compliance auditor found Healthy U Integrated's IS and processes to be partially compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Healthy U Integrated contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

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

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

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

Performance Measure Outcomes

Table 2-35 shows Healthy U Integrated's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-35—Healthy U Integrated HEDIS MY 2021 Results

HEDIS Measure	Healthy U MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**68.52%**	75.81%
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)	**60.00%**	60.80%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**47.12%**	51.00%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	74.92%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**39.90%**	56.26%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	87.35%	85.28%
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)	**44.04%**	50.81%
Controlling High Blood Pressure		

HEDIS Measure	Healthy U MY 2021 Rate	MY 2021 NCQA Quality Compass Average
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	62.03%	58.63%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NA	79.20%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.13%
Follow-Up After Emergency Department Visit for Mental Illness		
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up–Total)	**24.43%**	40.08%
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up–Total)	**31.82%**	53.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence		
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up–Total)	13.48%	13.35%
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up–Total)	23.51%	19.79%
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up–Total)	**29.54%**	38.44%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up–Total)	**50.18%**	58.73%
Initiation and Engagement of AOD Dependence Treatment		
Initiation of AOD Treatment: Adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or	44.63%	44.16%

HEDIS Measure	Healthy U MY 2021 Rate	MY 2021 NCQA Quality Compass Average
partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of AOD Treatment–Total)		
Engagement of AOD Treatment: Adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. (Engagement of AOD Treatment–Total)	**12.40%**	13.87%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**68.98%**	74.53%

*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.

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

Strengths

Healthy U Integrated exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Controlling High Blood Pressure*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*

Opportunities for Improvement

Healthy U Integrated fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Healthy U Integrated fell below the MY 2021 NCQA Quality Compass average for 11 of the 19 performance indicators (57.90 percent), indicating significant areas of opportunity. Improvement efforts could be focused on the following:

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

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

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-36 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Healthy U Integrated's total weighted compliance score was 92 percent. Following the CY 2022 CAP review, Healthy U Integrated improved its cumulative weighted score to 96 percent.

Table 2-36—Summary of Scores for the Standards for Healthy U Integrated

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	30	30	27	3	0	0	95%
II	Access and Availability	14	14	14	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	27	25	2	0	1	96%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
V	Grievance and Appeal System	28	28	23	5	0	0	91%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**157**	**156**	**144**	**12**	**0**	**1**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- Coordination and Continuity of Care
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that all Healthy U Integrated denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Healthy U Integrated UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- HSAG found that some NABD letters and member letters pertaining to appeals and grievances were not written at or below a sixth-grade reading level, as required. HSAG recommends that Healthy U Integrated UM managers and grievance and appeals managers develop a process to ensure that member correspondence is written in easy-to-understand language.
- Healthy U Integrated reported receiving only one member grievance for the period under review. HSAG recommends that Healthy U Integrated investigate why the number of reported grievances is so low and develop methods to ensure or inform members that they may report grievances to Healthy U Integrated directly through a variety of avenues (mail, email, telephone, etc.).

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-37 displays the number and percentage of provider categories by provider domain wherein Healthy U Integrated met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Healthy U Integrated in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-37—Compliance With Time/Distance Standards by Provider Domain—Healthy U Integrated

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

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

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

Opportunities for Improvement

Table 2-38 displays the provider domain and categories wherein Healthy U Integrated failed to meet the time/distance standards at the statewide level.

Table 2-38—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U Integrated*

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

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

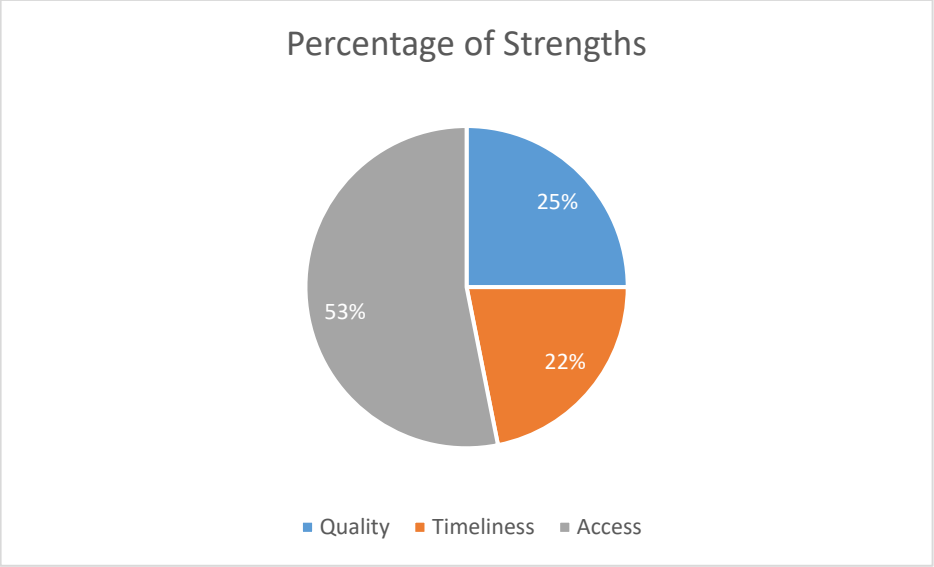
Recommendations

HSAG offers the following recommendation:

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

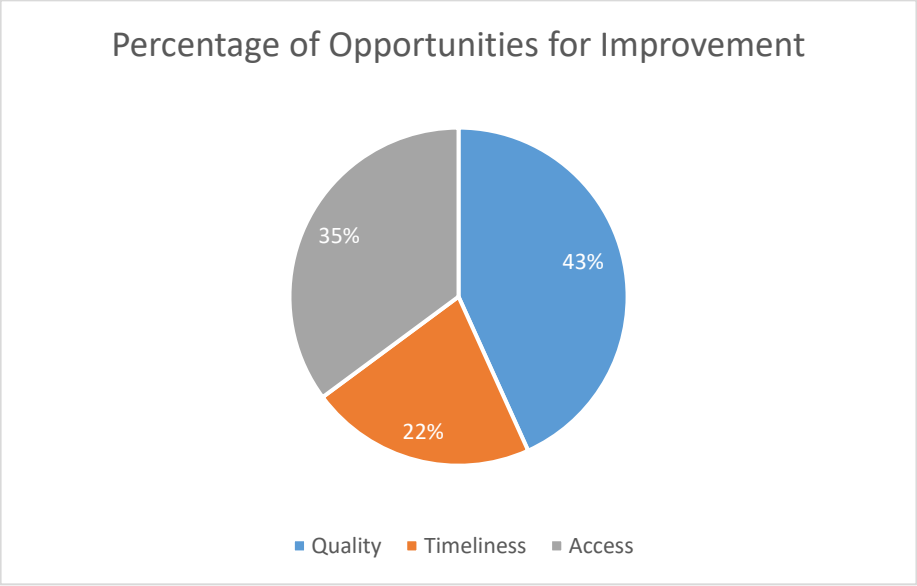
Molina (Molina UMIC)

Figure 2-15—Percentage of Strengths by Care Domain for Molina UMIC*



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

Figure 2-16—Percentage of Opportunities for Improvement by Care Domain for Molina UMIC*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022 validation, Molina UMIC continued its clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness*. The goal of this PIP is to improve the percentage of integrated Medicaid members receiving a follow-up visit with a mental health practitioner within 30 days of a hospital discharge for mental illness or intentional self-harm diagnoses. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of rehospitalization

Validation Results and Interventions

Molina UMIC submitted all the three PIP stages for this year's validation. Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*. Table 2-39 summarizes the PIP validation findings for CY 2022.

Table 2-39—CY 2022 Performance Improvement Project Validation Results for Molina UMIC (N=1 PIP)

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

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Outcomes Total	**1/2**	**0/2**	**1/2**
Percentage Score of Applicable Evaluation Elements *Met*		**95%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Molina UMIC progressed to reporting Remeasurement 1 results. Molina reported improvement in the Remeasurement 1 performance indicator rate; however, the improvement was not statistically significant over the baseline. Additionally, Molina UMIC did not achieve significant clinical or programmatic improvement.

Table 2-40 displays data for Molina UMIC's *Follow Up After Hospitalization for Mental Illness* PIP.

Table 2-40—PIP—*Follow Up After Hospitalization for Mental Illness*
Molina UMIC

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

N–Numerator; D–Denominator

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

For Remeasurement 1, Molina UMIC demonstrated a non-statistically significant increase of 3.3 percentage points in the performance indicator rate over the baseline to 49.1 percent.

Barriers

For the *Follow Up After Hospitalization for Mental Illness* PIP, Molina UMIC used a fishbone diagram and staff feedback to identify the following barriers and implemented the following intervention to address those barriers.

- No established behavioral health provider
- Poor outpatient treatment prior to inpatient care—no/poor patient/doctor relationship.
- Due to COVID-19, some patients may not feel comfortable going into an office setting.

Interventions

- Partner with Molina Care Connections to offer members an opportunity to meet telephonically with a licensed clinical social worker (LCSW) and complete a follow-up visit within 30 days of hospitalization.

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

Strengths

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.
- Molina UMIC conducted appropriate processes to identify the barriers, and it implemented interventions that were logically linked to the barriers.

Opportunities for Improvement

- Molina UMIC reported improvement in the Remeasurement 1 performance indicator rate; however, the improvement was not statistically significant over the baseline.

Recommendations

Related to the identified opportunities for improvement, as the PIP continues, HSAG recommends that Molina UMIC:

- Report the impact of each intervention by completely documenting evaluation results and outcomes. The next steps for each intervention must be supported by the intervention-specific evaluation results.
- Continually work on the PIP throughout the year.

- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of new interventions. Molina UMIC should also consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Molina UMIC's HEDIS compliance auditor found Molina UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Molina UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Molina UMIC's FAR revealed that Molina UMIC's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-41 shows Molina UMIC's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-41—Molina UMIC HEDIS MY 2021 Results

HEDIS Measure	Molina UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**66.85%**	75.81%
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)	**40.00%**	60.80%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**36.36%**	51.00%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		

HEDIS Measure	Molina UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	74.92%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**35.77%**	56.26%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	**83.94%**	85.28%
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)	**36.98%**	50.81%
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.	**43.55%**	58.63%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NA	79.20%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.13%
Follow-Up After Emergency Department Visit for Mental Illness		
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up–Total)	**20.12%**	40.08%
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up–Total)	**29.88%**	53.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence		
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up–Total)	16.29%	13.35%
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or	26.82%	19.79%

HEDIS Measure	Molina UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up–Total)		
Follow-Up After Hospitalization for Mental Illness		
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up–Total)	**28.52%**	38.44%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up–Total)	**49.10%**	58.73%
Initiation and Engagement of AOD Dependence Treatment		
Initiation of AOD Treatment: Adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of AOD Treatment)	**40.21%**	44.16%
Engagement of AOD Treatment: Adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. (Engagement of AOD Treatment)	**13.37%**	13.87%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**71.14%**	74.53%

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

Strengths

Molina UMIC exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —30-Day Follow-Up—Total*

Opportunities for Improvement

Molina UMIC fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Molina UMIC fell below the MY 2021 NCQA Quality Compass average for 14 of the 19 performance indicators (73.68 percent), indicating significant areas of opportunity. Improvement efforts could be focused on the following:

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

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

- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example, determine whether:
  - Members are showing up for care, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health Plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the quality strategy is aligned with performance goals.
- Establish partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Consider providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the Molina UMIC care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-42 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Molina UMIC's total weighted compliance score was 96 percent. Following the CY 2022 CAP review, Molina UMIC improved its cumulative weighted score to 99 percent.

Table 2-42—Summary of Scores for the Standards for Molina UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	25	23	2	0	0	96%
II	Access and Availability	14	14	14	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	27	1	0	0	98%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**152**	**148**	**4**	**0**	**0**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- Coordination and Continuity of Care
- Grievance and Appeal System
- Subcontractual Relationships and Delegation

- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information (Includes Confidentiality)
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that all Molina UMIC denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Molina UMIC UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment, timely, and include complete information.
- HSAG found that some member letters pertaining to appeals were not written at or below a sixth-grade reading level, as required. HSAG recommends that Molina UMIC UM managers develop a process to ensure that member correspondence is written in easy-to-understand language.
- HSAG recommends that Molina UMIC review pertinent provider-facing documents to ensure accurate and consistent time frames related to appeals and State fair hearings.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-43 displays the number and percentage of provider categories by provider domain wherein Molina UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Molina UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-43—Compliance With Time/Distance Standards by Provider Domain—Molina UMIC

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	2	66.7%	
Behavioral Health—Facilities	4	2	50.0%	

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

Opportunities for Improvement

Table 2-44 displays the provider domains and categories wherein Molina UMIC failed to meet the time/distance standards at the statewide level.

Table 2-44—Provider Categories That Failed to Meet Time/Distance Standards—Molina UMIC*

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

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

** No data were submitted for the provider category.

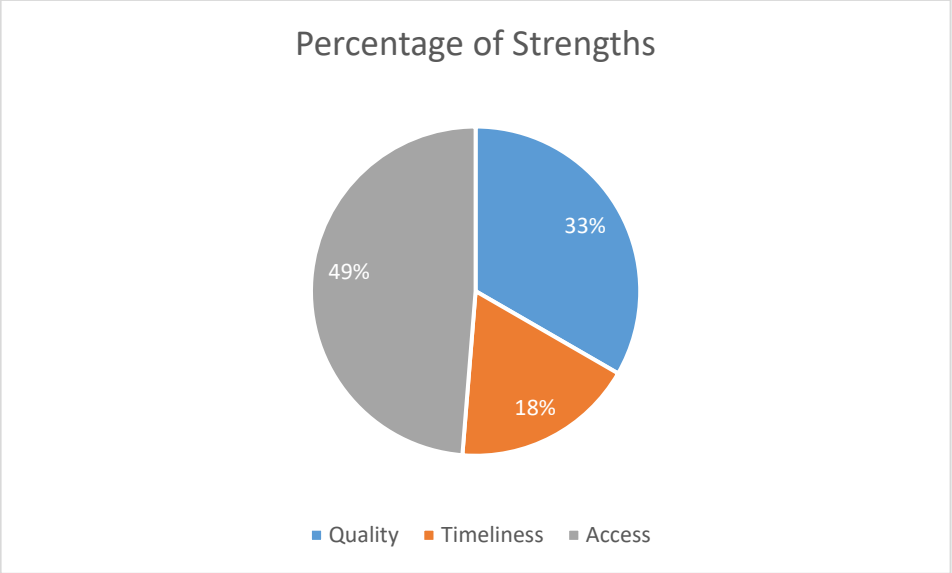
Recommendations

HSAG offers the following recommendations:

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

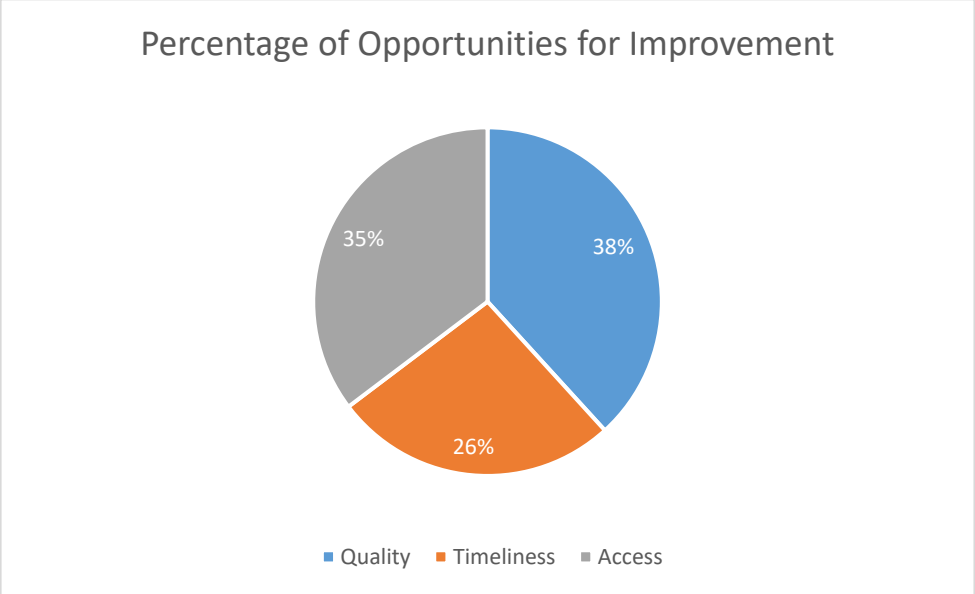
SelectHealth CC (SelectHealth CC UMIC)

Figure 2-17—Percentage of Strengths by Care Domain for SelectHealth CC UMIC*



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

Figure 2-18—Percentage of Opportunities for Improvement by Care Domain for SelectHealth CC UMIC*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, SelectHealth CC UMIC submitted its clinical PIP topic: *7–Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members.* The goal of this PIP is to improve the percentage of integrated Medicaid members receiving a follow-up visit with a mental health practitioner within 30 days of a hospital discharge for mental illness or intentional self-harm diagnoses.

Validation Results and Interventions

Table 2-45 summarizes the validation findings for each stage validated for CY 2022. Overall, 85 percent of all applicable evaluation elements validated received a score of *Met.*

Table 2-45—CY 2022 Performance Improvement Project Validation Results for SelectHealth CC UMIC (N=1 PIP)

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

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Outcomes Total	**1/2**	**1/2**	**0/2**
	Percentage Score of Applicable Evaluation Elements *Met*	**85%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**90%**		
	Validation Status	***Partially Met***		

Indicator Outcomes

For this year's validation, SelectHealth CC UMIC progressed to reporting Remeasurement 1 results. SelectHealth CC UMIC had improvement in the performance indicator from the baseline; however, the improvement was not statistically significant. Additionally, SelectHealth CC UMIC documented its intervention of conducting monthly interdisciplinary care team meetings as programmatic improvement; however, the data to support how these meetings have resulted in positive outcomes were not included.

Table 2-46 displays the data for SelectHealth CC UMIC's *7–Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* PIP.

Table 2-46—PIP—7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members SelectHealth CC UMIC

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

N–Numerator D–Denominator

The baseline rate for the percentage of eligible members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within seven days after discharge was 36.5 percent. For Remeasurement 1, the performance indicator rate was 38.2 percent, which demonstrates a non-statistically significant increase of 1.7 percentage points over the baseline.

Barriers

For the *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* PIP, SelectHealth CC UMIC used brainstorming and a fishbone diagram to identify the following barriers to achieving desired PIP outcomes:

- Lack of member care coordination before discharge.
- Unscheduled follow-up appointment.
- Other social determinants of health (SDoH) that impact members' ability to fully engage in health care.
- Due to an increase in the eligible member population, difficulty for members trying to access seven-day follow-up appointments.

Interventions

To address the identified barriers, SelectHealth CC UMIC implemented the following interventions:

- Care manager identifies admitted members and works with the patient navigator to connect with each member and to verify a seven-day follow-up appointment has been scheduled before discharge.
- Care manager confirms the appointment and maintains contact with the member.
- Care manager provides support and resources as needed, such as appointment rescheduling, transportation assistance, childcare services, and basic needs. This program has been implemented at one facility, and SelectHealth CC UMIC intends to roll it out to a second location and eventually to all the facilities.
- Monthly interdisciplinary care team meetings were established to talk about individual cases and find solutions to access issues.

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

Strengths

HSAG identified the following strengths:

- SelectHealth CC UMIC documented a sound PIP design and used appropriate QI processes to identify barriers and implement interventions.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- The PIP received an overall *Partially Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 85 percent of overall evaluation elements across all steps completed and validated.
- SelectHealth CC UMIC had opportunities for improvement in capturing appropriate data to evaluate interventions for effectiveness.
- The improvement in the performance indicator rate during Remeasurement 1 was not statistically significant over the baseline rate.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that SelectHealth CC UMIC:

- Develop a process for evaluating each PIP intervention and its impact on the performance indicator. For example, SelectHealth CC UMIC should provide data to support how the monthly interdisciplinary care team meetings have resulted in positive outcomes. SelectHealth CC UMIC may track how many members on the waitlist who were prioritized during these meetings, were reached successfully with a timely follow-up visit. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.
- Address the *Partially Met* scores in the next annual submission.
- Continually work on the PIP throughout the year.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that SelectHealth CC UMIC's HEDIS compliance auditor found SelectHealth CC UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. SelectHealth CC UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

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

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

Performance Measure Outcomes

Table 2-47 shows SelectHealth CC UMIC's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table 2-47—SelectHealth CC UMIC HEDIS MY 2021 Results

HEDIS Measure	SelectHealth CC UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	75.83%	75.81%
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	**59.49%**	60.80%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	57.35%	51.00%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	74.92%

HEDIS Measure	SelectHealth CC UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	57.95%	56.26%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	88.32%	85.28%
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)	53.77%	50.81%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	68.33%	58.63%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	80.81%	79.20%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	67.13%
Follow-Up After Emergency Department Visit for Mental Illness		
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up–Total)	**34.73%**	40.08%
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up–Total)	**46.86%**	53.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence		
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up–Total)	13.51%	13.35%
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up–Total)	23.42%	19.79%
Follow-Up After Hospitalization for Mental Illness		

HEDIS Measure	SelectHealth CC UMIC MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up–Total)	**38.24%**	38.44%
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up–Total)	**56.72%**	58.73%
Initiation and Engagement of AOD Dependence Treatment		
Initiation of AOD Treatment: Adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of AOD Treatment–Total)	44.97%	44.16%
Engagement of AOD Treatment: Adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. (Engagement of AOD Treatment–Total)	**13.53%**	13.87%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**71.61%**	74.53%

*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.

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

Strengths

SelectHealth CC UMIC exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*

Opportunities for Improvement

SelectHealth CC UMIC fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

SelectHealth CC UMIC fell below the MY 2021 NCQA Quality Compass average for seven of the 19 performance indicators (36.84 percent), indicating some areas of opportunity. Improvement efforts could be focused on the following:

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

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

- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example determine whether:
  - Members are showing up for care, answering the phone, working with providers/care managers on scheduling services, following instructions, and filling prescriptions.
  - Providers are following standards of care or clinical guidelines, providing complete claim data, addressing missing services, or partnering with the health plan on initiatives.
  - Health Plans have the right programs (such as care management and education), the right QI strategies or programs, the right motivational programs (e.g., incentives) for members and providers, and whether the health plan is collecting and using data to focus efforts and drive performance.
  - Policies for billing are aligned with HEDIS measure specifications, funding policies are sufficient for making an impact, contracting policies are aligned with quality goals, and whether the quality strategy is aligned with performance goals.
- Establish partnerships that support (e.g., care management support, transportation, and data on needed services) and reward (e.g., patient referrals, care coordination fee, incentive payments based on HEDIS performance, and VBR contracts) specialty behavioral health providers for helping to coordinate preventive, medical management, or transition of care services.
- Consider providing training on motivational interviewing techniques and monitoring tools that show needed HEDIS services for each member to care managers in the SelectHealth CC UMIC care management program.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-48 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met, Partially Met, Not Met,* or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, SelectHealth CC UMIC's total weighted compliance score was 94 percent. Following the CY 2022 CAP review, SelectHealth CC UMIC improved its cumulative weighted score to 98 percent.

Table 2-48—Summary of Scores for the Standards for SelectHealth CC UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	25	25	0	0	0	100%
II	Access and Availability	14	14	14	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	26	2	0	0	96%
V	Grievance and Appeal System	28	28	25	3	0	0	95%
VI	Provider Selection and Program Integrity	20	20	20	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	4	3	1	0	0	88%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**152**	**146**	**6**	**0**	**0**	**98%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Provider Selection and Program Integrity

- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Subcontractual Relationships and Delegation

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that SelectHealth CC UMIC implement a process to ensure updated member documents are made available to members on its website.
- During the CY 2022 record review, HSAG found that all SelectHealth CC UMIC grievance records and some appeal records lacked full compliance, For example, all grievance acknowledgement letters contained incorrect information and some appeals were not resolved in a timely manner. HSAG recommends that SelectHealth CC UMIC develop processes to ensure grievances and appeals are resolved in a timely manner and letters being sent to members contain accurate information.
- HSAG recommends that SelectHealth CC UMIC leadership review grievance policies and processes related to acknowledgement and resolution time frames to identify any issues and implement appropriate corrections.
- HSAG recommends that SelectHealth CC UMIC review delegated agreements related to administrative services to ensure subcontractor agreement to comply with applicable Medicaid laws, regulations, and contract provisions.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-49 displays the number and percentage of provider categories by provider domain wherein SelectHealth CC UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and SelectHealth CC UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-49—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CC UMIC

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	2	2	100.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Adult	17	17	100.0%	
Additional Physical Health—Providers	6	6	100.0%	
Additional Physical Health—Facilities	7	4	57.1%	
Hospitals	1	1	100.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	2	66.7%	
Behavioral Health—Facilities	4	1	25.0%	

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

Opportunities for Improvement

Table 2-50 displays the provider domains and categories wherein SelectHealth CC UMIC failed to meet the time/distance standards at the statewide level.

Table 2-50—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CC UMIC*

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

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

** No data were submitted for the provider category.

Recommendations

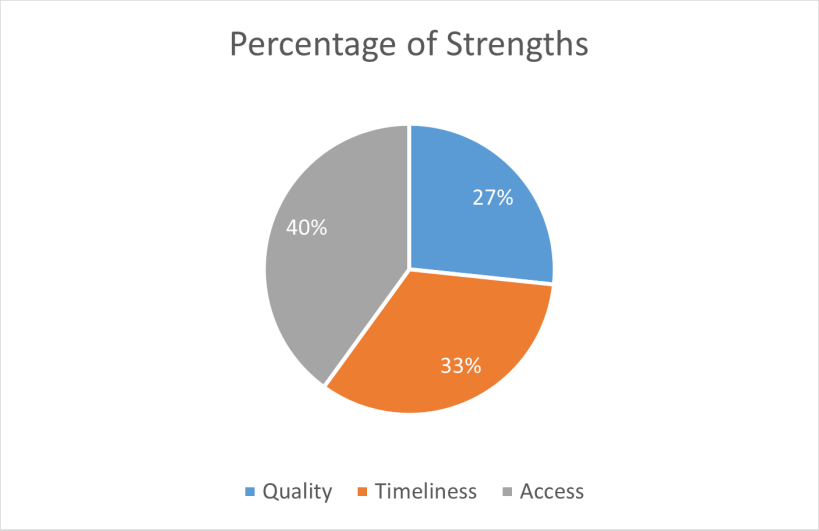
HSAG offers the following recommendation:

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

Medicaid PIHP PMHPs Providing Mental Health and Substance Use Disorder Services

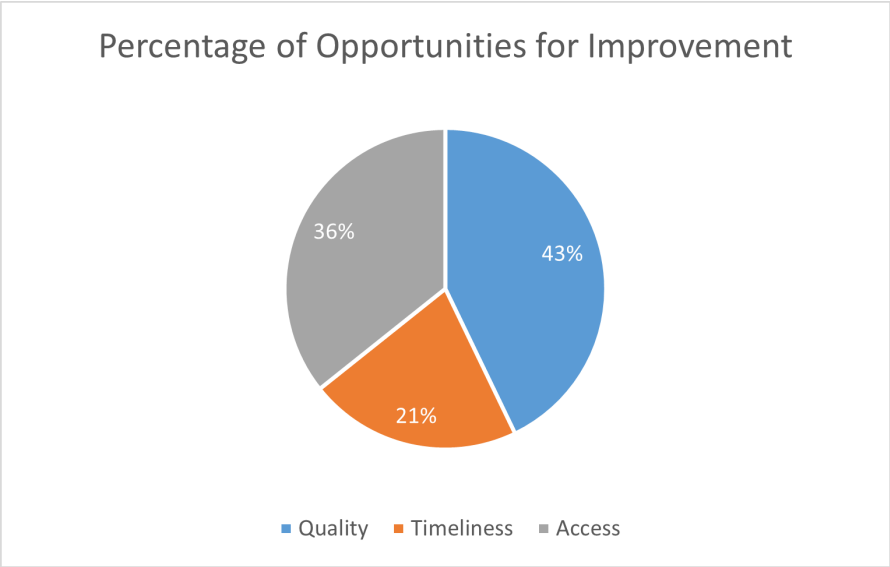
Bear River Mental Health Services (Bear River)

Figure 2-19—Percentage of Strengths by Care Domain for Bear River*



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

Figure 2-20—Percentage of Opportunities for Improvement by Care Domain for Bear River*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Bear River submitted its PIP topic: *Youth Outcome Questionnaires (YOQ) or Outcome Questionnaires (OQ).* The goal of this PIP is to improve processes and outcomes of members' mental health care, by using outcome measurement instruments to increase clinician awareness of each member's current level of well-being or distress, which will provide a way to calibrate treatment interventions based on feedback as well as measure progress in treatment. The outcomes measurement instruments used in the PIP are Outcome Questionnaires (OQ 30.2) for adults 18 years and older, and Youth Outcome Questionnaires (YOQ 30.2) for members 5–18 years of age.

Validation Results and Interventions

Table 2-51 summarizes the validation findings for each stage validated for CY 2022. Overall, 92 percent of all applicable evaluation elements received a score of *Met.*

Table 2-51—CY 2022 Performance Improvement Project Validation Results for Bear River (N=1 PIP)

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

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total	***Not Assessed***		
	Percentage Score of Applicable Evaluation Elements *Met*	**92%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**86%**		
	Validation Status	***Partially Met***		

Indicator Outcomes

For this year's validation, Bear River reported baseline data. Bear River had not progressed to the point of assessment for outcomes.

Table 2-52 displays data for Bear River's *YOQ or OQ* PIP.

Table 2-52—PIP—*YOQ or OQ*
Bear River

Performance Indicator Results					
Performance Indicators	**Baseline (12/01/2021–05/31/2022)**		**Remeasurement 1**		**Sustained Improvement**
1a. Frequency of OQ completed by each member in a year.	N: 5,063 D: 15,525	32.6%			*Not Assessed*
1b. Frequency of YOQ completed by each member in a year.	N: 3,580 D: 9,052	39.5%			*Not Assessed*
2a. Percentage of OQ reports reviewed by clinician within three days.	N: 4,354 D: 5,662	76.9%			*Not Assessed*
2b. Percentage of YOQ reports reviewed by clinician within three days.	N: 2,527 D:3,806	66.4%			*Not Assessed*

N–Numerator D–Denominator

The baseline rates for percentage of eligible members who completed an OQ and YOQ in a year were 32.6 percent and 39.5 percent, respectively.

The baseline rates for percentage of OQ and YOQ reports reviewed by clinician within three days of OQ/YOQ administration were 76.9 percent and 66.4 percent, respectively.

There appeared to be errors in the reported baseline data. It was unclear why the numerators for performance indicators 1a and 1b were different than the denominators for performance indicators 2a and 2b, respectively. HSAG's understanding is that those two numbers should be the same based on the performance indicators' definitions in Step 5 of the PIP Submission Form. Bear River should correct the data as needed, and Bear River will be assessed for improvement in outcomes during the next measurement period.

Barriers

Bear River had not progressed to the point of identification of barriers during this validation cycle.

Interventions

Bear River had not progressed to the point of implementation of interventions during this validation cycle.

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

Strengths

HSAG identified the following strengths:

- Bear River designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- The PIP received an overall *Partially Met* validation status, with a *Met* score for 86 percent of critical evaluation elements and 92 percent of overall evaluation elements across all steps completed and validated.
- There were opportunities to improve the documentation of the data collection process and performance indicators' data.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Bear River:

- Address the Validation Feedback associated with any *Met* score and the *Partially Met* scores in the next annual submission.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. Additionally, member input should also be considered while determining barriers.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- Continually work on the PIP throughout the year.
- Ensure that the reported data in the PIP Submission Form are accurate and in alignment with the performance indicators' specifications.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-53 presents Bear River's MY 2021 performance measure results.

Table 2-53—Bear River MY 2021 *FUH* Results

Indicator	Bear River Rate	Statewide PMHP Average
Follow-Up Within 7 Days	60.30%	53.92%
Follow-Up Within 30 Days	74.37%	70.68%

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

Strengths

HSAG identified the following strengths for Bear River:

- Bear River employed creative strategies and staff incentives to ensure that Bear River was fully staffed and able to meet the health care needs of the population it served.

- Bear River embraced telehealth as an additional option to render services. Bear River received a telehealth grant and had several clinicians providing completely virtual services.
- Bear River demonstrated notable increases in its performance measure rates driven by previous process improvements that continue to improve timely follow-up after discharge from an inpatient setting.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the 2021 PMV review.

Recommendations

HSAG did not identify any recommendations related to PMV.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-54 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Bear River's total weighted compliance score was 92 percent. Following the CY 2022 CAP review, Bear River improved its cumulative weighted score to 96 percent.

Table 2-54—Summary of Scores for the Standards for Bear River

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	28	28	27	1	0	0	98%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	6	1	0	0	93%
IV	Member Rights and Information (Includes Confidentiality)	27	26	23	3	0	1	94%
V	Grievance and Appeal System	28	28	24	4	0	0	93%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VI	Provider Selection and Program Integrity	19	19	17	2	0	0	95%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**141**	**136**	**125**	**11**	**0**	**5**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Coordination and Continuity of Care
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that Bear River leadership review the requirements at 42 CFR §438.114 (Emergency and Poststabilization Services) and 42 CFR §438.400 (Grievance and Appeal System) to ensure that its policies, procedures, defined terms, and member-facing documents are in alignment with federal regulations and the State contract, and that any revisions are formally implemented within a reasonable time frame.
- HSAG recommends that Bear River formally document care coordination processes into policies and/or procedures, as appropriate.
- HSAG found that several member-facing documents were not written at or below a sixth-grade reading level, as required. HSAG recommends that Bear River develop a process to ensure that member correspondence is written in easy-to-understand language.
- HSAG recommends that Bear River implement a process to ensure updated member-facing documents are made available to members on its website.
- During the CY 2022 record review, HSAG found that some Bear River grievance records lacked full compliance. For example, some records did not contain all required information, such as the date of acknowledgement or title of decision maker. HSAG recommends that Bear River develop processes to ensure grievances are being documented and resolved appropriately.
- During the CY 2022 credentialing record review, HSAG found that Bear River did not ensure all licensed providers were in good standing with the State or document prior credentialing dates. HSAG recommends that Bear River implement processes to ensure documentation of license verification and prior credentialing. HSAG further recommends that Bear River maintain employee files for a minimum of 10 years after termination.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-55 displays the number and percentage of provider categories wherein Bear River met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-55—Compliance With Time/Distance Standards by Urbanicity—Bear River*

		Frontier		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Bear River	10	3	30.0%	3	30.0%	

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

Opportunities for Improvement

Table 2-56 displays the provider domains and categories wherein Bear River failed to meet the time/distance standards.

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

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

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

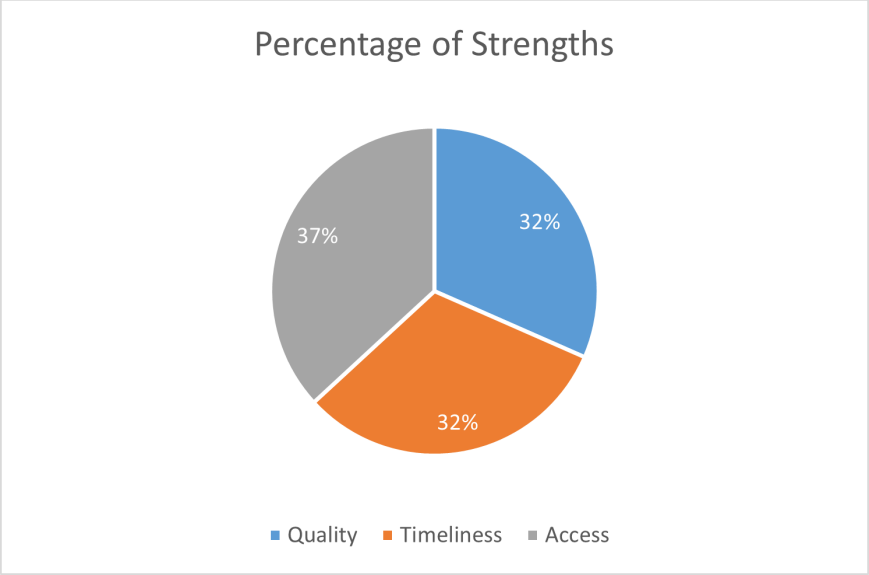
Recommendations

HSAG offers the following recommendations:

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

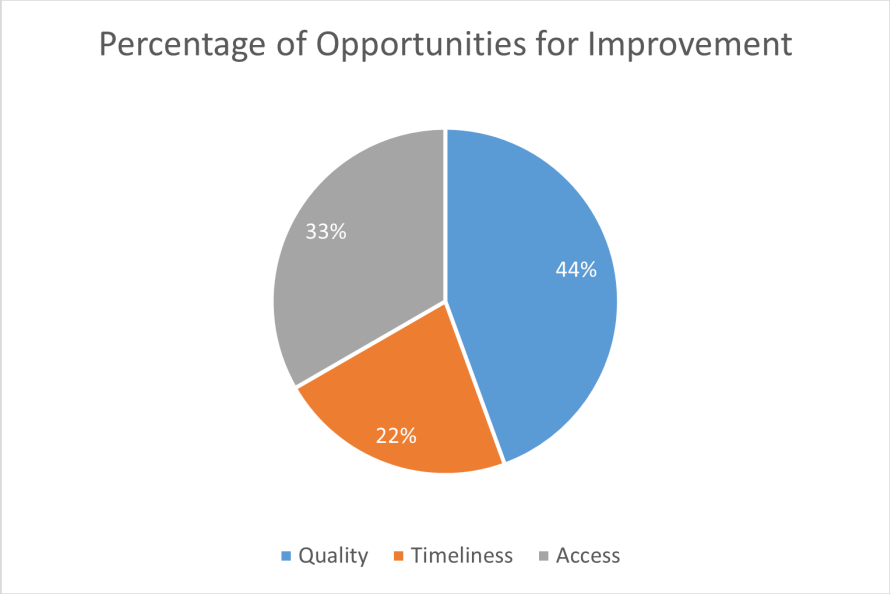
Central Utah Counseling Center (Central)

Figure 2-21—Percentage of Strengths by Care Domain for Central*



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

Figure 2-22—Percentage of Opportunities for Improvement by Care Domain for Central*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Central submitted its clinical PIP topic: *Inpatient Readmission Rates*. The goal of this PIP is to improve processes and outcomes of members' mental health care and decrease readmission to inpatient psychiatric hospitals.

Validation Results and Interventions

Table 2-57 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-57—CY 2022 Performance Improvement Project Validation Results for Central (N=1 PIP)

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

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

Central progressed to reporting Remeasurement 1 results. Central documented an increase in the Remeasurement 1 rate over the baseline performance indicator rate; however, the improvement was not statistically significant. Central documented implementation of the mobile crisis outreach team (MCOT) services intervention as significant programmatic improvement in processes of care.

Table 2-58 displays data for Central's *Inpatient Readmission Rates* PIP.

Table 2-58—PIP—*Inpatient Readmission Rates*
Central

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

N–Numerator D–Denominator

The baseline rate for the percentage of psychiatric discharges during CY 2019 that did not have a psychiatric readmission within the next 12 months was 68.9 percent. For Remeasurement 1, Central reported a rate of 72.6 percent, which represents a non-statistically significant improvement of 3.7 percentage points over the baseline.

Barriers

For the *Inpatient Readmission Rates* PIP, Central used data mining and process-level analysis to identify the following barrier to achieving desired PIP outcomes:

- For members coming out of high levels of care (specifically inpatient hospitals), there has been a varied approach on how to meet their needs.

Interventions

To address the identified barrier, Central implemented the following intervention:

- Implement a standardized care approach wherein all Medicaid enrollees will not only have a primary therapist assigned to the case, but an additional and specific case manager who will make frequent/weekly outreach to individuals discharged from inpatient settings for one year following discharge.
- A new MCOT was developed and initiated. The MCOT will respond to crisis situations throughout the six-county area that Central covers.

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

Strengths

- During Remeasurement 1, Central achieved improvement in the performance indicator rate and reported MCOT services intervention as significant programmatic improvement in processes of care.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of overall evaluation elements and 100 percent of critical evaluation elements across all steps completed and validated.

Opportunities for Improvement

- The improvement in the performance indicator rate was not statistically significant over the baseline.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Central:

- Have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Central should track readmission rates in members who were provided case management services and members who received services from MCOT. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.

- 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.
- Address any validation feedback comments associated with a *Met* score in the next annual submission. If the validation feedback is not addressed, the corresponding evaluation element's score in the PIP Validation Tool may be impacted.
- Reference the PIP Completion Instructions annually to ensure that all requirements for each completed activity have been addressed.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-59 presents Central's MY 2021 performance measure results.

Table 2-59—Central MY 2021 *FUH* Results

Indicator	Central Rate	Statewide PMHP Average
Follow-Up Within 7 Days	79.10%	53.92%
Follow-Up Within 30 Days	92.54%	70.68%

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

Strengths

HSAG identified the following strengths:

- Central implemented HSAG's recommendation from the previous year to verify discharges captured in the denominator against members' discharge summaries to ensure the accuracy of discharge dates used for measure calculation. Additionally, Central added a field in its tracking spreadsheet to document its rationale for including or excluding a member for measure reporting.
- Central implemented a MCOT to expand Central's ability to reach members in need of mental health services and to reduce avoidable psychiatric hospitalizations. Central also engaged in efforts to identify factors that increase the likelihood of readmissions, such as length of stay.

Opportunities for Improvement

HSAG identified no opportunities for improvement during the 2021 PMV review.

Recommendations

HSAG identified no recommendations related to PMV.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-60 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Central's total weighted compliance score was 93 percent. Following the CY 2022 CAP review, Central improved its cumulative weighted score to 98 percent.

Table 2-60—Summary of Scores for the Standards for Central

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	27	27	27	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	26	25	1	0	1	98%
V	Grievance and Appeal System	28	28	25	3	0	0	95%
VI	Provider Selection and Program Integrity	19	19	18	1	0	0	97%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**140**	**135**	**130**	**5**	**0**	**5**	**98%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that Central review policies and pertinent member-facing documents related to grievances and appeals to ensure accurate time frames and written and oral appeal requirements.
- During the 2022 grievance record review, Central reported three grievances. HSAG recommends that Central analyze member grievance data and develop methods to ensure members understand

the definition of "grievance" and inform members that grievances can be reported to Central directly.

- During the 2022 record review, HSAG found that some credentialing records lacked compliance due to missing information, such as completed applications. HSAG recommends that Central implement a process to ensure credentialing records are complete.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-61 displays the number and percentage of provider categories wherein Central met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-61—Compliance With Time/Distance Standards by Urbanicity—Central*

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

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

Opportunities for Improvement

Table 2-62 displays the provider domains and categories wherein Central failed to meet the time/distance standards.

Table 2-62—Provider Categories That Failed to Meet Time/Distance Standards—Central*

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

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Providers	Behavioral Medical—Adult**; Behavioral Medical—All**; Behavioral Medical—Pediatric**; Behavioral Therapist—Adult**; Behavioral Therapist—Pediatric**	

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

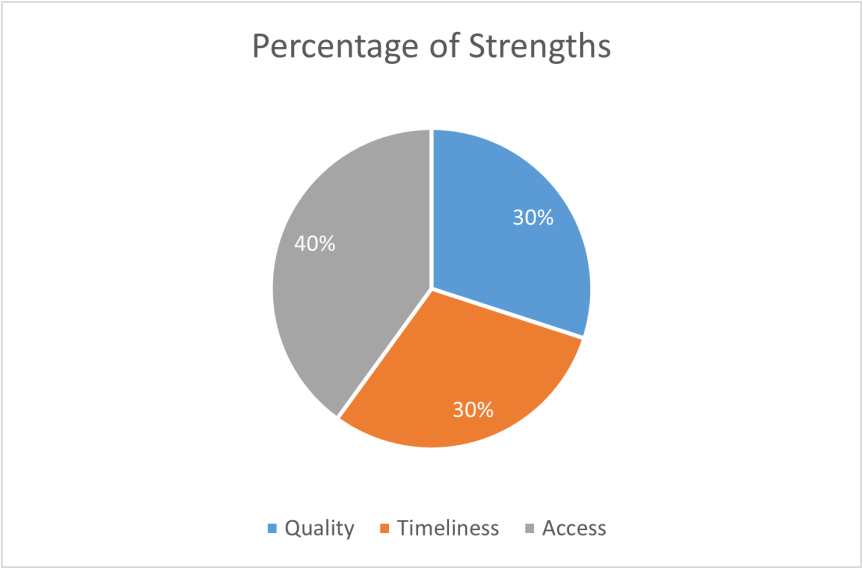
Recommendations

HSAG offers the following recommendations:

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

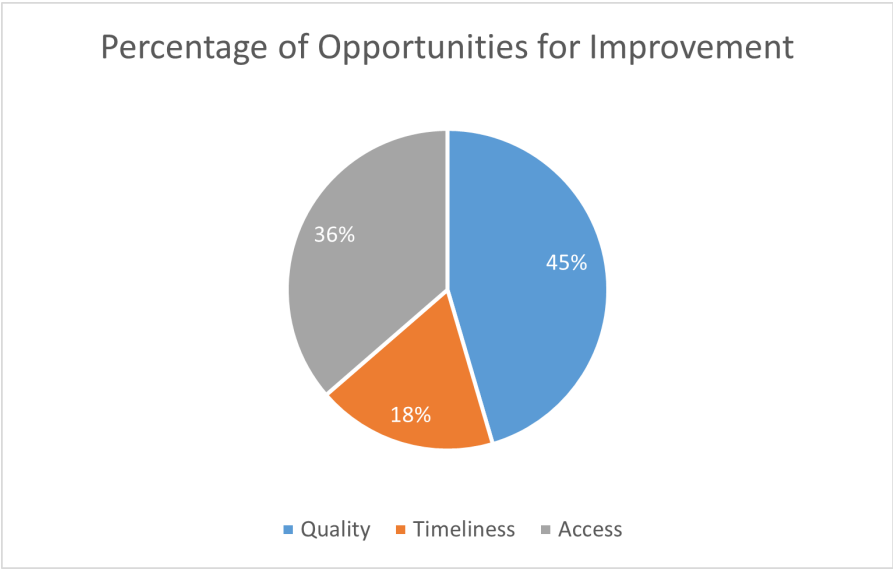
Davis Behavioral Health (Davis)

Figure 2-23—Percentage of Strengths by Care Domain for Davis*



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

Figure 2-24—Percentage of Opportunities for Improvement by Care Domain for Davis*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Davis submitted its clinical PIP topic: *Access to Care.* The PIP Davis submitted aims to increase access to care by improving the timeliness of substance use treatment from the date of initial contact by the member for treatment to the first two clinical appointments offered to the member.

Validation Results and Interventions

Table 2-63 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-63—CY 2022 Performance Improvement Project Validation Results for Davis (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	0
	Outcomes Total	**2/2**	**0/2**	**0/2**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Davis progressed to reporting Remeasurement 2 results. Davis achieved statistically significant improvement in both performance indicator rates over the baseline.

Table 2-64 displays data for Davis' *Access to Care* PIP.

Table 2-64—PIP—*Access to Care*
Davis

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Sustained Improvement**
1. Percentage of initial appointments scheduled within 7 calendar days from first contact.	N: 126 D: 428	29.4%	N: 417 D: 531	78.5%*	N: 699 D: 764	91.5%*	*Not Assessed*
2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	N: 195 D: 226	86.3%	N: 292 D: 323	90.4%	N: 376 D: 412	91.3%*	*Not Assessed*

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

The baseline rate for the percentage of members who had an initial appointment scheduled within seven calendar days from the first contact was 29.4 percent. For Remeasurement 2, the Performance Indicator 1 rate of 91.5 percent demonstrated a statistically significant increase ($p < 0.0001$) of 62.1 percentage points over the baseline.

The baseline rate for the percentage of members who had a second appointment scheduled within 14 calendar days from treatment admission was 86.3 percent. For Remeasurement 2, the Performance Indicator 2 rate of 91.3 percent demonstrated a statistically significant increase ($p < 0.0001$) of 5.0 percentage points over the baseline.

Davis will be assessed for sustained improvement over the baseline in the next validation cycle.

Barriers

For the *Access to Care* PIP, Davis used a fishbone diagram to identify the following barriers to achieving PIP outcomes:

- Staff members were not previously required to schedule an access appointment within seven calendar days of initial contact.
- The viral pandemic impacted access and follow-up care.
- Follow-up appointment is not scheduled or rescheduled after provider cancellation or client selecting to not schedule next appointment.
- Staff members were unavailable to facilitate the initial appointment within seven days or the follow-up appointment within 14 days.
- Members scheduled multiple (two or more) initial appointments, but members did not attend appointments.

Interventions

To address the identified barriers, Davis implemented the following interventions:

- Intake and evaluating staff members have been informed of the seven-calendar-day requirement.
- Implemented electronic form access and telehealth protocols, platforms, and training.
- Recovery Support Services (RSS) outreaches members to attempt to schedule a follow-up appointment.
- The Substance Treatment Program director monitors clinical staff availability. The director follows up when a clinical staff member is unavailable within the time frames.
- Walk-in evaluation clinic option offered to members who schedule but do not attend the initial appointment.

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

Strengths

HSAG identified the following strengths:

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

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Davis:

- Continue with its improvement efforts to sustain the improvement achieved in PIP outcomes.
- 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.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-65 presents Davis' MY 2021 performance measure results.

Table 2-65—Davis MY 2021 *FUH* Results

Indicator	Davis Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**51.64%**	53.92%
Follow-Up Within 30 Days	78.69%	70.68%

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

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

Strengths

HSAG identified the following strengths for Davis:

- Davis worked to address the mental health needs of adults and children residing in Davis County. Davis facilitated access to mental health and substance use services through programs offered to

the Davis County population. These programs included the Receiving Center Program, which offers detox and residential treatment services to adults detained by law enforcement for substance use, and the Club House Program, which helps individuals with chronic mental health needs develop independent living skills.

Opportunities for Improvement and Recommendations

HSAG identified the following opportunities for improvement for Davis:

- Davis' rate for the *Follow-Up Within 7 Days* indicator was below the statewide PMHP average.

Recommendations

HSAG recommends that Davis:

- Continue to contact members identified for follow-up services after discharge from a hospital. Davis should contact members multiple times to schedule follow-up services.
- Regularly verify that documentation provided by the hospital is saved within Credible to ensure that Davis stores proper documentation.
- Perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-66 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Davis' total weighted compliance score was 94 percent. Following the CY 2022 CAP review, Davis improved its cumulative weighted score to 99 percent.

Table 2-66—Summary of Scores for the Standards for Davis

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	27	27	27	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	25	1	0	1	98%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	19	19	18	1	0	0	97%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**140**	**135**	**133**	**2**	**0**	**5**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care

- Grievance and Appeal System
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- Ensure that its website contains language indicating that information available electronically is also available in paper form, without charge, within five business days.
- Implement a mechanism to ensure documentation of license verification prior to hire.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-67 displays the number and percentage of provider categories wherein Davis met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-67—Compliance With Time/Distance Standards by Urbanicity—Davis*

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

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

Opportunities for Improvement

Table 2-68 displays the provider domains and categories wherein Davis failed to meet the time/distance standards.

Table 2-68—Provider Categories That Failed to Meet Time/Distance Standards—Davis*

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

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

** No data were submitted for the provider category.

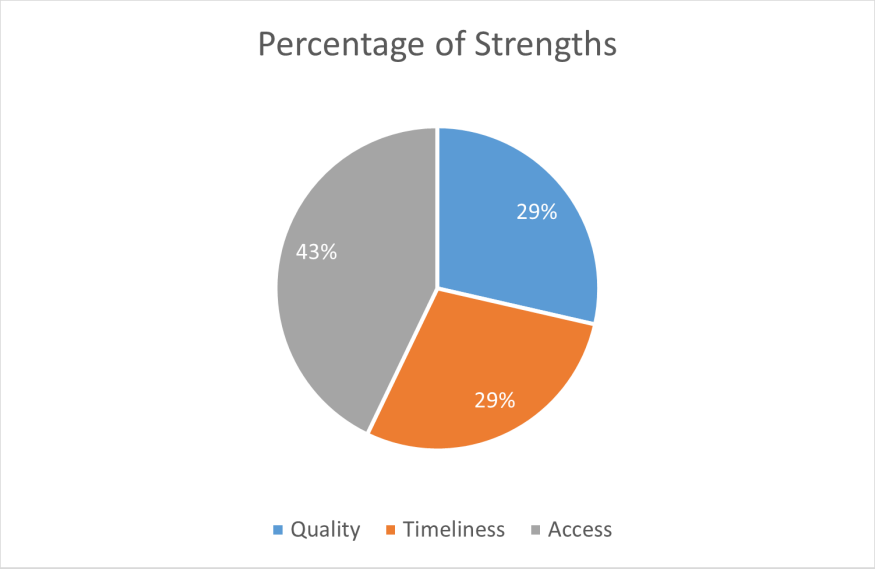
Recommendations

HSAG offers the following recommendations:

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

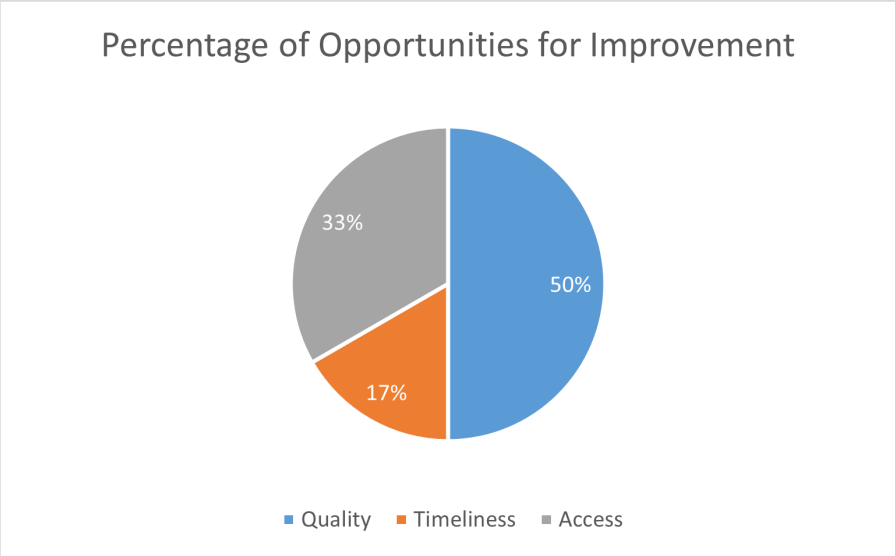
Four Corners Community Behavioral Health (Four Corners)

Figure 2-25—Percentage of Strengths by Care Domain for Four Corners*



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

Figure 2-26—Percentage of Opportunities for Improvement by Care Domain for Four Corners*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Four Corners submitted its clinical PIP topic: *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*. The PIP Four Corners submitted aims to improve processes and outcomes to ensure members with an opioid use disorder (OUD) are getting the support and outreach needed to maintain engagement and participation in treatment.

Validation Results and Interventions

Table 2-69 summarizes the PIP validation findings for CY 2022. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 2-69—CY 2022 Performance Improvement Project Validation Results for Four Corners (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	2	1	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**8/9**	**1/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	0
	Outcomes Total	**2/2**	**0/2**	**0/2**
Percentage Score of Applicable Evaluation Elements *Met*		**95%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Validation Status	***Met***		

Indicator Outcomes

Four Corners reported state fiscal year (SFY) 2020–2021 as the Remeasurement 1 period for this PIP. Four Corners achieved statistically significant improvement in the performance indicator rate over the baseline.

Table 2-70 displays data for Four Corners' *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder* PIP.

Table 2-70—PIP—Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder Four Corners

Performance Indicator Results							
Performance Indicator	**Baseline (07/01/2019–06/30/2020)**		**Remeasurement 1 (07/01/2020–06/30/2021)**		**Remeasurement 2 (07/01/2021–06/30/2022)**		**Sustained Improvement**
Percentage of members diagnosed with opioid use disorder, who received 20 or more services within 6 months of admission into OUD treatment.	N: 689 D: 1,182	58.3%	N: 1,128 D: 1,605	70.3%*			*Not Assessed*

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

The baseline rate for the percentage of eligible members who were diagnosed with OUD during SFY 2019–2020 and who received 20 or more services within six months of admission into OUD treatment was 58.3 percent. For Remeasurement 1, Four Corners reported a rate of 70.3 percent, which represents a statistically significant improvement ($p < 0.001$) of 12.0 percentage points over the baseline.

Four Corners will be assessed for achievement of sustained improvement in the next validation cycle.

Barriers

For the *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder* PIP, Four Corners used staff feedback and data analysis to identify the following barriers:

- Co-occurring mental health conditions.
- Lack of peer and social supports.
- Household instability (access to stable housing).

Interventions

To address the identified barriers, Four Corners implemented the following interventions:

- Implement the improved appointment confirmation process. Shift applicable services to case managers to free up clinician time for psychotherapy treatment.
- Develop a relationship with a local peer support program to advertise peer support services. Create a process for promoting and advertising pro-social events in the area. Reinstitute the monthly family/friend group as part of the maintenance program.
- Develop and have accessible an up-to-date housing resource sheet to distribute to members.

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

Strengths

HSAG identified the following strengths:

- The PIP received an overall *Met* validation status, with a *Met* score for 95 percent of overall evaluation elements and 100 percent of critical evaluation elements across all steps completed and validated.
- Four Corners achieved statistically significant improvement in the performance indicator rate over the baseline.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- There were opportunities to improve documentation of factors impacting the validity and comparability of the reported remeasurement data with the baseline.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Four Corners:

- Have a process in place for evaluating each PIP intervention and its impact on the PIP 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.

- Address the *Validation Feedback* associated with any *Met* score and the *Partially Met* scores in the next annual submission.
- Continue with its improvement efforts to sustain the improvement achieved in PIP outcomes.
- 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.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-71 presents Four Corners' MY 2021 performance measure results.

Table 2-71—Four Corners MY 2021 *FUH* Results

Indicator	Four Corners Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**49.09%**	53.92%
Follow-Up Within 30 Days	**60.00%**	70.68%

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

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

Strengths

- Four Corners' establishment of an Opioid Treatment Program for OUDs has improved the stability of members with dual mental health and SUD diagnoses and is expected to lead to a reduction in hospital stays for this population.
- Four Corners' MCOT has contributed to the improvement of the performance measure rates, which increased more than 10 percentage points for both the 7- and 30-day indicators.

Opportunities for Improvement

- HSAG recommends that Four Corners have at least two different team members perform additional validation of its numerator positive cases and eligible population in the denominator to

reduce potential errors. HSAG also recommends validation of hospital discharge dates against claims that are documented in the electronic health record (EHR), along with validation of dates of follow-up services. Validation should include checking age at the time of discharge to ensure proper age stratification between the two measure indicators, checking to ensure that the follow-up and discharge do not occur on the same day, checking for readmissions within 30 days, and checking to ensure that the date of discharge is not after December 1 of the measurement year to ensure alignment with measure specifications.

- HSAG recommends that Four Corners perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

Recommendations

HSAG recommends that Four Corners:

- Have at least two different team members perform additional validation of its numerator positive cases and eligible population in the denominator to reduce potential errors. HSAG also recommends validation of hospital discharge dates against claims that are documented in the EHR, along with validation of dates of follow-up services. Validation should include checking age at the time of discharge to ensure proper age stratification between the two measure indicators, checking to ensure that the follow-up and discharge do not occur on the same day, checking for readmissions within 30 days, and checking to ensure that the date of discharge is not after December 1 of the measurement year to ensure alignment with measure specifications.
- Perform an analysis of non-compliant cases to identify barriers that were experienced by the members that prevented a follow-up visit within 7 or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-72 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Four Corners' total weighted compliance score was 94 percent. Following the CY 2022 CAP review, Four Corners improved its cumulative weighted score to 98 percent.

Table 2-72—Summary of Scores for the Standards for Four Corners

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	28	28	28	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	25	1	0	1	98%
V	Grievance and Appeal System	28	28	25	3	0	0	95%
VI	Provider Selection and Program Integrity	19	19	17	2	0	0	95%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**141**	**136**	**130**	**6**	**0**	**5**	**98%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- QAPIP, Practice Guidelines, and Health Information Systems

- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG provided the following recommendations for Four Corners:

- HSAG recommends that Four Corners implement a process to ensure updated member-facing documents are made available to members on its website.
- During the CY 2022 record review, HSAG found that some Four Corners grievance records and credentialing records lacked full compliance. For example, for grievances, Four Corners did not always document the resolution date or provide written resolution for written grievances. HSAG also found that the grievance log did not contain all required documentation. For credentialing, Four Corners did not always check providers against federal exclusion lists prior to hire. HSAG recommends that Four Corners develop processes to ensure it documents all required credentialing and grievance information and that written grievances are resolved in writing.
- HSAG recommends that Four Corners compliance officer assess strengths and opportunities for improvement in the area of compliance and seek out training related to gaps in related knowledge.
- HSAG recommends that Four Corners complete a fraud, waste, and abuse (FWA) root cause analysis to evaluate for potential FWA risks and develop policies or processes defining routine monitoring and auditing..

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-73 displays the number and percentage of provider categories wherein Four Corners met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-73—Compliance With Time/Distance Standards by Urbanicity—Four Corners*

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

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

Opportunities for Improvement

Table 2-74 displays the provider domains and categories wherein Four Corners failed to meet the time/distance standards.

Table 2-74—Provider Categories That Failed to Meet Time/Distance Standards—Four Corners*

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

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

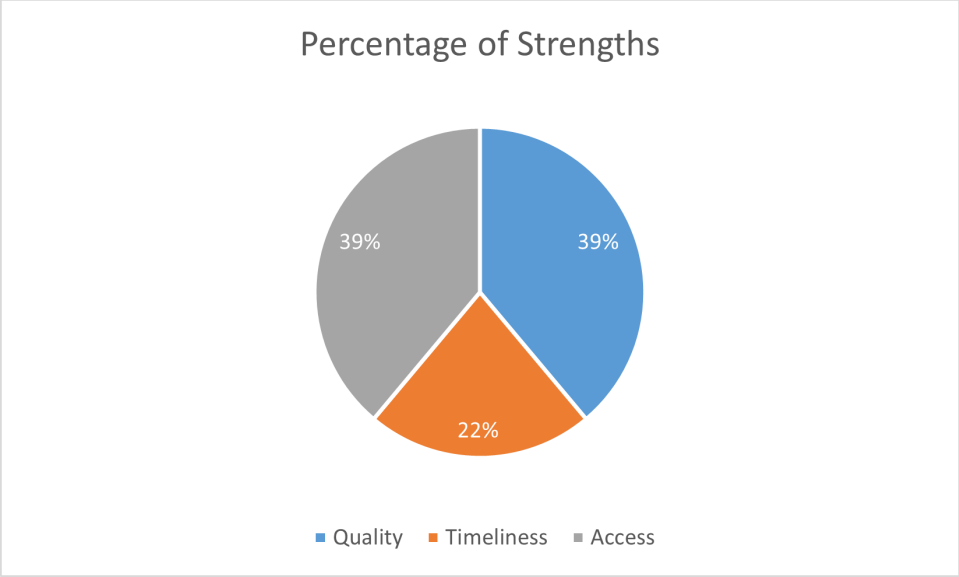
Recommendations

HSAG offers the following recommendations:

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

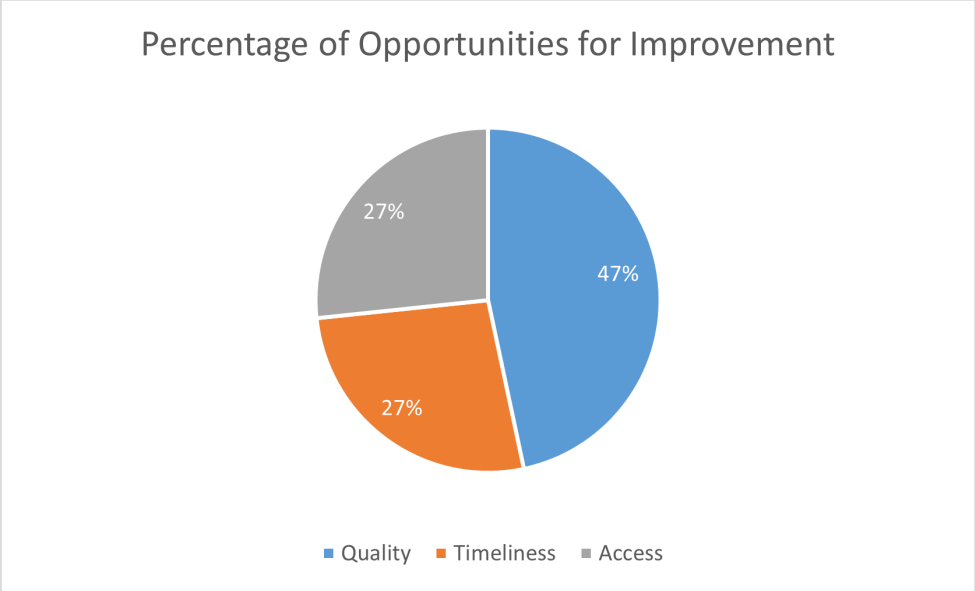
Healthy U Behavioral

Figure 2-27—Percentage of Strengths by Care Domain for Healthy U Behavioral*



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

Figure 2-28—Percentage of Opportunities for Improvement by Care Domain for Healthy U Behavioral*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Healthy U Behavioral submitted its clinical PIP topic, *Improving Follow-up After Hospitalization for Mental Illness*, for its Summit County PMHP members.

Validation Results and Interventions

Table 2-75 summarizes the validation findings for the PIP validated for CY 2022. Overall, 84 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-75—CY 2022 Performance Improvement Project Validation Results for Healthy U Behavioral (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	4	2	0
	Implementation Total	**7/9**	**2/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	0	1
	Outcomes Total	**1/2**	**0/2**	**1/2**
Percentage Score of Applicable Evaluation Elements *Met*		**84%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**89%**		
Validation Status		***Partially Met***		

Indicator Outcomes

Healthy U Behavioral reported Remeasurement 1 results in the CY 2022 submission. Healthy U Behavioral did not achieve significant clinical or programmatic improvement in PIP outcomes. The performance indicator rates for both indicators were below the baseline.

Table 2-76 displays data for Healthy U Behavioral's *Improving Follow-up After Hospitalization for Mental Illness* PIP.

Table 2-76—PIP—Improving Follow-up After Hospitalization for Mental Illness
Healthy U Behavioral

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

N–Numerator D–Denominator

The baseline rate for the percentage of discharges for members 6 years of age and older who were hospitalized for mental illness and who had a follow-up visit within seven days was 66.7 percent. For Remeasurement 1, the Performance Indicator 1 rate of 36.4 percent represents a decrease of 30.3 percentage points from the baseline.

The baseline rate for the percentage of discharges for members 6 years of age and older who were hospitalized for mental illness and who had a follow-up visit within 30 days was 77.8 percent. For Remeasurement 1, the Performance Indicator 2 rate of 68.2 percent represents a decrease of 9.6 percentage points from the baseline.

The eligible denominator size for the Healthy U Behavioral PIP is small. During a technical assistance call with HSAG and DHHS, Healthy U Behavioral reiterated that the selected PIP topic has a potential to improve member outcomes and is an important area of focus for the health plan. DHHS gave approval

to continue with the PIP topic. Due to the smaller denominator size, Healthy U Behavioral may not have an opportunity to realize statistically significant improvement in performance indicator rates. As the PIP progresses, Healthy U Behavioral will be assessed for any significant clinical and programmatic improvement in outcomes.

Barriers

For the *Improving Follow-up After Hospitalization for Mental Illness* PIP, Healthy U Behavioral used a fishbone diagram and data analysis to identify the following barriers to achieving desired PIP outcomes:

- Follow-up visit is not scheduled by hospital discharge planner within seven days after discharge.
- Members may not understand the importance of timely follow-up after hospital discharge.
- There may be SDoH barriers that prevent members from attending the follow-up visit.

Interventions

To address the identified barriers, Healthy U Behavioral implemented the following interventions:

- For members hospitalized at Huntsman Mental Health Institute (HMHI), the University of Utah Health Plans (UUHP) care management team reaches out to the HMHI discharge planner via Smart Web or email to ensure that a follow-up appointment has been scheduled within seven days after discharge. If needed, UUHP care managers assist the discharge planner in finding available in-network providers to see members.
- Upon notification of hospital admission, UUHP will provide care management support to hospitalized members to ensure timely follow-up visits after discharge. Care management support involves identifying and mitigating the specific barriers for each member that may prevent the member from attending a follow-up visit.

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

Strengths

HSAG identified the following strengths:

- Healthy U Behavioral documented a sound PIP design and implemented system interventions that were related to barriers identified through appropriate QI processes.
- Healthy U Behavioral reported that it is continuing with the interventions implemented during 2021.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- The PIP received an overall *Partially Met* validation status, with a *Met* score for 89 percent of critical evaluation elements and 84 percent of overall evaluation elements across all steps completed and validated.
- Healthy U Behavioral did not provide intervention evaluation data; therefore, HSAG could not determine whether the next steps for the interventions were based on evaluation of each intervention for effectiveness.
- Healthy U Behavioral did not achieve improvement during Remeasurement 1.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Healthy U Behavioral:

- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis to determine any new barriers and implement new interventions to address lack of improvement in PIP outcomes. Healthy U Behavioral should also consider seeking member input in order to better understand member-related barriers to access to care.
- Have a process in place for evaluating each PIP intervention and its impact on the performance indicators. For example, for the care management support intervention, Healthy U Behavioral should provide data for how many members were assisted by the care management support team to mitigate member barriers toward getting a timely follow-up visit and whether the intervention resulted in a compliant follow-up visit. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation data must be included in the next annual submission.
- Provide data-driven rationale for demonstrating programmatic and clinical improvement.
- Address the *Validation Feedback* comments associated with any *Met* scores and the *Partially Met/Not Met* scores in the next annual submission.
- Continually work on the PIP throughout the year.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

The 2022 PMV Report indicated that HSAG found Healthy U Behavioral's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the performance measure indicators for *Follow-Up After*

Hospitalization for Mental Illness—7-Day and 30-Day Follow-Up should receive a designation of *Reportable* (*R*).

Performance Measure Outcomes

Table 2-77 presents Healthy U Behavioral's MY 2021 performance measure results.

Table 2-77—Healthy U Behavioral MY 2021 *FUH* Results

Indicator	Healthy U Behavioral Rate*	Statewide PMHP Average
Follow-Up Within 7 Days	**36.36%**	53.92%
Follow-Up Within 30 Days	**68.18%**	70.68%

*Rates with small denominators are likely to be subject to wild swings in performance, and interpretations should be made with caution.
Rates in **red** font indicate the rate fell below the statewide PMHP average.

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

Strengths

HSAG identified the following strengths:

- Healthy U Behavioral demonstrated the ability to continuously meet the health care needs of its membership throughout the COVID-19 pandemic via telephonic intervention and other process adjustments. HSAG noted that this process adjustment has been more efficient for providers, and they have continued to see a higher demand for behavioral health services.
- Healthy U Behavioral accelerated access to its behavioral health care and social needs by partnering with schools, promoting behavioral health services, and expanding access to bilingual and bicultural behavioral health services.

Opportunities for Improvement

Healthy U Behavioral's FUH measure rate for both indicators was below the statewide PMHP average.

Recommendations

HSAG recommends that Healthy U Behavioral perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-78 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Healthy U Behavioral's total weighted compliance score was 90 percent. Following the CY 2022 CAP review, Healthy U Behavioral improved its cumulative weighted score to 96 percent.

Table 2-78—Summary of Scores for the Standards for Healthy U Behavioral

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	30	27	24	3	0	3	94%
II	Access and Availability	14	12	12	0	0	0	100%
III	Coordination and Continuity of Care	9	7	7	0	0	2	100%
IV	Member Rights and Information (Includes Confidentiality)	28	25	23	2	0	3	96%
V	Grievance and Appeal System	28	28	23	5	0	0	91%
VI	Provider Selection and Program Integrity	20	19	18	1	0	0	97%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	12	12	0	0	4	100%
IX	Enrollment and Disenrollment	8	4	4	0	0	4	100%
	Totals	**157**	**138**	**127**	**11**	**0**	**19**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- Coordination and Continuity of Care
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG provided the following recommendations for Healthy U Behavioral:

- During the CY 2022 record review, HSAG found that all Healthy U Behavioral denial records were missing content as required at 42 CFR §438.404(b) (*Content of Notice*). HSAG recommends that Healthy U Behavioral UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- HSAG found that some NABD letters and member letters pertaining to appeals and grievances were not written at or below a sixth-grade reading level, as required. HSAG recommends that Healthy U Behavioral UM managers and grievance and appeals managers develop a process to ensure that member correspondence is written in easy-to-understand language.
- Healthy U Behavioral reported that it did not receive any member grievances for the period under review. HSAG recommends that Healthy U Behavioral investigate why it did not receive any

grievances and develop methods to ensure or inform members that they may report grievances to Healthy U Behavioral directly through a variety of avenues (mail, email, telephone, etc.).

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-79 displays the number and percentage of provider categories wherein Healthy U Behavioral met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Healthy U Behavioral in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-79—Compliance With Time/Distance Standards by Urbanicity—Healthy U Behavioral*

		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Healthy U Behavioral	12	12	100.0%	

*Analyses were restricted to counties and urbanicities in Healthy U Behavioral's Summit County service area.

Opportunities for Improvement

Table 2-80 displays the provider domains and categories wherein Healthy U Behavioral failed to meet the time/distance standards.

Table 2-80—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U Behavioral*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
NA**	NA	NA

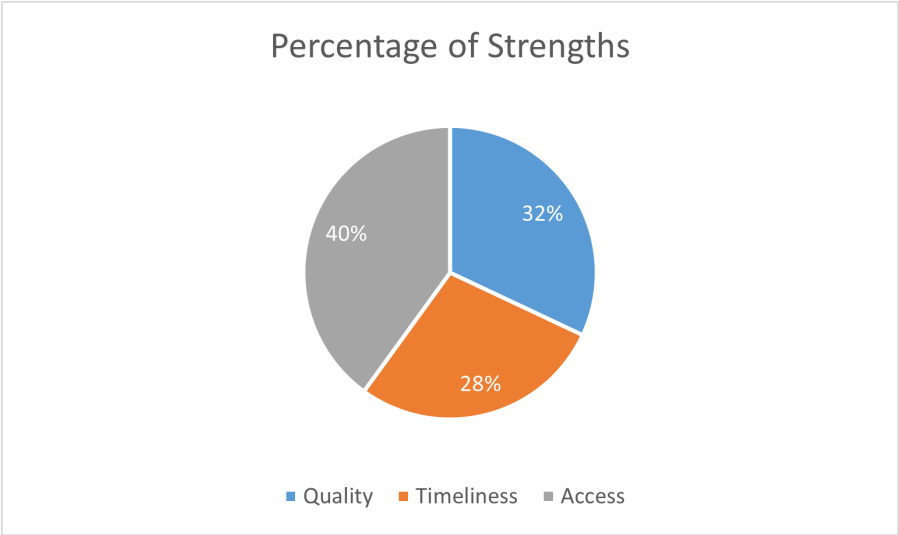
*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).
** No data were submitted for the provider category.

Recommendations

HSAG does not have any network adequacy recommendations for Healthy U Behavioral.

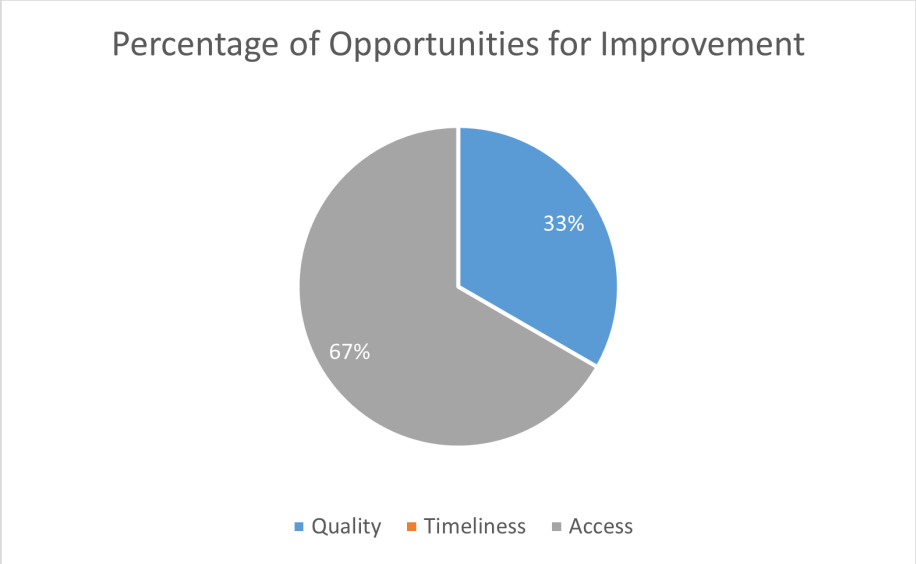
Northeastern Counseling Center (Northeastern)

Figure 2-29—Percentage of Strengths by Care Domain for Northeastern*



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

Figure 2-30—Percentage of Opportunities for Improvement by Care Domain for Northeastern*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Northeastern submitted its clinical PIP topic: *Inpatient Post Discharge Engagement and Suicide Intervention*. Northeastern aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions for members discharged from an inpatient hospital stay.

Validation Results and Interventions

Table 2-81 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-81—CY 2022 Performance Improvement Project Validation Results for Northeastern (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	0
	Outcomes Total	**2/2**	**0/2**	**0/2**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Validation Status	***Met***		

Indicator Outcomes

Northeastern progressed to reporting Remeasurement 2 results for this validation cycle. Northeastern improved performance across all four performance indicators. The Remeasurement 2 rates for all four performance indicators demonstrated a statistically significant improvement over the baseline.

Table 2-82 displays data for Northeastern's *Inpatient Post Discharge Engagement and Suicide Intervention* PIP.

Table 2-82—PIP—*Inpatient Post Discharge Engagement and Suicide Intervention*
Northeastern

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Sustained Improvement**
1. Percentage of inpatient discharges where members received a formal covered service per the HEDIS protocol or a documented "Caring Contact" (i.e., documented "outreach") 1 to 3 business days post discharge.	N: 18 D: 30	60.0%	N: 50 D: 59	84.7%*	N: 64 D: 79	81.0%*	*Not Assessed*
2. Percentage of inpatient discharges where members received a personalized Safety Plan 1–7 days post discharge with or through Northeastern Counseling.	N: 6 D: 26	23.1%	N: 16 D: 50	32.0%	N: 35 D: 66	53.0%*	*Not Assessed*
3. Percentage of inpatient discharges where members received a Columbia Suicide Severity Risk Screening 1–7 days post discharge.	N: 7 D: 26	26.9%	N: 15 D: 50	30.0%	N: 38 D: 66	57.6%*	*Not Assessed*
4. Percentage of inpatient discharges where members received a formal covered service or a documented "Caring Contact" (i.e., documented	N: 16 D: 30	53.3%	N: 47 D:59	79.7%*	N: 61 D: 79	77.2%*	*Not Assessed*

Performance Indicator Results							
Performance Indicators	Baseline (01/01/2019–12/31/2019)		Remeasurement 1 (01/01/2020–12/31/2020)		Remeasurement 2 (01/01/2021–12/31/2021)		Sustained Improvement
"outreach") 31 to 60 days post discharge.							

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

The baseline rate for the percentage of discharges wherein members receiving a formal covered service or a documented Caring Contact (outreach) within one to three business days post-discharge was 60 percent. For Remeasurement 2, the rate increased to 81.0 percent, and Northeastern demonstrated a statistically significant increase ($p < 0.05$) of 21.0 percentage points over the baseline.

The baseline rate for the percentage of inpatient discharges wherein members received a personalized safety plan one to seven days post-discharge was 23.1 percent. For Remeasurement 2, the rate increased to 53.0 percent, and Northeastern demonstrated a statistically significant increase ($p < 0.05$) of 29.9 percentage points over the baseline.

The baseline rate for the percentage of inpatient discharges wherein members received a Columbia Suicide Severity Risk Screening (C-SSRS) one to seven days post discharge was 26.9 percent. For Remeasurement 2, the rate increased to 57.6 percent, and Northeastern demonstrated a statistically significant increase ($p < 0.05$) of 30.7 percentage points over the baseline.

The baseline rate for the percentage of inpatient discharges wherein members received a formal covered service or a documented Caring Contact 31 to 60 days post-discharge was 53.3 percent. For Remeasurement 2, the rate increased to 77.2 percent, and Northeastern demonstrated a statistically significant increase ($p < 0.05$) of 23.9 percentage points over the baseline.

Barriers

For the *Inpatient Post Discharge Engagement and Suicide Intervention* PIP, Northeastern used data analysis to identify the following barriers to achieving desired PIP outcomes:

- Clinical staff members, support staff members, and the suicide prevention specialist lack knowledge of the expectations regarding inpatient discharge follow-up as described in this project. When inpatient providers call Northeastern for inpatient follow-up, the patient must be scheduled/offered within the three-business-day period.
- Clinical staff members and the suicide prevention specialists need to understand the requirement for 31- to-60-day follow-up and Caring Contacts including how these are tracked in Credible (Northeastern's EHR system) and on the tracking spreadsheet. Members who choose not to have Northeastern provide services must still be tracked and contacted.

- Lack of identification and tracking of the post-inpatient discharge population in real time to meet the additional expectations as outlined in this PIP.
- During day-to-day practice, clinicians see many types of members who have additional clinical criteria and required practices. Clinicians forget to administer risk screening and complete a safety plan.

Interventions

To address these identified barriers, Northeastern implemented the following interventions:

- In-person training of all staff members that the three-business-day follow-up requirement applies to anyone being discharged from an inpatient unit and clinicians need to complete a safety plan and C-SSRS on the first service post-discharge from the inpatient unit. An email summary of the training is sent to the staff members three times during a year.
- Train clinicians and suicide prevention specialists regarding service and/or Caring Contact expectations (i.e., within 31 to 60 days) that include the following:
  - Tracking in Credible and on the tracking spreadsheet is required for 31- to 60-day follow-up and Caring Contacts.
  - Members who choose to follow up with providers other than Northeastern must still have Caring Contacts within the time frames of this project, including 31 to 60 days.
  - Members who do not show up for an appointment or who do not cancel the appointment with support staff members are to be contacted by the clinician or suicide prevention specialist within the time frames of this project and are to use the Caring Contact follow-up service in the EHR to document those actions 31 to 60 days post-inpatient discharge.
- The clinical director, suicide prevention specialist, and back-up specialist have developed a spreadsheet to track inpatient discharges as they occur with daily follow-up. A marker in the EHR has also been added for inpatient discharge members, which remains in place for 60 days post-inpatient discharge.
- The clinical services note used for hospital discharge follow-up has been altered to include "Was this Individual just discharged from an Inpatient Psychiatric Hospital?" Answering "yes" brings up this reminder:

  You must complete the following for this visit:

  1. Columbia Suicide Severity Risk Screening
  2. Safety Plan

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

Strengths

HSAG identified the following strengths:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- Northeastern demonstrated a statistically significant improvement over the baseline for all four performance indicators.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Northeastern:

- Continually work on the PIP throughout the year.
- 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.
- Continue with its improvement efforts to sustain the improvement achieved across all the performance indicators.
- Continue to evaluate the performance of each intervention and its impact on the performance indicators. Intervention-specific evaluation results should guide next steps for each individual intervention.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-83 presents Northeastern's MY 2021 performance measure results.

Table 2-83—Northeastern MY 2021 *FUH* Results

Indicator	Northeastern Rate	Statewide PMHP Average
Follow-Up Within 7 Days	60.47%	53.92%
Follow-Up Within 30 Days	73.26%	70.68%

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

Strengths

HSAG identified the following strengths:

- Northeastern worked to develop relationships in the Wasatch Front region, resulting in additional services for residential treatment and other substance abuse treatment services for Northeastern's members.
- To provide immediate on-site treatment to members and the community at large, Northeastern started a MCOT that helps individuals who are experiencing a mental health crisis.

Opportunities for Improvement

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

Recommendations

HSAG did not identify any recommendations.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-84 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Northeastern's total weighted compliance score was 93 percent. Following the CY 2022 CAP review, Northeastern improved its cumulative weighted score to slightly below 100 percent.

Table 2-84—Summary of Scores for the Standards for Northeastern

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	28	28	28	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	26	0	0	1	100%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	19	19	18	1	0	0	97%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**141**	**136**	**135**	**1**	**0**	**5**	**100%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Member Rights and Information (Includes Confidentiality)

- Grievance and Appeal System
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- During the 2022 grievance record review, Northeastern reported three grievances. HSAG recommends that Northeastern analyze member grievance data and develop methods to ensure members understand the definition of "grievance" and inform members that grievances can be reported to Northeastern directly.
- During the CY 2022 credentialing record review, HSAG found that Northeastern did not ensure all provider licenses were verified through the Division of Occupational and Professional Licensing (DOPL). HSAG recommends that Northeastern implement processes to ensure documentation of license verification.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-85 displays the number and percentage of provider categories wherein Northeastern met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Northeastern in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-85—Compliance With Time/Distance Standards by Urbanicity—Northeastern*

		Northeastern		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Northeastern	12	2	16.7%	

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

Opportunities for Improvement

Table 2-86 displays the provider domains and categories wherein Northeastern failed to meet the time/distance standards.

Table 2-86—Provider Categories That Failed to Meet Time/Distance Standards—Northeastern*

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

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

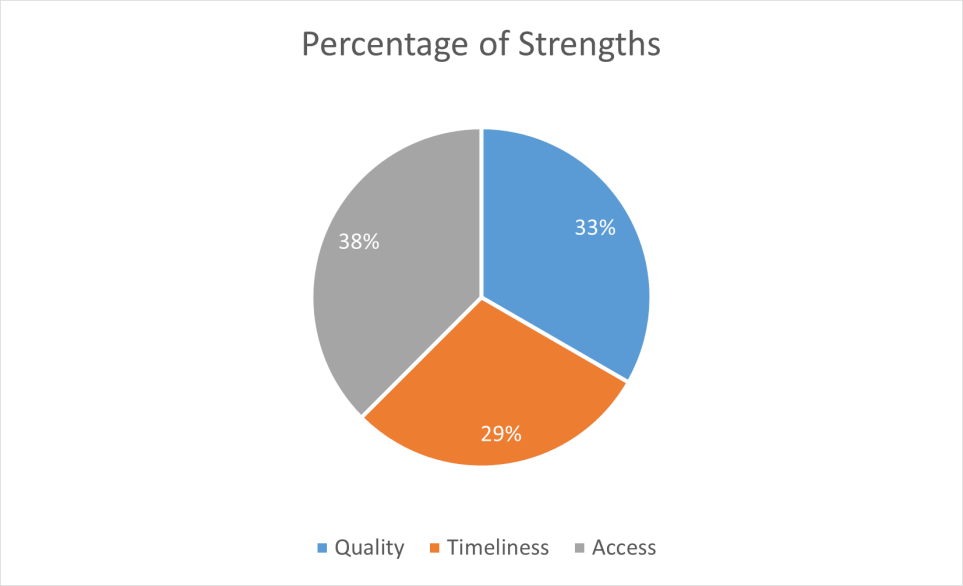
Recommendations

HSAG offers the following recommendations:

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

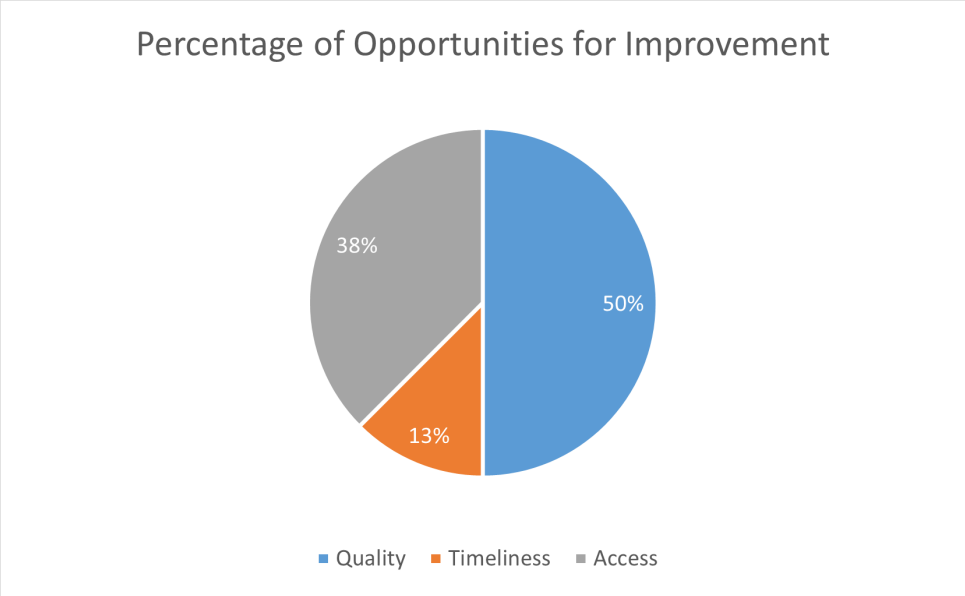
Optum/Tooele

Figure 2-31—Percentage of Strengths by Care Domain for Optum/Tooele*



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

Figure 2-32—Percentage of Opportunities for Improvement by Care Domain for Optum/Tooele*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Optum/Tooele submitted its clinical PIP topic, *Increasing Youth Engagement in Treatment Services in Tooele County*. The goal of this PIP is to increase member engagement in treatment services for youth with a mental health or SUD diagnosis.

Validation Results and Interventions

Table 2-87 summarizes the validation findings for each stage validated for CY 2022. Overall, 93 percent of all applicable evaluation elements received a score of *Met*.

Table 2-87—CY 2022 Performance Improvement Project Validation Results for Optum/Tooele (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	2	1	0
	8. Assess the Improvement Strategies	3	0	0
	Implementation Total	**5/6**	**1/6**	**0/6**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**93%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Optum/Tooele reported baseline data. Optum/Tooele will be assessed for improvement in outcomes in the next annual validation.

Table 2-88 displays data for Optum/Tooele's *Increasing Youth Engagement in Treatment Services in Tooele County* PIP.

Table 2-88—PIP—Increasing Youth Engagement in Treatment Services for Tooele County PIP

Performance Indicator Results			
Performance Indicators	**Baseline (09/01/2021–02/28/2022)**		**Sustained Improvement**
1. Percentage of eligible members 17 years or younger, who received at least one behavioral health service during the measurement period.	N: 356 D: 4,634	7.7%	*Not Assessed*
2. Percentage of eligible members 17 years or younger, who received at least one family peer support service during the measurement period.	N: 3 D: 356	0.8%	*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for the percentage of eligible members 17 years or younger who received at least one behavioral health service during the measurement period was 7.7 percent.

The baseline rate for the percentage of eligible members 17 years or younger who received at least one family peer support service during the measurement period was almost negligible at 0.8 percent.

Barriers

For the *Increasing Youth Engagement in Treatment Services in Tooele County* PIP, Optum/Tooele used data analysis to identify the following barriers to achieving desired PIP outcomes:

- Residents are unaware of available behavioral health services and supports for Medicaid-eligible youth in Tooele County.
- No family peer support specialists within the Optum/Tooele provider network.

Interventions

To address these identified barriers, Optum/Tooele implemented the following interventions:

- Implementation of an information campaign targeting youth directly and those who support youth to inform them of the available services and to increase youth engagement in treatment services. The information campaign includes posting English and Spanish flyers on social media sites of the selected network providers.
- Flyers will also be posted in several community locations such as libraries, coffee houses, arcades, skate parks, etc.
- Two certified family peer support specialists will be added to the provider network.

Optum/Tooele—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strength:

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 93 percent of overall evaluation elements across all steps completed and validated.

Opportunities for Improvement

Optum/Tooele had opportunities to improve the narrative interpretation of data.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Optum/Tooele:

- Have a process in place for evaluating each PIP intervention and its impact on the performance indicators. For example, for the informational campaign intervention, Optum/Tooele should collect data to evaluate whether the flyers are being effective in engaging youth. Interventions should be adapted or revised as needed based on the evaluation data.
- Address the *Validation Feedback* comments associated with any *Met* scores and the *Partially Met* scores in the next annual submission.
- Continually work on the PIP throughout the year.

- 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.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the health plan.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results and Interventions

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

Performance Measure Outcomes

Table 2-89 presents Optum/Tooele's MY 2021 performance measure results.

Table 2-89—Optum/Tooele MY 2021 *FUH* Results

Indicator	Optum/Tooele Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**47.52%**	53.92%
Follow-Up Within 30 Days	**58.42%**	70.68%

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

Optum/Tooele—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HSAG identified the following strengths:

- Optum/Tooele continued to expand its services to members who speak Spanish by partnering with a local organization to connect Spanish-speaking families with Spanish-speaking providers who are able to provide in-home and community-based services.
- Optum/Tooele implemented new programs and successfully contracted with more providers to provide mental health and SUD services, therefore significantly increasing Optum/Tooele's provider network from four to 15 providers at the time of the review.
- Optum/Tooele implemented a process improvement plan to engage youth in mental health and SUD treatment services.

Opportunities for Improvement

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

Recommendations

While HSAG did not identify any opportunities for improvement, HSAG recommends that Optum/Tooele perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Optum/Tooele—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-90 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Optum/Tooele's total weighted compliance score was 94 percent. Following the CY 2022 CAP review, Optum/Tooele improved its cumulative weighted score to 99 percent.

Table 2-90—Summary of Scores for the Standards for Optum/Tooele

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	28	28	28	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	25	1	0	1	98%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	19	19	19	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VII	Subcontractual Relationships and Delegation	4	4	3	0	1	0	75%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**141**	**140**	**138**	**1**	**1**	**1**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Subcontractual Relationships and Delegation

Recommendations

HSAG offers the following recommendation:

- HSAG recommends that Optum/Tooele develop and implement processes to assess and ensure it maintains a provider directory that is in a machine-readable file and format as specified by the Secretary of Health and Human Services.
- HSAG recommends that Optum/Tooele review delegated agreements related to administrative services to ensure subcontractor agreement to comply with applicable Medicaid laws, regulations, and contract provisions.
- During the 2022 grievance record review, Optum/Tooele reported that it did not have any grievances. HSAG recommends that Optum/Tooele analyze member grievance data and develop methods to ensure members understand the definition of "grievance" and inform members that they can report grievances to Optum/Tooele directly.

VALIDATION OF NETWORK ADEQUACY

Optum/Tooele—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-91 displays the number and percentage of provider categories wherein Optum/Tooele met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Optum/Tooele in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-91—Compliance With Time/Distance Standards by Urbanicity—Optum/Tooele*

		Frontier		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Optum	12	11	91.7%	

*Analyses were restricted to counties and urbanicities within Optum's Tooele County service area.

Opportunities for Improvement

Table 2-92 displays the provider domains and categories wherein Optum/Tooele failed to meet the time/distance standards.

Table 2-92—Provider Categories That Failed to Meet Time/Distance Standards—Optum/Tooele*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Providers	Behavioral Medical—All**	

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

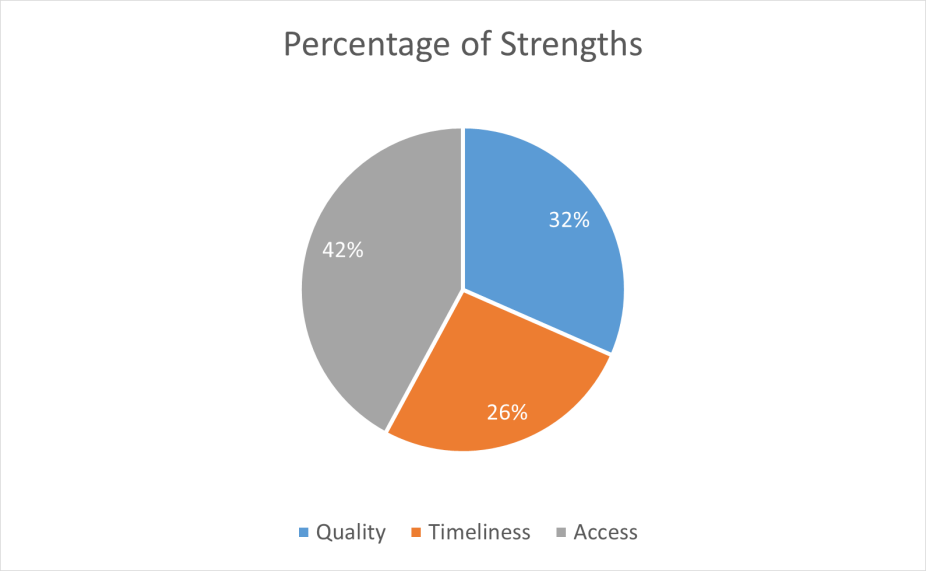
Recommendations

HSAG offers the following recommendations:

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

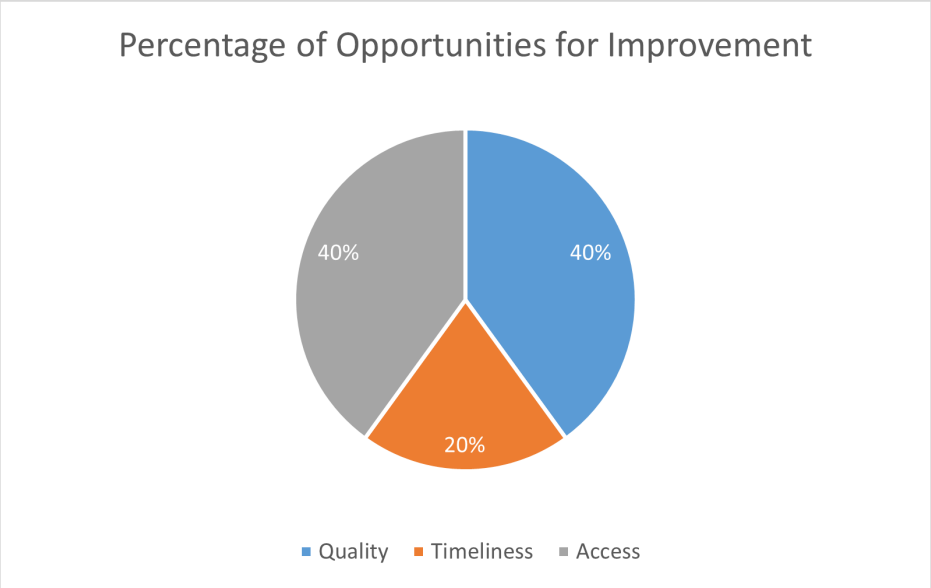
Salt Lake County Division of Behavioral Health Services (Salt Lake)

Figure 2-33—Percentage of Strengths by Care Domain for Salt Lake*



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

Figure 2-34—Percentage of Opportunities for Improvement by Care Domain for Salt Lake*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Salt Lake submitted its PIP topic: *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County.* Salt Lake aims to improve behavioral health outcomes by increasing member engagement and retention in OUD treatment by providing MAT services.

Validation Results and Interventions

Table 2-93 summarizes the validation findings for each stage validated for CY 2022. Overall, 80 percent of all applicable evaluation elements received a score of *Met.*

Table 2-93—CY 2022 Performance Improvement Project Validation Results for Salt Lake County (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	1	2	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**7/9**	**2/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	0	1	1
	Outcomes Total	**0/2**	**1/2**	**1/2**
Percentage Score of Applicable Evaluation Elements *Met*		**80%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**89%**		
Validation Status		***Partially Met***		

Indicator Outcomes

Salt Lake progressed to reporting Remeasurement 2 results during this validation cycle. Salt Lake did not achieve any improvement in performance indicators or outcomes. Salt Lake reported that due to PIP data collection issues, it will discontinue this PIP.

Table 2-94 displays data for Salt Lake's *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County* PIP.

Table 2-94—PIP—Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County
Salt Lake

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Sustained Improvement**
1. Percentage of members who have been diagnosed with an OUD and who may have received MAT services.	N: 66	75.0%	N: 48	57.8%	N: 37	38.5%	*Not Assessed*
	D: 88		D: 83		D: 96		
2. Percentage of members who received MAT services and remained in treatment longer than 6 months.	N: 25	28.4%	N: 35	42.2%	N: 19	19.8%	*Not Assessed*
	D: 88		D: 83		D: 96		

N–Numerator D–Denominator

The baseline rate for the percentage of members diagnosed with an OUD, who initiated a SUD treatment, and who may have received MAT services was 75.0 percent. For Remeasurement 2, the rate decreased to 38.5 percent, and Salt Lake demonstrated a decline of 36.5 percentage points from the baseline.

The baseline rate for the percentage of members who received MAT services and remained in treatment longer than six months was 28.4 percent. For Remeasurement 2, the rate decreased by 8.6 percentage points from the baseline to 19.8 percent.

Salt Lake reported that due to the data collection issues, the reported performance indicators' data may have been underreported and should therefore be interpreted with caution.

Barriers

For the *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County* PIP, Salt Lake used staff feedback and data analysis to identify the following barriers toward achieving desired PIP outcomes:

- The COVID-19 pandemic impacted service delivery with a reduction in overall services provided in CY 2020.
- Staff lacked awareness to support the use of MAT as recovery from OUD.
- Data collection issues—unable to capture initiation of treatment start date and engagement in treatment services subsequent to initiating MAT.

Interventions

- To address the identified barriers, Salt Lake implemented the following interventions:
  - Extended the MAT training to all staff members of three providers with the fewest number of members with OUD diagnosis who were referred for MAT services.
  - MAT training is to be provided to the entire staffs of three providers with the fewest number of members with OUD referral for MAT screening.
- Different data sources such as the Utah Web Infrastructure for Treatment Services (UWITS) and Treatment Episode Data Set (TEDS) were investigated for gathering relevant data.

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

Strengths

Due to issues with collecting reliable PIP data, no strengths were identified in Salt Lake's PIP submission.

Opportunities for Improvement

- Salt Lake documented that due to changes in the billing codes and staffing of service providers, it is unable to produce valid outcomes for the PIP performance indicators. Salt Lake will discontinue this PIP.

Recommendations

Related to the opportunities for improvement, HSAG recommends that Salt Lake:

- Select a new PIP topic based on an opportunity for improvement as indicated by historical/baseline data. The PIP design and data collection methodology should be thoroughly reviewed, and anticipated barriers to data collection should be considered while designing the PIP.
- Apply any lessons learned and knowledge gained through the QI processes of this PIP as it initiates a new PIP topic.
- Seek DHHS' approval on the new PIP topic prior to next year's annual submission.
- Seek technical assistance from HSAG and DHHS as needed prior to next year's annual submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-95 presents Salt Lake's MY 2021 performance measure results.

Table 2-95—Salt Lake MY 2021 FUH Results

Indicator	Salt Lake Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**47.88%**	53.92%
Follow-Up Within 30 Days	**64.84%**	70.68%

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

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

Strengths

- Salt Lake demonstrated a proactive approach to meeting the health care needs of its members by having a youth care coordinator work with children and their families. The youth care coordinator followed up with guardians of youth within 24 hours of inpatient discharge to help children and their families with the next steps of receiving follow-up services that are offered.
- Salt Lake added residential services for at-risk members to assist them with finding housing. In addition, Salt Lake collaborated with the ACOs to address medical needs for those with higher levels of needs.

Opportunities for Improvement and Recommendations

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

Recommendations

While HSAG did not identify any opportunities for improvement, HSAG offers the following recommendation:

- HSAG recommends that Salt Lake perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-96 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Salt Lake's total weighted compliance score was 96 percent. Following the CY 2022 CAP review, Salt Lake improved its cumulative weighted score to 99 percent.

Table 2-96—Summary of Scores for the Standards for Salt Lake

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	28	28	28	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	25	1	0	1	98%
V	Grievance and Appeal System	28	28	26	2	0	0	96%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VI	Provider Selection and Program Integrity	19	19	19	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**141**	**140**	**137**	**3**	**0**	**1**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that Salt Lake develop and implement processes to assess and ensure it maintains a provider directory that is in a machine-readable file and format as specified by the Secretary of Health and Human Services.
- During the 2022 grievance record review, HSAG found that some grievance records lacked full compliance. For example, some grievances were not acknowledged or resolved appropriately. HSAG recommends that Salt Lake develop processes to ensure all grievances are acknowledged and resolved, as required.
- HSAG recommends that Salt Lake document provider retention strategies within its provider selection and retention policies.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-97 displays the number and percentage of provider categories wherein Salt Lake met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Salt Lake in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-97—Compliance With Time/Distance Standards by Urbanicity—Salt Lake*

		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Salt Lake	12	10	83.3%	

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

Opportunities for Improvement

Table 2-98 displays the provider domains and categories wherein Salt Lake failed to meet the time/distance standards.

Table 2-98—Provider Categories That Failed to Meet Time/Distance Standards—Salt Lake*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**	🔑
Behavioral Health—Providers	Behavioral Medical—All**	🔑

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

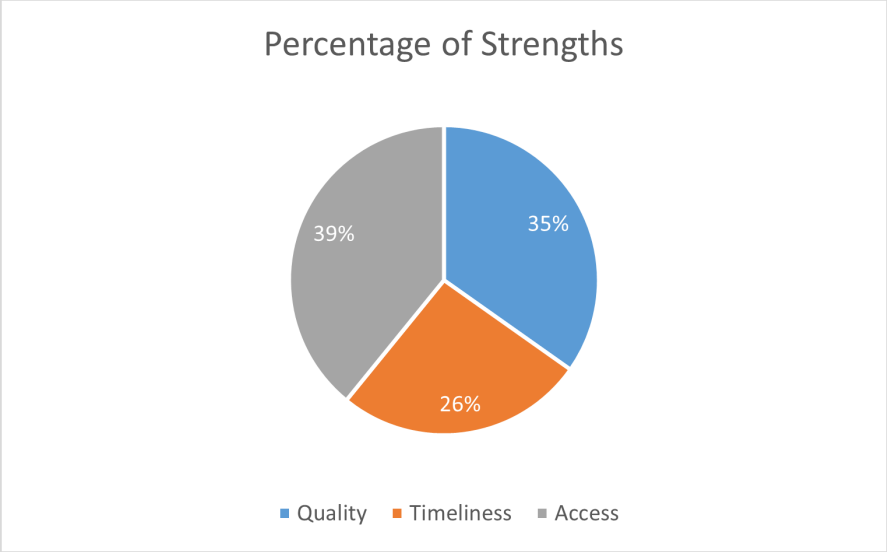
** No data were submitted for the provider category.

Recommendations

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

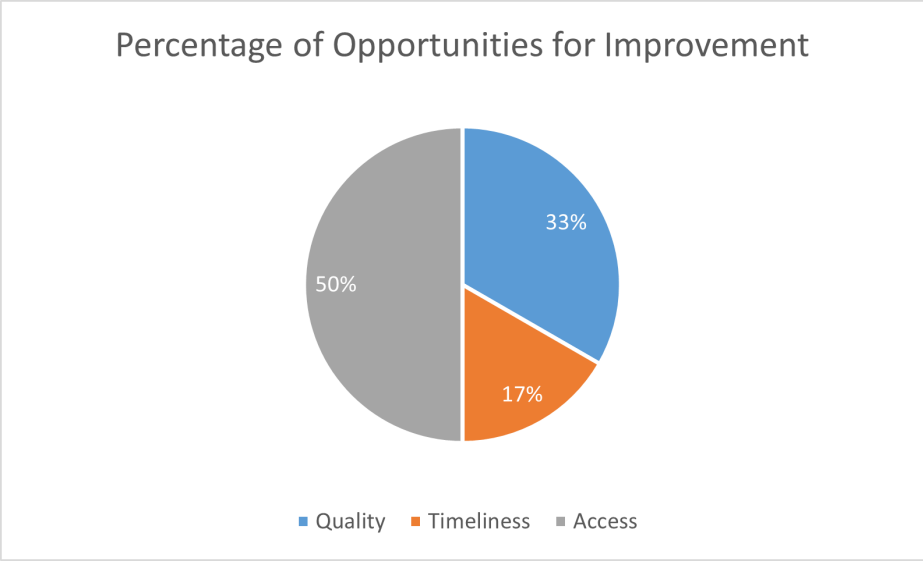
Southwest Behavioral Health Center (Southwest)

Figure 2-35—Percentage of Strengths by Care Domain for Southwest*



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

Figure 2-36—Percentage of Opportunities for Improvement by Care Domain for Southwest*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Southwest submitted its PIP topic: *Increased Number of PMHP Clients Receiving Peer Support Services*. The goal of this PIP is to improve processes and outcomes of members' mental health care by increasing the percentage of eligible members receiving peer support services.

Validation Results and Interventions

Table 2-99 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-99—CY 2022 Performance Improvement Project Validation Results for Southwest (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (is sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicator(s)	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		
	8. Assess the Improvement Strategies			
	Implementation Total			
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred			
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

SFY 2022 is the baseline year for this PIP. Southwest had not progressed to the point of reporting PIP outcomes.

Barriers

Southwest had not progressed to the point of identifying barriers for this PIP.

Interventions

Southwest had not progressed to the point of identifying and implementing PIP interventions.

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

Strengths

- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated. Southwest designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Southwest:

- Continually work on the PIP throughout the year.
- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input, in addition to other stakeholder input, during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

- Address *Validation Feedback* comments associated with *Met* scores in the next annual submission. If the validation feedback is not addressed, the corresponding evaluation element's score in the PIP Validation Tool may be impacted.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-100 presents Southwest's MY 2021 performance measure results.

Table 2-100—Southwest MY 2021 *FUH* Results

Indicator	Southwest Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**51.95%**	53.92%
Follow-Up Within 30 Days	**64.50%**	70.68%

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

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

Strengths

HSAG identified the following strengths:

- Southwest maintained strong system controls related to users entering data into its EHR system, Credible. Southwest also used monthly reports to track incomplete service documentation in the Credible system, which helped to ensure completeness of data for performance measure reporting.
- Southwest worked diligently to establish a working relationship with Vive, a new adolescent psychiatric free-standing institution for mental disease, to ensure appropriate coverage and reporting of hospital stays and quality follow-up services. Vive is collaborating with Southwest on discharge planning, preauthorization, and monitoring length of stay as a result of sustained efforts from Southwest to improve communication and coordination.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement.

Recommendations

While HSAG did not identify any opportunities for improvement, HSAG offers the following recommendations:

- That Southwest conduct additional validation to verify that numerator compliant cases are based on services that were submitted to DHHS as encounters for future reporting.
- That Southwest perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-101 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Southwest's total weighted compliance score was 93 percent. Following the CY 2022 CAP review, Southwest improved its cumulative weighted score to 100 percent.

Table 2-101—Summary of Scores for the Standards for Southwest

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	27	27	27	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	26	0	0	1	100%
V	Grievance and Appeal System	28	28	28	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VI	Provider Selection and Program Integrity	19	19	19	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**140**	**135**	**135**	**0**	**0**	**5**	**100%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

HSAG did not identify any opportunities for improvement and as such does not have any recommendations.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-102 displays the number and percentage of provider categories wherein Southwest met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Southwest in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-102—Compliance With Time/Distance Standards by Urbanicity—Southwest*

		Frontier		Rural		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Southwest	12	5	41.7%	5	41.7%	

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

Opportunities for Improvement

Table 2-103 displays the provider domains and categories wherein Southwest failed to meet the time/distance standards.

Table 2-103—Provider Categories That Failed to Meet Time/Distance Standards—Southwest*

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

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

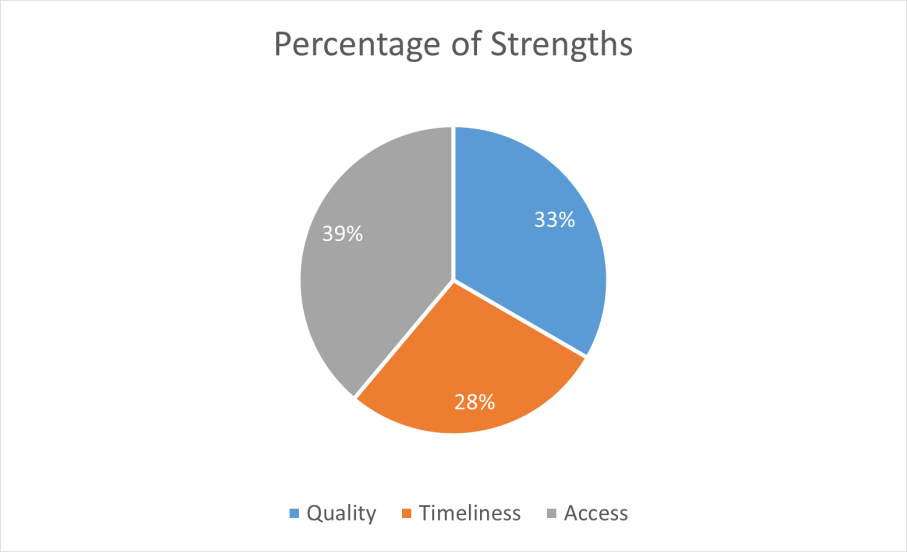
** No data were submitted for the provider category.

Recommendations

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

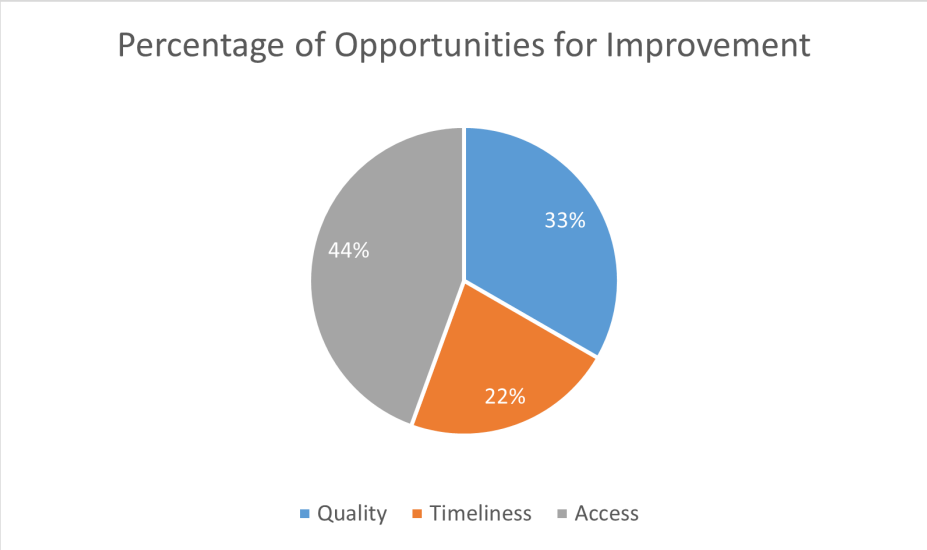
Wasatch Behavioral Health (Wasatch)

Figure 2-37—Percentage of Strengths by Care Domain for Wasatch*



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

Figure 2-38—Percentage of Opportunities for Improvement by Care Domain for Wasatch*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Wasatch submitted its PIP topic: *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ [Youth Outcomes Questionnaire] Outcome Measures*. Wasatch aims to improve behavioral therapy by increasing the administration of the Clinical Support Tool (CST) in conjunction with Y/OQ instruments during outpatient individual psychotherapy. According to the PIP documentation, the appropriate use of CSTs will improve treatment outcomes and decrease the frequency of deterioration for the most at-risk members.

Validation Results and Interventions

Table 2-104 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-104—CY 2022 Performance Improvement Project Validation Results for Wasatch (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Method (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3	0	0
	Outcomes Total	**3/3**	**0/3**	**0/3**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Wasatch progressed to reporting Remeasurement 2 results. Wasatch sustained statistically significant improvement in the performance indicator rate over the baseline for two consecutive remeasurement periods.

Table 2-105 displays data for Wasatch's *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures* PIP.

Table 2-105—PIP—*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*
Wasatch

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Sustained Improvement**
The percentage of Y/OQ signal cases wherein CST was administered during a four-month window surrounding the signal event.	N: 292	6.2%	N: 425	15.1%*	N: 1,265	37.8%*	*Yes*
	D: 4,700		D: 2,821		D: 3,346		

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

The baseline rate for the percentage of Y/OQ signal cases wherein CST was administered within the four-month window (including two calendar months before the signal month, the signal month, and one calendar month after the signal month) was 6.2 percent. For Remeasurement 1, Wasatch documented an 8.9 percentage point increase in the performance indicator rate, indicating a statistically significant ($p < 0.0001$) improvement over the baseline. For Remeasurement 2, Wasatch documented a rate of 37.8 percent, which represents a statistically significant ($p < 0.0001$) improvement of 31.6 percentage points over the baseline.

Wasatch sustained statistically significant improvement in the performance indicator rate over the baseline for two consecutive remeasurement periods.

Barriers

For the *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures* PIP, Wasatch used staff feedback and data analysis to identify the following barriers to achieving desired PIP outcomes:

- Lack of manager awareness of CST use among clinicians.
- Lack of manager accountability for CST use.

Interventions

To address the identified barriers, Wasatch implemented the following interventions:

- Reports on CST usage will be provided monthly to program managers. Reports will contain:
  - The percentage of clinicians who administered CSTs within the last four months, indicated by the Y/OQ instruments.
  - Information on which clinicians are using the CSTs accurately and which clinicians are not.
- Program managers will provide monthly reports to the executive director regarding improvement in the number of CSTs the clinics are collecting.

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

Strengths

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

Opportunities for Improvement

- HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, HSAG recommends that Wasatch:

- Initiate a new PIP topic in consultation with DHHS for next year's validation.
- Build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

- Apply any lessons learned and knowledge gained through this PIP in other QI activities, as deemed appropriate.
- Reach out to HSAG for technical assistance as it determines a new PIP topic for next year's submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-106 presents Wasatch's MY 2021 performance measure results.

Table 2-106—Wasatch MY 2021 *FUH* Results

Indicator	Wasatch Rate	Statewide PMHP Average
Follow-Up Within 7 Days	61.59%	53.92%
Follow-Up Within 30 Days	77.17%	70.68%

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

Strengths

- Wasatch was able to successfully maintain its effective data tracking and reporting process for the *FUH-UT* measure in MY 2021. Front-end edits in its EHR system (Junction) and an audit of 70–80 percent of clinical notes helped to ensure the accuracy and completeness of Wasatch's performance measure data. Additionally, the use of a query to produce the measure indicator rates directly from medical record data prevented risks inherent in manual rate calculation, and staff knowledge of measure inclusion and exclusion criteria during the validation stage ensured that the data reported met measure specifications.
- Despite staffing challenges, Wasatch had a reliable process in place for following members after discharge and continued to monitor the rates at least quarterly for opportunities to improve performance and ensure close coordination of discharge services with the local hospitals.

Opportunities for Improvement

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

Recommendations

HSAG did not identify any opportunities for improvement and as such does not have any recommendations.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-107 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Wasatch's total weighted compliance score was 91 percent. Following the CY 2022 CAP review, Wasatch improved its cumulative weighted score to 96 percent.

Table 2-107—Summary of Scores for the Standards for Wasatch

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	27	27	27	0	0	0	100%
II	Access and Availability	12	12	11	1	0	0	96%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	22	4	0	1	92%
V	Grievance and Appeal System	28	28	25	3	0	0	95%
VI	Provider Selection and Program Integrity	19	19	17	2	0	0	95%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	12	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**140**	**135**	**125**	**10**	**0**	**5**	**96%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Coordination and Continuity of Care
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendation:

- HSAG recommends that Wasatch leadership review applicable policies, procedures, and contract agreements to ensure that performance standards apply to contracted network providers and subcontractors, and that contract agreements include all required provisions.
- HSAG recommends that Wasatch implement procedures to inform members that electronic information is available in alternative formats, including paper form.
- HSAG recommends that Wasatch review the requirements at 42 CFR §438.10 (h) and ensure its provider directory includes all required information for employed and contracted providers.
- During the 2022 grievance record review, HSAG found that some grievance records lacked full compliance. For example, some records did not include evidence of resolution, and some records

did not match Wasatch's related record-keeping. HSAG recommends that Wasatch determine its organizational processes and revise applicable policies and documents to ensure that it completes and resolves all grievances within the required time frames.

- HSAG recommends that Wasatch review pertinent member- and provider-facing documents, as well as internal policies and procedures, to ensure accurate and consistent processes and time frames for processing grievances and appeals.
- During the CY 2022 credentialing record review, HSAG found that Wasatch did not provide evidence that it verified providers' licenses prior to hire. HSAG recommends that Wasatch implement processes to ensure documentation of license verification.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-108 displays the number and percentage of provider categories wherein Wasatch met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Wasatch in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-108—Compliance With Time/Distance Standards by Urbanicity—Wasatch*

		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Wasatch	12	1	8.3%	

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

Opportunities for Improvement

Table 2-109 displays the provider domains and categories wherein Wasatch failed to meet the time/distance standards.

Table 2-109—Provider Categories That Failed to Meet Time/Distance Standards—Wasatch*

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

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

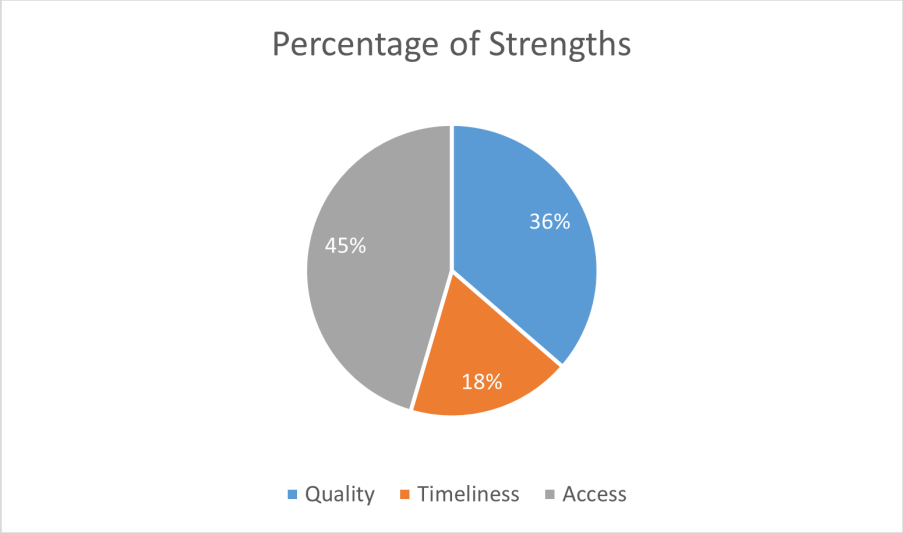
** No data were submitted for the provider category.

Recommendations

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

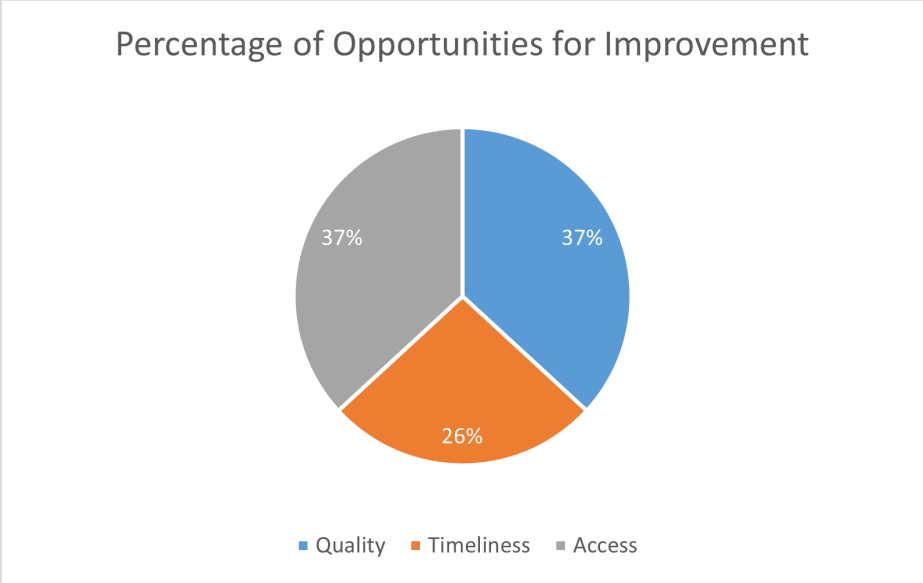
Weber Human Services (Weber)

Figure 2-39—Percentage of Strengths by Care Domain for Weber*



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

Figure 2-40—Percentage of Opportunities for Improvement by Care Domain for Weber*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Weber submitted its clinical PIP topic: *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder (OUD)*. Weber aims to improve processes and outcomes of members' behavioral health care by increasing member engagement and retention in OUD treatment.

Validation Results and Interventions

Table 2-110 summarizes the validation findings for each stage validated for CY 2022. Overall, 68 percent of all applicable evaluation elements received a score of *Met*.

Table 2-110—CY 2022 Performance Improvement Project Validation Results for Weber (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	2	0	0
	6. Review the Data Collection Procedures	2	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	2	1	0
	8. Assess the Improvement Strategies	2	3	1
	Implementation Total	**4/9**	**4/9**	**1/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	1	1	0
	Outcomes Total	**1/2**	**1/2**	**0/2**
Percentage Score of Applicable Evaluation Elements *Met*		**68%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**78%**		
Validation Status		***Partially Met***		

Indicator Outcomes

For this year's validation, Weber progressed to reporting Remeasurement 2 results. During Remeasurement 1, Weber had achieved statistically significant improvement over the baseline for the Performance Indicator 1 rate; however, there was a decline in the rate for Performance Indicator 2. During Remeasurement 2, none of the performance indicators demonstrated a statistically significant improvement over the baseline. Additionally, Weber did not achieve significant clinical or programmatic improvement.

Table 2-111 displays data for Weber's *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder (OUD)* PIP.

Table 2-111—PIP—Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder Weber

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Sustained Improvement**
1. The percentage of members diagnosed with opioid use disorder, who received at least 6 case management or peer support services per year.	N: 33	33.3%	N: 49	56.3%*	N: 32	42.1%	*Not Assessed*
	D: 99		D: 87		D: 76		
2. The percentage of members diagnosed with opioid use disorder that were discharged from treatment and who successfully completed the treatment.	N: 4	21.1%	N: 1	3.7%	N: 5	21.7%	*Not Assessed*
	D: 19		D: 27		D: 23		

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

The baseline rate for the percentage of members who received at least six case management or peer support services per year was 33.3 percent. For Remeasurement 2, the Performance Indicator 1 rate was 42.1 percent, which represents a decline from the Remeasurement 1 rate of 56.3 percent; however, it demonstrated a non-statistically significant increase of 8.8 percentage points over the baseline.

The baseline rate for the percentage of members who were discharged and successfully completed the treatment was 21.1 percent. For Remeasurement 2, Weber documented a marginal increase of 0.6 percentage points in the Performance Indicator 2 rate over the baseline.

Barriers

For the *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder* PIP, Weber used data analysis to identify the following barriers to achieving desired PIP outcomes:

- Case managers are not educated well on performance indicators and use of correct service codes. The COVID-19 pandemic has also been a barrier to outreach.
- Members in the MAT clinic were not getting timely access to case management/peer support services.
- Clinicians and case managers are struggling with engagement strategies during the COVID-19 pandemic because members are not returning to treatment following intake.
- Reduction in case managers and peer support employees and clinicians during 2021 (staff turnover) limiting potential for case management/peer support interventions.

Interventions

To address the identified barriers, Weber implemented the following interventions:

- Provided service code training, presented on the PIP Aim statement, and ways to increase outreach during the COVID-19 pandemic.
- Case manager/peer support placed in the MAT clinic for eight hours a week to readily assess member needs and provide assistance.
- Provided training to clinicians and case managers via Zoom on how to better engage members in treatment during the COVID-19 pandemic.
- Trained clinical staff and continued training and monitoring of case managers and peer support employees

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

Strengths

- Weber designed a scientifically sound project that was supported by using key research principles.

Opportunities for Improvement

- The PIP received an overall *Partially Met* validation status, with a *Met* score for 78 percent of critical evaluation elements and 68 percent of overall evaluation elements across all steps completed and validated.
- There were multiple opportunities of improvement in the documentation and assessment of improvement strategies.
- Additionally, during Remeasurement 2, Weber did not achieve significant improvement in outcomes. None of the performance indicators had a statistically significant improvement over the baseline.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Weber:

- Document the barriers and interventions in the Barriers/Interventions table. Each intervention should be logically linked to the documented barrier.
- Develop a data-driven evaluation methodology to determine the effectiveness of each implemented intervention and report evaluation results. In addition to the overall data, Weber should also collect and report intervention-specific data. For example, for the intervention regarding case manager/peer support employees placed in the MAT clinic for eight hours a week, Weber should provide data regarding how many members were assisted with peer support services in the MAT clinic. Intervention-specific evaluation results should guide next steps for each individual intervention.
- Address the *Partially Met* and *Not Met* comments in the PIP Validation Tool in the next annual submission.
- Continually work on the PIP throughout the year.
- 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. In addition to data analysis, Weber should consider using QI science-based tools, such as process mapping and FMEA, and seeking member input for causal/barrier analysis.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

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

Performance Measure Outcomes

Table 2-112 presents Weber's MY 2021 performance measure results.

Table 2-112—Weber MY 2021 *FUH* Results

Indicator	Weber Rate	Statewide PMHP Average
Follow-Up Within 7 Days	**47.22%**	53.92%
Follow-Up Within 30 Days	**65.48%**	70.68%

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

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

Strengths

Weber employed creative strategies and staff incentives to ensure it was fully staffed and able to meet the health care needs of the population it served. Many Weber staff members volunteered to receive additional training and provided support and help where needed.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during this year's PMV activity.

Recommendations

HSAG recommends that Weber perform an analysis of noncompliant cases to identify barriers that members experienced which prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-113 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Weber's total weighted compliance score was 93 percent. Following the CY 2022 CAP review, Weber improved its cumulative weighted score to 98 percent.

Table 2-113—Summary of Scores for the Standards for Weber

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	27	27	26	1	0	0	98%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	7	7	7	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	26	25	1	0	1	98%
V	Grievance and Appeal System	28	28	27	0	1	0	96%
VI	Provider Selection and Program Integrity	19	19	19	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	12	12	11	1	0	0	96%
IX	Enrollment and Disenrollment	4	4	4	0	0	0	100%
	Totals	**140**	**135**	**131**	**3**	**1**	**5**	**98%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Access and Availability
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- QAPIP, Practice Guidelines, and Health Information Systems

Recommendations

HSAG offers the following recommendations:

- During the CY 2022 record review, HSAG found that some denial records and grievance records lacked full compliance. For example, Weber did not always relay timely denial decisions to the member or resolve written grievances in writing. HSAG recommends that Weber leadership review requirements related to notifying members of denial decisions and resolving grievances and implement mechanisms to ensure requirements are followed.
- HSAG recommends that Weber review pertinent member- and provider-facing documents to ensure the accurate time frames for processing grievances and appeals.
- HSAG recommends that Weber leadership review federal and State requirements related to QAPIP in order to develop and implement an ongoing comprehensive QAPIP.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-114 displays the number and percentage of provider categories wherein Weber met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-114—Compliance With Time/Distance Standards by Urbanicity—Weber*

		Rural		Urban		
PMHP	Number of Provider Categories	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Count of Categories Within Time Distance Standard	Percent of Categories Within Time Distance Standard (%)	Impact: Quality, Access, and/or Timeliness
Weber	12	9	75.0%	9	75.0%	

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

Opportunities for Improvement

Table 2-115 displays the provider domains and categories wherein Weber failed to meet the time/distance standards.

Table 2-115—Provider Categories That Failed to Meet Time/Distance Standards—Weber*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health—Facilities	Behavioral Health Hospital**	
Behavioral Health—Providers	Behavioral Medical—Adult**; Behavioral Therapist—Pediatric**	

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

** No data were submitted for the provider category.

Recommendations

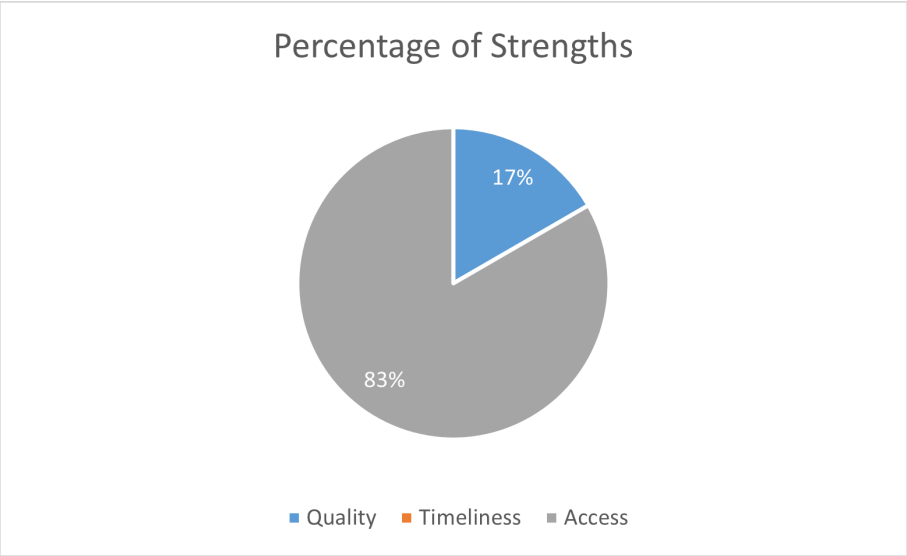
HSAG offers the following recommendations:

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

Medicaid PAHPs Providing Dental Services

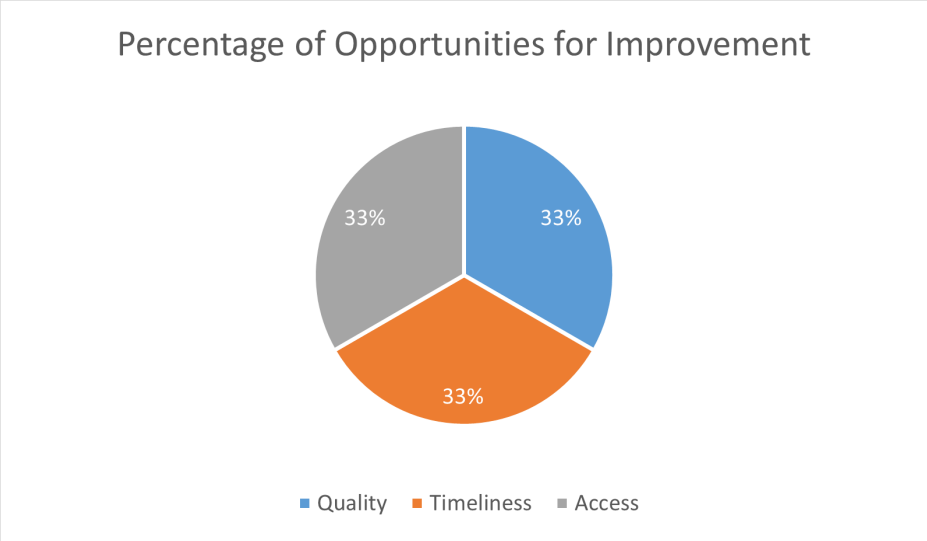
Premier Access

Figure 2-41—Percentage of Strengths by Care Domain for Premier Access*



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

Figure 2-42—Percentage of Opportunities for Improvement by Care Domain for Premier Access*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Premier Access submitted its PIP topic: *School Based Care for Medicaid Members.* The goal of this PIP is to increase dental care delivery in a school-based setting to improve dental care utilization.

Validation Results and Interventions

Table 2-116 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-116—CY 2022 Performance Improvement Project Validation Results for Premier Access (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicator(s)	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total			
	Percentage Score of Applicable Evaluation Elements *Met*	**100%**		

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Premier Access reported baseline results. Premier Access will be assessed for achievement of outcomes in the next annual validation. Table 2-117 displays data for Premier Access' *School Based Care for Medicaid Members* PIP.

Table 2-117—PIP—*School Based Care for Medicaid Members*
Premier Access

Performance Indicator Results					
Performance Indicators	**Baseline (08/01/2021–05/31/2022)**		**Remeasurement 1 (08/01/2021–05/31/2022)**		**Sustained Improvement**
Percentage of Premier Access Medicaid members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 184 D: 7,935	2.3%			*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for the percentage of eligible Medicaid members 5–10 years of age who received dental care in a school was 2.3 percent.

Barriers

For the *School Based Care for Medicaid Members* PIP, Premier Access used feedback from the dental provider groups to identify the following barriers:

- Members do not have signed consent forms on the day that the provider is in the school.
- Members do not receive consent text messages.

Interventions

To address the identified barriers, Premier Access implemented the following interventions:

- Send text messages with the link to consent forms to parents.
- Mail consent forms to members' home addresses.

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

Strengths

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

Opportunities for Improvement

- HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no opportunities for improvement, as the PIP continues, HSAG recommends that Premier Access:

- Continually work on the PIP throughout the year.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Consider using QI science-based tools, such as process mapping and FMEA, to identify barriers toward improvement.
- Have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed based on the evaluation data. For example, the dental plan must track how many members who were sent the text messages actually received school-based care.
- Ensure that it has accurate member contact information. Success of member outreach through mailers and text interventions is dependent on the accuracy of member contact information.
- Address the *Validation Feedback* comments associated with any *Met* scores and the *Partially Met* scores in the next annual submission.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the health plan.

- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Premier Access' HEDIS compliance auditor found Premier Access' IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Premier Access contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier Access' FAR revealed that Premier Access' HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-118 shows Premier Access' HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-118—Premier HEDIS MY 2021 Results

HEDIS Measure	Premier Access MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	44.49%	36.00%
4–6 Years	64.08%	55.01%
7–10 Years	66.84%	57.69%
11–14 Years	61.75%	53.18%
15–18 Years	52.08%	46.49%
19–20 Years	35.67%	31.09%
Total	58.89%	47.26%

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

Strengths

Premier Access exceeded the MY 2021 NCQA Quality Compass average for all of the performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*

- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—19–20 Years*
- *Annual Dental Visit—Total*

Opportunities for Improvement

Premier Access did not fall below the MY 2021 NCQA Quality Compass average for any of the performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and as such does not have any recommendations.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-119 presents the number of requirements within each of the nine standards for Premier's Medicaid dental PAHP; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Premier Access' total weighted compliance score was 84 percent. Following the CY 2022 CAP review, Premier Access improved its cumulative weighted score to 91 percent.

Table 2-119—Summary of Scores for the Standards for Premier Access Medicaid

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	22	22	20	2	0	0	95%
II	Access and Availability	12	12	11	1	0	0	96%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
IV	Member Rights and Information (Includes Confidentiality)	27	27	24	2	1	0	93%
V	Grievance and Appeal System	28	28	22	6	0	0	89%
VI	Provider Selection and Program Integrity	20	20	17	1	2	0	88%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	10	6	0	0	81%
IX	Enrollment and Disenrollment	7	7	7	0	0	0	100%
	Totals	**145**	**141**	**120**	**18**	**3**	**4**	**91%**

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

Strengths

- Coordination and Continuity of Care
- Enrollment and Disenrollment

Opportunities for Improvement

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Recommendations

- HSAG recommends that Premier Access review pertinent member- and provider-facing documents to ensure the accurate and consistent use of definitions, including "grievance" and what constitutes "medically necessary covered services," and time frames for processing grievances and appeals.
- During the CY 2022 record review, HSAG found that some Premier Access denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Premier Access UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- HSAG recommends that Premier Access leadership review policies related to access; its grievance and appeal system; and detection of FWA to ensure alignment with federal requirements and those required by State contract.
- HSAG recommends that Premier Access develop and implement procedures to ensure that members receive all required information and can readily access its website and all electronically available member information.
- During the CY 2022 record review, HSAG found that Premier Access did not document all grievances received. HSAG recommends that Premier Access leadership review its system capabilities and internal procedures to ensure that Premier Access identifies and reports all grievances.
- HSAG recommends that Premier Access leadership review federal and State requirements related to QAPIP to identify missing required information and implement appropriate corrections.

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

Strengths

Table 2-120 displays the number and percentage of provider categories by provider domain wherein Premier Access met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Premier Access in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-120—Compliance With Time/Distance Standards by Provider Domain—Premier Access

		Premier Access		
Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
General Dental	2	2	100.0%	

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

Opportunities for Improvement

Table 2-121 displays the provider domains and categories wherein Premier Access failed to meet the time/distance standards.

Table 2-121—Provider Categories That Failed to Meet Time/Distance Standards—Premier Access*

Provider Domain	Provider Category
NA	NA

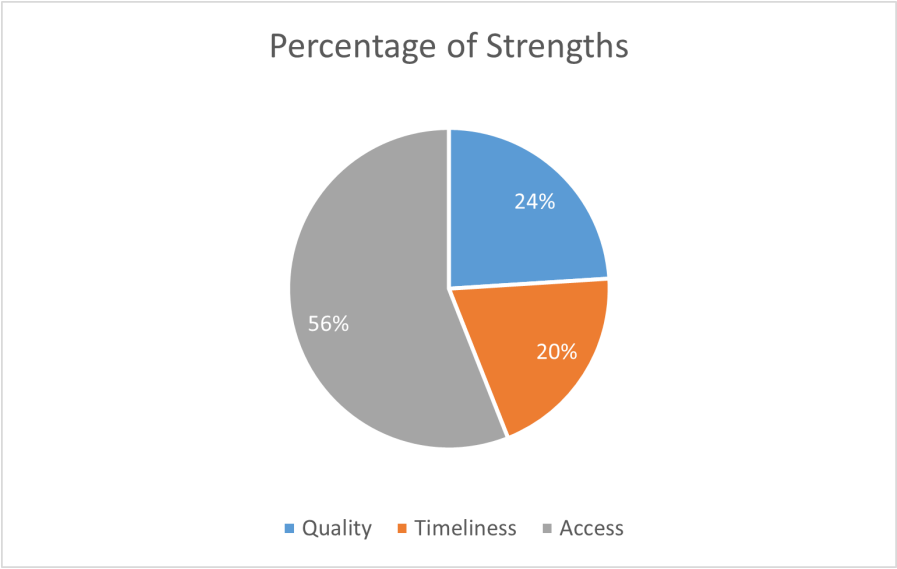
*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

HSAG does not have any network adequacy recommendations for Premier Access.

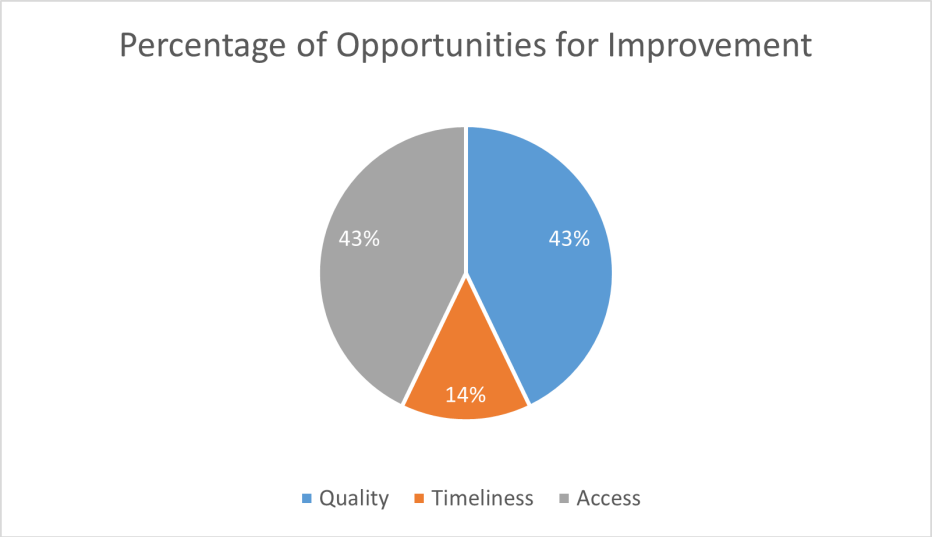
MCNA

Figure 2-43—Percentage of Strengths by Care Domain for MCNA*



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

Figure 2-44—Percentage of Opportunities for Improvement by Care Domain for MCNA*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, MCNA submitted its PIP topic: *Annual Dental Visits.* The goal of this PIP is to improve processes and outcomes of members' oral health by improving detection of dental care needs.

Validation Results and Interventions

Table 2-122 summarizes the validation findings for the PIP validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-122—CY 2022 Performance Improvement Project Validation Results for MCNA (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**8/8**	**0/8**	**0/8**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	3	0	0
	Outcomes Total	**3/3**	**0/3**	**0/3**
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

MCNA progressed to reporting Remeasurement 2 data for this validation cycle. There was a decline in rates for both performance indicators during Remeasurement 2; however, MCNA documented significant clinical improvement using the care gap alerts and text message interventions.

Table 2-123 displays the data for MCNA's PIP.

Table 2-123—PIP—*Annual Dental Visits*
MCNA

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2019–12/31/2019)**		**Remeasurement 1 (01/01/2020–12/31/2020)**		**Remeasurement 2 (01/01/2021–12/31/2021)**		**Sustained Improvement**
1. The percentage of members ages 1–20 years who had at least one dental visit during the measurement year.	N: 30,020	52.5%	N: 27,323	49.7%	N: 32,036	49.3%	*Not Assessed*
	D: 57,218		D: 55,013		D: 65,039		
2. The percentage of members ages 21 years and older who had at least one dental visit during the measurement year.	N: 5,756	27.4%	N: 4,882	23.4%	N: 1,062	20.7%	*Not Assessed*
	D: 20,980		D: 20,831		D: 5,130		

N–Numerator; D–Denominator

The baseline rate for members 1 to 20 years of age who had at least one dental visit during the measurement year was 52.5 percent. For Remeasurement 1, the Performance Indicator 1 rate decreased by 2.8 percentage points to 49.7 percent, and for Remeasurement 2, the Performance Indicator 1 rate decreased to 49.3 percent.

The baseline rate for members ages 21 years and older who accessed a dentist at least once during the measurement year was 27.4 percent. For Remeasurement 1, the Performance Indicator 2 rate decreased by 4.0 percentage points to 23.4 percent, and for Remeasurement 2, the Performance Indicator 2 rate decreased to 20.7 percent.

Even though MCNA documented a decline in its performance indicator remeasurement rates, the dental plan documented data-driven, significant clinical improvement in annual dental visits using the care gap alerts and text message interventions.

Barriers

For the *Annual Dental Visits* PIP, MCNA used a fishbone diagram and data analysis to identify the following barriers to achieving desired PIP outcomes:

- The members' lack of knowledge of coverage benefits and of the importance and frequency of routine dental checkups.
- Providers have a limited or non-robust appointment reminder system.

Interventions

To address the identified barriers, MCNA implemented/will implement the following interventions:

- MCNA member service representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls, which indicates the member is overdue for a preventive dental visit. The MSR offers to locate a provider if the member does not already have one and performs a three-way call, if necessary, with the provider office to schedule an appointment.
- Send text messages once a month to members who have no claims history on file. Members will continue to receive a text message until an encounter is received.

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

Strengths

- The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- MCNA indicated that it achieved significant clinical improvement in annual dental visits using the care gap alerts and text message interventions.

Opportunities for Improvement

- MCNA documented a decline in its performance indicators rates for a second consecutive year.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that MCNA:

- Continue to evaluate the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

- 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.
- Consider expanding the successful interventions to a larger population, given that the number of members impacted by the care gap alerts and text message interventions was small as compared to the total eligible population. By doing so, MCNA could impact the overall indicator rate.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that MCNA's HEDIS compliance auditor found MCNA's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. MCNA contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of MCNA's FAR revealed that MCNA's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-124 shows MCNA's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-124—MCNA HEDIS MY 2021 Results

HEDIS Measure	MCNA MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	39.24%	36.00%
4–6 Years	59.60%	55.01%
7–10 Years	63.54%	57.69%
11–14 Years	58.29%	53.18%
15–18 Years	50.44%	46.49%
19–20 Years	31.66%	31.09%
Total	55.04%	47.26%

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

Strengths

MCNA exceeded the MY 2021 NCQA Quality Compass average for all of the performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*
- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—19–20 Years*
- *Annual Dental Visit—Total*

Opportunities for Improvement

MCNA did not fall below the 2021 NCQA Quality Compass average for any of the performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and as such does not have any recommendations.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

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

Table 2-125 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, MCNA's total weighted compliance score was 96 percent. Following the CY 2022 CAP review, MCNA improved its cumulative weighted score to 99 percent.

Table 2-125—Summary of Scores for the Standards for MCNA

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	22	22	22	0	0	0	100%
II	Access and Availability	12	12	12	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	27	26	1	0	0	98%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	7	7	7	0	0	0	100%
	Totals	**145**	**145**	**143**	**2**	**0**	**0**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Grievance and Appeal System
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Member Rights and Information (Includes Confidentiality)
- Provider Selection and Program Integrity

Recommendations

HSAG offers the following recommendations:

- HSAG recommends that MCNA review pertinent member- and provider-facing documents to ensure accurate grievance and appeal process time frames.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-126 displays the number and percentage of provider categories by provider domain wherein MCNA met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and MCNA in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-126—Compliance With Time/Distance Standards by Provider Domain—MCNA

		MCNA		
Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
General Dental	2	1	50.0%	

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

Opportunities for Improvement

Table 2-127 displays the provider domains and categories wherein MCNA failed to meet the time/distance standards.

Table 2-127—Provider Categories That Failed to Meet Time/Distance Standards—MCNA*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
General Dental	Pediatric Dentists	

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

Recommendations

HSAG offers the following recommendations:

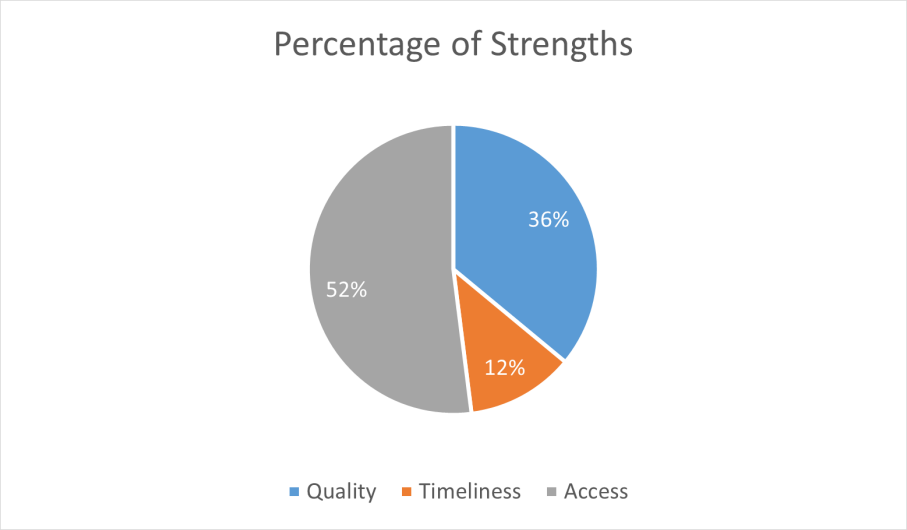
- For the provider categories for which MCNA did not meet the time/distance standard, HSAG recommends that MCNA assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard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

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

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

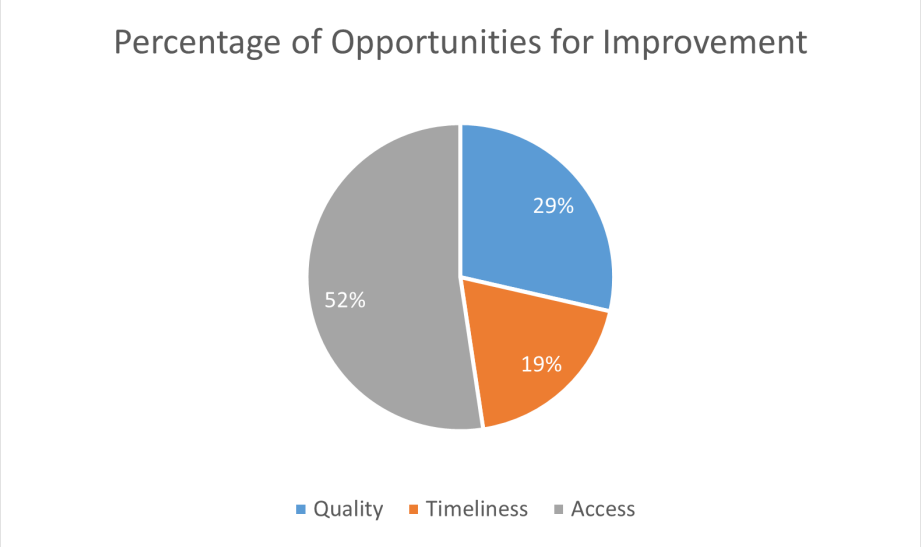
Molina Healthcare of Utah CHIP (Molina CHIP)

Figure 2-45—Percentage of Strengths by Care Domain for Molina CHIP*



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

Figure 2-46—Percentage of Opportunities for Improvement by Care Domain for Molina CHIP*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Molina CHIP submitted its clinical PIP topic: *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*. The goal of this PIP is to increase the body mass index (BMI) screening rate among its CHIP members.

Validation Results and Interventions

Table 2-128 summarizes the validation findings for each stage validated for CY 2022. Overall, 96 percent of all applicable evaluation elements received a score of *Met*.

Table 2-128—CY 2022 Performance Improvement Project's Validation Results for Molina CHIP (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review Sampling Methods (if sampling was used)	7	0	0
	5. Review the Selected Performance Indicators	1	0	0
	6. Review the Data Collection Procedures	4	0	0
	Design Total	**16/16**	**0/16**	**0/16**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	2	0	1

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	Outcomes Total	**2/3**	**0/3**	**1/3**
	Percentage Score of Applicable Evaluation Elements *Met*	**96%**		
	Percentage Score of Applicable Critical Evaluation Elements *Met*	**100%**		
	Validation Status	***Met***		

Indicator Outcomes

For this year's validation, Molina CHIP progressed to reporting Remeasurement 3 results. Molina CHIP indicated achievement of significant programmatic improvement in the six high-volume pediatric groups participating in the interventions. However, Molina CHIP was unable to sustain the statistically significant improvement in the performance indicator rate that was achieved during Remeasurement 1.

Table 2-129 displays data for Molina CHIP's *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening* PIP.

Table 2-129—PIP—Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening Molina CHIP

Performance Indicator Results									
Performance Indicator	**Baseline (01/01/2018–12/31/2018)**		**Remeasurement 1 (01/01/2019–12/31/2019)**		**Remeasurement 2 (01/01/2020–12/31/2020)**		**Remeasurement 3 (01/01/2021–12/31/2021)**		**Sustained Improvement**
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.	N: 265 D: 411	64.5%	N: 335 D: 411	81.5%*	N: 275 D: 411	66.9%	N: 246 D: 411	59.9%	*No*

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

For the baseline measurement period, Molina CHIP reported that 64.5 percent of children 3 to 17 years of age had evidence of BMI percentile documentation during the measurement year. For Remeasurement 1, Molina CHIP demonstrated a statistically significant ($p < 0.0001$) improvement of 17.0 percentage points over the baseline. For Remeasurement 2, the rate decreased to 66.9 percent; however, it was 2.4 percentage points above the baseline. For Remeasurement 3, the rate was 4.6 percentage points below the baseline at 59.9 percent.

Molina CHIP was unable to sustain statistically significant improvement in the performance indicator rate that was achieved during Remeasurement 1.

Barriers

For the *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening* PIP, Molina CHIP used a fishbone diagram and staff feedback to identify the following barriers to achieving desired PIP outcomes:

- Members are not obtaining a well-child exam. Possible reasons for noncompliance include:
  - No vaccinations necessary in older children.
  - Not required for school or other activities.
  - Parent availability.
  - Only seek medical care when ill.
  - No established PCP.
- Providers are not capturing or reporting BMI accurately.
- Providers' lack of understanding of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* HEDIS measure and requirements.
- Billing codes from providers do not include the correct codes for numerator compliance with the *WCC* measure.

Interventions

To address these identified barriers, Molina CHIP implemented the following interventions:

- Conducted targeted outreach to six high-volume pediatric groups to disseminate monthly reports of children in need of well-child visits.
- Disseminate a missing services list to value-based contracting (VBC) groups and conduct monthly discussions with providers for support.
- Research billing code issue reasons. Collaborate with various health plan staff members to develop mitigation strategies. Educate providers regarding coding issues and resolutions.

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

Strengths

- Molina CHIP demonstrated statistically significant improvement in the performance indicator rate over the baseline during Remeasurement 1.
- Molina CHIP indicated achievement of significant programmatic improvement in the six high-volume pediatric groups participating in the interventions.

Opportunities for Improvement

- The performance indicator rate decreased during Remeasurement 2 and Remeasurement 3.

Recommendations

Related to the identified opportunities for improvement and as the PIP continues, HSAG recommends that Molina CHIP:

- Continue to evaluate the performance of each intervention and its impact on the performance indicator. Intervention-specific evaluation results should guide next steps for each individual intervention.
- Continually work on the PIP throughout the year.
- 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. To address the decrease in the overall performance indicator rates, Molina CHIP should consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. Molina CHIP should also consider seeking member input during the identification of barriers.
- Expand successful interventions to additional provider groups to realize improvement in the overall performance indicator rate.
- Apply any lessons learned and knowledge gained through the QI process as the PIP progresses.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Molina CHIP's HEDIS compliance auditor found Molina CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Molina CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Molina CHIP's FAR revealed that Molina CHIP's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-130 shows Molina CHIP's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table 2-130—Molina CHIP HEDIS MY 2021 Results

HEDIS Measure	Molina CHIP 2020 Rate	MY 2021 NCQA Quality Compass Average
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	96.44%	93.22%
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)	67.61%	63.03%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	83.92%	77.68%
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)	**59.85%**	76.11%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	69.57%	54.10%
Child and Adolescent Well-Care Visits		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**53.38%**	57.13%

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

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

Strengths

Molina CHIP exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for URI*
- *Childhood Immunization Status—Combination 3*

- *Immunizations for Adolescents—Combination 1*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

Opportunities for Improvement

Molina CHIP fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Child and Adolescent Well-Care Visits—3–11 Years*

Recommendations

Molina CHIP fell below the MY 2021 NCQA Quality Compass average for two of six performance indicators (33.3 percent), indicating some areas of opportunity. Improvement efforts could be focused on the following:

- Consider a segmentation analysis in which the eligible population for a measure is divided into subsets to identify the biggest opportunity for improving performance. This type of analysis is highly applicable to demographics (e.g., age/race/gender stratifications) but can be applied to provider types or other measure variables. Additional data elements can be included for another layer of analysis (e.g., network adequacy data, inpatient/emergency room/pharmacy utilization data) to identify potential access issues or understand behavior patterns of noncompliant members that will help to focus QI efforts.
- Use results from data analysis, survey responses, outreach campaigns, or operations data (e.g., appeals and grievances, claims reports) to determine the type of intervention with the greatest potential for impact for each measure. For example:
  - Member—are members showing up for care, are they answering the phone, are they working with providers/care managers on scheduling services, are they following instructions and filling prescriptions?
  - Provider—are the providers following standards of care or clinical guidelines, are they providing complete claim data, are they addressing missing services, or partnering with the health plan on initiatives?
  - Health Plan—are the right programs in place (such as care management and education), are the right QI strategies or programs in place, is the plan using the right motivational programs (e.g., incentives) for members and providers, is the health plan collecting and using data to focus efforts and drive performance?

  - Policy—are billing policies aligned with HEDIS measure specifications, are funding policies sufficient for making an impact, are contracting policies aligned with quality goals, is the quality strategy aligned with performance goals?
- Consider a focus on programs that address barriers most experienced by women in the Utah Medicaid population (e.g., mobile or telehealth services or food assistance programs), since most of the Molina CHIP measures falling below the national average rely on women receiving preventive care or coordinating preventive care for their children.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

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

Table 2-131 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review for the CHIP. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Molina CHIP's total weighted compliance score was 96 percent. Following the CY 2022 CAP review, Molina CHIP improved its cumulative weighted score to 98 percent.

Table 2-131—Summary of Scores for the Standards for Molina CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	24	22	2	0	1	96%
II	Access and Availability	14	14	13	1	0	0	96%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	26	2	0	0	96%
V	Grievance and Appeal System	28	28	27	1	0	0	98%
VI	Provider Selection and Program Integrity	20	20	19	1	0	0	98%
VII	Subcontractual Relationships and Delegation	4	4	4	0	0	0	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**151**	**144**	**7**	**0**	**1**	**98%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coordination and Continuity of Care
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity

Recommendations

- During the CY 2022 record review, HSAG found that all Molina CHIP denial records were missing content as required at 42 CFR §438.404(b) (*Content of Notice*). HSAG recommends that Molina CHIP UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment, timely, and include complete information.

- HSAG recommends that Molina CHIP review policies and pertinent member- and provider-facing documents to ensure accurate and consistent time frames related to appeals and State fair hearings.
- HSAG recommends that Molina CHIP implement a process to ensure updated member- and provider-facing documents are made available to members and providers on its website.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-132 displays the number and percentage of provider categories by provider domain wherein Molina CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Molina CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-132—Compliance With Time/Distance Standards by Provider Domain—Molina CHIP

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	2	1	50.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Pediatric	17	2	11.8%	
Additional Physical Health—Providers	5	4	80.0%	
Additional Physical Health—Facilities	6	0	0.0%	
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	2	66.7%	
Behavioral Health—Facilities	3	0	0.0%	

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

Opportunities for Improvement

Table 2-133 displays the provider domains and categories wherein Molina CHIP failed to meet the time/distance standards.

Table 2-133—Provider Categories That Failed to Meet Time/Distance Standards—Molina CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology; Laboratory; Outpatient Dialysis; Outpatient Infusion/Chemotherapy**; Skilled Nursing Facility; Surgical Services (Outpatient or ASC)	🔑
Additional Physical Health—Providers	Audiologist	🔑
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit	🔑
Behavioral Health—Providers	Substance Abuse Counselor	🔑
Hospitals	Hospital—Pediatric	🔑
PCP—Pediatric	PCP—Midlevel—Pediatric	🔑
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric**; Endocrinology, Pediatric; Gastroenterology, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric**; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	🔑

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

**No data were submitted for the provider category.

Recommendations

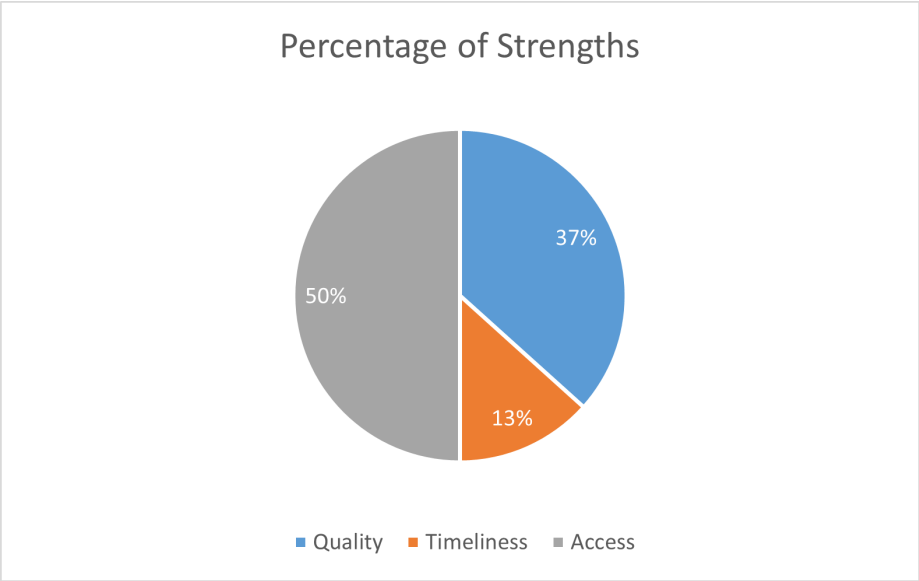
HSAG offers the following recommendations:

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

is due to data concerns, Molina CHIP should ensure all providers are appropriately identified in future data submissions.

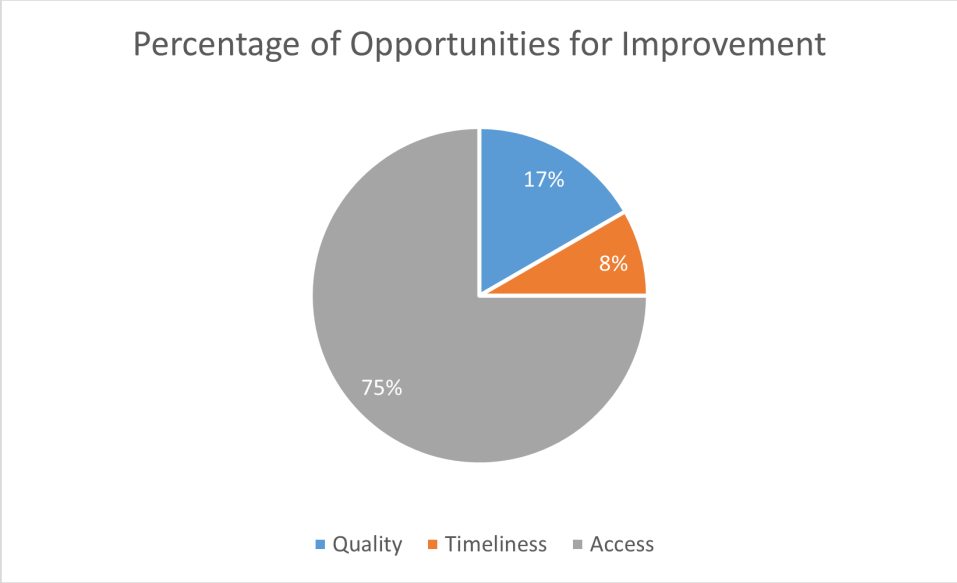
SelectHealth CHIP

Figure 2-47—Percentage of Strengths by Care Domain for SelectHealth CHIP*



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

Figure 2-48—Percentage of Opportunities for Improvement by Care Domain for SelectHealth CHIP*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, SelectHealth CHIP submitted its clinical PIP topic, *Well-Child Visits for CHIP Members*. The goal of this PIP is to improve the percentage of CHIP members who had at least one comprehensive well-care visit during the measurement year.

Validation Results and Interventions

Table 2-134 summarizes the PIP validation findings for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-134—CY 2022 Performance Improvement Project Validation Results for SelectHealth CHIP (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Method (if sampling was made)	Not Applicable		
	5. Review the Selected Performance Indicator(s)	1	0	0
	6. Review the Data Collection Procedures	2	0	0
Design Total		**7/7**	**0/7**	**0/7**
Implementation	7. Review Data Analysis and Interpretation of Results	*Not Assessed*		
	8. Assess the Improvement Strategies			
Implementation Total				
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred			
Outcomes Total				
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		

Stage	Step	Number/Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

CY 2022 is the baseline year for this PIP. SelectHealth CHIP had not progressed to the point of reporting PIP outcomes.

Barriers

SelectHealth CHIP had not progressed to the point of identifying barriers.

Interventions

SelectHealth CHIP had not progressed to the point of implementing PIP interventions.

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

Strengths

- SelectHealth CHIP designed a scientifically sound project that was supported by using key research principles.
- The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.

Opportunities for Improvement

- HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that SelectHealth CHIP:

- Continually work on the PIP throughout the year.

- Document the process and steps used to determine barriers to improvement and attach completed QI tools used for the causal/barrier analysis.
- Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Consider seeking member input, in addition to other stakeholder input, during the identification of barriers in order to better understand member-related barriers to access to care.
- Implement interventions in a timely manner to impact the Remeasurement 1 rates.
- Develop an evaluation methodology to determine the performance of each intervention and its impact on the PIP outcomes. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
- Address any *Validation Feedback* comments associated with *Met* scores in the next annual submission.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that SelectHealth CHIP's HEDIS compliance auditor found SelectHealth CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. SelectHealth CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

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

- The auditor commended SelectHealth CHIP again for reporting nearly all ECDS measures for some submissions and suggested that SelectHealth CHIP continue to explore possible source systems of record it may access and use for future continuation and expansion of ECDS reporting.
- Several of SelectHealth CHIP's initiatives, incentives, and forward-thinking updates to processes have resulted in notable increases in rates. For example:
  - For the *WCC* measure, SelectHealth CHIP's increase in education handouts attached to the visit in the EHR enabled verification that anticipatory guidance for nutrition was given to the patient via the education handout.
- The supplemental data impact report included events for measures that were not included in the events list used for PSV selection for nonstandard data sources. These events were immaterial to reporting for the measures that were affected. HSAG recommends that Selectealth CHIP ensure that all measures are included in the events list submitted for PSV for all nonstandard data sources used for future HEDIS reporting.
- During review of Roadmap Section 5: Supplemental Data, multiple discrepancies were noted across numerous data sources. SelectHealth CHIP was able to successfully address these discrepancies in

every Section 5 where they occurred. HSAG recommends that Selectealth CHIP develop a process to reconcile all questions in Roadmap Section 5 against the designed supplemental data reporting strategy.

Performance Measure Outcomes

Table 2-135 shows SelectHealth CHIP's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table 2-135—SelectHealth CHIP HEDIS MY 2021 Results

HEDIS Measure	SelectHealth CHIP MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Appropriate Treatment for URI		
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	95.39%	93.22%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	73.83%	63.03%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	90.11%	77.68%
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)	88.52%	76.11%
Well-Child Visits in the First 30 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	74.70%	54.10%
Child and Adolescent Well-Care Visits*		
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	61.11%	57.13%

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

SelectHealth CHIP—Assessment With Respect to Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth CHIP exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- Appropriate Treatment for URI
- Childhood Immunization Status—Combination 3
- Immunizations for Adolescents—Combination 1
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total
- Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months
- Child and Adolescent Well-Care Visits—3–11 Years

Opportunities for Improvement

SelectHealth CHIP did not fall below the MY 2021 NCQA Quality Compass average for any of the performance indicators.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

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

Table 2-136 presents the number of requirements within each of the nine standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review for the CHIP. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, SelectHealth CHIP's total weighted compliance score was 94 percent. Following the CY 2022 CAP review, SelectHealth CHIP improved its cumulative weighted score to 99 percent.

Table 2-136—Summary of Scores for the Standards for SelectHealth CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	25	24	24	0	0	1	100%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
II	Access and Availability	14	14	13	1	0	0	96%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	28	28	26	2	0	0	96%
V	Grievance and Appeal System	28	28	28	0	0	0	100%
VI	Provider Selection and Program Integrity	20	20	20	0	0	0	100%
VII	Subcontractual Relationships and Delegation	4	4	3	1	0	0	88%
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	16	0	0	0	100%
IX	Enrollment and Disenrollment	8	8	8	0	0	0	100%
	Totals	**152**	**151**	**147**	**4**	**0**	**1**	**99%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Coordination and Continuity of Care
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Subcontractual Relationships and Delegation

Recommendations

- HSAG recommends that SelectHealth CHIP implement a process to ensure updated member documents are made available to members on its website.
- HSAG recommends that SelectHealth CHIP review delegated agreements related to administrative services to ensure subcontractor agreement to comply with applicable Medicaid laws, regulations, and contract provisions.

VALIDATION OF NETWORK ADEQUACY

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

Strengths

Table 2-137 displays the number and percentage of provider categories by provider domain wherein SelectHealth CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and SelectHealth CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-137—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CHIP

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	2	1	50.0%	
Prenatal Care and Women's Health Providers	2	2	100.0%	
Specialists—Pediatric	17	0	0.0%	
Additional Physical Health—Providers	5	4	80.0%	
Additional Physical Health—Facilities	6	1	16.7%	

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
Hospitals	2	1	50.0%	
Ancillary—Facilities	1	1	100.0%	
Behavioral Health—Providers	3	1	33.3%	
Behavioral Health—Facilities	3	0	0.0%	

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

Opportunities for Improvement

Table 2-138 displays the provider domains and categories wherein SelectHealth CHIP failed to meet the time/distance standards.

Table 2-138—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Additional Physical Health—Facilities	Diagnostic Radiology**; Laboratory; Outpatient Dialysis; Outpatient Infusion/Chemotherapy; Surgical Services (Outpatient or ASC)	
Additional Physical Health—Providers	Audiologist	
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit**	
Behavioral Health—Providers	Behavioral Medical—Pediatric; Substance Abuse Counselor**	
Hospitals	Hospital—Pediatric	
PCP—Pediatric	PCP—Midlevel—Pediatric	
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric;	

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
	Otolaryngology, Pediatric; Physical Medicine, Pediatric**; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric	

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

** No data were submitted for the provider category.

Recommendations

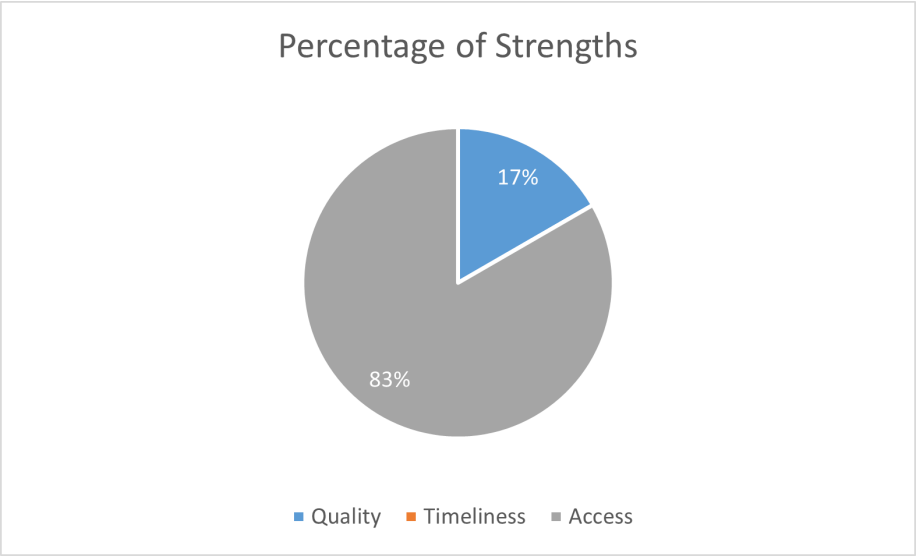
HSAG offers the following recommendations:

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

CHIP PAHP Providing Dental Services

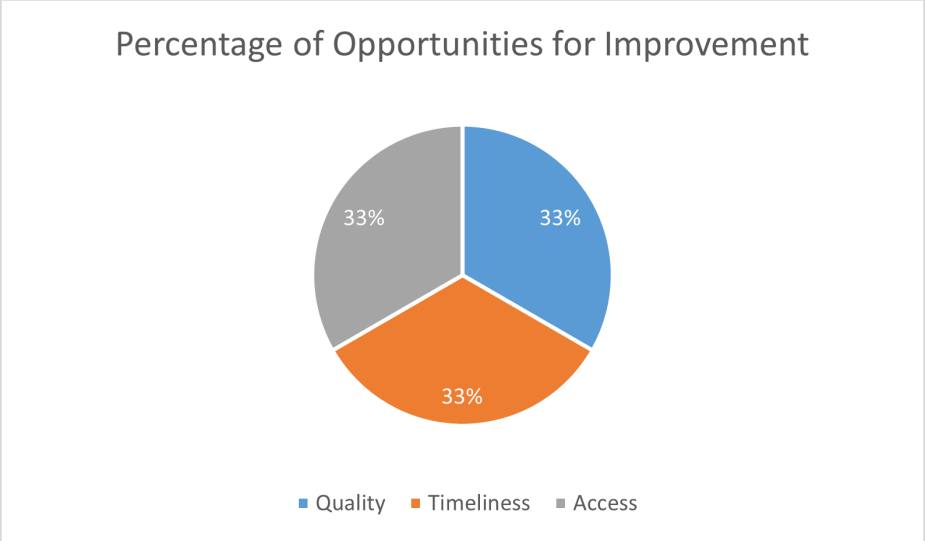
Premier Access—CHIP

Figure 2-49—Percentage of Strengths by Care Domain for Premier Access CHIP*



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

Figure 2-50—Percentage of Opportunities for Improvement by Care Domain for Premier Access CHIP*



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

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

Quality =

Timeliness =

Access =

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2022, Premier Access CHIP submitted its PIP topic: *School Based Care for CHIP Members.* The goal of this PIP is to increase dental care delivery in a school-based setting to improve dental care utilization.

Validation Results and Interventions

Table 2-139 summarizes the validation findings for each stage validated for CY 2022. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-139—CY 2022 Performance Improvement Project Validation Results for Premier Access CHIP (N=1 PIP)

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	1. Review the Selected PIP Topic	2	0	0
	2. Review the PIP Aim Statement	1	0	0
	3. Review the Identified PIP Population	1	0	0
	4. Review the Sampling Methods (if sampling was used)	Not Applicable		
	5. Review the Selected Performance Indicator(s)	2	0	0
	6. Review the Data Collection Procedures	3	0	0
	Design Total	**9/9**	**0/9**	**0/9**
Implementation	7. Review Data Analysis and Interpretation of Results	3	0	0
	8. Assess the Improvement Strategies	6	0	0
	Implementation Total	**9/9**	**0/9**	**0/9**
Outcomes	9. Assess the Likelihood that Significant and Sustained Improvement Occurred	*Not Assessed*		
	Outcomes Total			
Percentage Score of Applicable Evaluation Elements *Met*		**100%**		

Stage	Step	Number/Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100%**		
Validation Status		***Met***		

Indicator Outcomes

For this year's validation, Premier Access CHIP reported baseline results. Premier Access CHIP will be assessed for achievement of outcomes in the next annual validation. Table 2-140 displays data for Premier Access CHIP's *School Based Care for CHIP Members* PIP.

Table 2-140—PIP—*School Based Care for CHIP Members*
Premier Access CHIP

Performance Indicator Results					
Performance Indicators	**Baseline (08/01/2021–05/31/2022)**		**Remeasurement 1 (08/01/2021–05/31/2022)**		**Sustained Improvement**
Percentage of Premier Access CHIP members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 13 D: 681	1.9%			*Not Assessed*

N–Numerator; D–Denominator

The baseline rate for the percentage of eligible CHIP members 5–10 years of age who received dental care in a school was 1.9 percent.

Barriers

For the *School Based Care for CHIP Members* PIP, Premier Access CHIP used feedback from the dental provider groups to identify the following barriers:

- Members do not have signed consent forms on the day that the provider is in the school.
- Members do not receive consent text messages.

Interventions

To address the identified barriers, Premier Access CHIP implemented the following intervention:

- Send text messages with the link to consent forms to parents.
- Mail consent forms to members' home addresses.

Premier Access CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

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

Opportunities for Improvement

- HSAG identified no opportunities for improvement.

Recommendations

Although HSAG identified no specific opportunities for improvement, as the PIP continues, HSAG recommends that Premier Access CHIP:

- Continually work on the PIP throughout the year.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Consider using QI science-based tools, such as process mapping and FMEA, to identify barriers toward improvement.
- Have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed based on the evaluation data. For example, the dental plan must track how many members who were sent the text messages actually received school-based care.
- Ensure that it has accurate member contact information. Success of member outreach through mailers and text interventions is dependent on the accuracy of member contact information.
- Address the *Validation Feedback* comments associated with any *Met* scores and the *Partially Met* scores in the next annual submission.
- Apply any lessons learned and knowledge gained through this PIP to other QI processes within the health plan.

- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS MY 2021 showed that Premier Access CHIP's HEDIS compliance auditor found Premier Access CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2021. Premier Access CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier Access CHIP's FAR revealed that Premier Access CHIP's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-141 shows Premier Access CHIP's HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates for the *Annual Dental Visit* measure. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP measure rates to these averages should be interpreted with caution.

Table 2-141—Premier Access CHIP HEDIS MY 2021 Results

HEDIS Measure	Premier CHIP MY 2021 Rate	MY 2021 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	60.77%	36.00%
4–6 Years	76.24%	55.01%
7–10 Years	81.94%	57.69%
11–14 Years	78.67%	53.18%
15–18 Years	66.30%	46.49%
19–20 Years	64.29%	31.09%
Total	75.29%	47.26%

Premier Access CHIP—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Premier Access CHIP exceeded the MY 2021 NCQA Quality Compass average for all of the performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*
- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—19–20 Years*
- *Annual Dental Visit—Total*

Opportunities for Improvement

Premier CHIP did not fall below the MY 2021 NCQA Quality Compass average for any of the performance indicators.

ASSESSMENT OF COMPLIANCE WITH CHIP MANAGED CARE REGULATIONS

Premier Access CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

Table 2-142 presents the number of requirements within each of the nine standards for Premier's CHIP dental PAHP; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review. Standards that are shaded indicate that full compliance was met during the review conducted in CY 2021; therefore, HSAG did not conduct a further review of these standards in CY 2022. In CY 2021, Premier Access CHIP's total weighted compliance score was 88 percent. Following the CY 2022 CAP review, Premier Access CHIP improved its cumulative weighted score to 91 percent.

Table 2-142—Summary of Scores for the Standards for Premier Access CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
I	Coverage and Authorization of Services	22	22	20	2	0	0	95%
II	Access and Availability	12	12	11	1	0	0	96%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Member Rights and Information (Includes Confidentiality)	27	27	24	2	1	0	93%

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Not Applicable	Weighted Score*
V	Grievance and Appeal System	28	28	21	7	0	0	88%
VI	Provider Selection and Program Integrity	20	20	17	1	2	0	88%
VII	Subcontractual Relationships and Delegation	4	0	0	0	0	4	NA
VIII	QAPIP, Practice Guidelines, and Health Information Systems	16	16	10	6	0	0	81%
IX	Enrollment and Disenrollment	7	7	7	0	0	0	100%
	Totals	**145**	**141**	**119**	**19**	**3**	**4**	**91%**

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

Strengths

HSAG identified strengths within the following standard areas:

- Coordination and Continuity of Care
- Enrollment and Disenrollment

Opportunities for Improvement

HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information (Includes Confidentiality)
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Recommendations

- HSAG recommends that Premier Access CHIP review pertinent member- and provider-facing documents to ensure the accurate and consistent use of definitions, including "grievance" and what constitutes "medically necessary covered services," and time frames for processing grievances and appeals.
- During the CY 2022 record review, HSAG found that some Premier Access CHIP denial records were missing content as required at 42 CFR §438.404(b). HSAG recommends that Premier Access CHIP UM leadership review the requirements at 42 CFR §438.404(b) and confirm that UM procedures for communicating denials to members are in alignment and include complete information.
- HSAG recommends that Premier Access CHIP leadership review policies related to access; its grievance and appeal system; and detection of FWA to ensure alignment with federal requirements and those required by State contract.
- HSAG recommends that Premier Access CHIP develop and implement procedures to ensure that members receive all required information and can readily access its website and all electronically available member information.
- During the CY 2022 record review, HSAG found that Premier Access CHIP did not appropriately document grievances. HSAG recommends that Premier Access CHIP leadership review its system capabilities and internal procedures to ensure that Premier Access CHIP identifies and reports all grievances.
- HSAG recommends that Premier Access CHIP leadership review federal and State requirements related to QAPIP to identify missing required information and implement appropriate corrections.

VALIDATION OF NETWORK ADEQUACY

Premier Access CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-143 displays the number and percentage of provider categories by provider domain wherein Premier Access CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Premier Access CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-143—Compliance With Time/Distance Standards by Provider Domain—Premier Access CHIP

Provider Domain	Number of Provider Categories	Count of Categories Within Time Distance Standard*	Percent of Categories Within Time Distance Standard (%)*	Impact: Quality, Access, and/or Timeliness
General Dental	2	2	100.0%	

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

Opportunities for Improvement

Table 2-144 displays the provider domains and categories wherein Premier CHIP failed to meet the time/distance standards.

Table 2-144—Provider Categories That Failed to Meet Time/Distance Standards—Premier Access CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
NA	NA	NA

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

Recommendations

HSAG did not have any network adequacy recommendations for Premier Access CHIP.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix A. Objectives and Methodology for External Quality Review by EQR Activity

Validation of Performance Improvement Projects

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a health plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence in the health plans' improvement strategies and that reported improvement in study indicator outcomes is supported by significant change.

Description of Data Obtained

DHHS required each health plan to conduct one PIP during CY 2022. Each health plan chose its own PIP topic. HSAG obtained the data needed to conduct the PIP validations from each health plan's CY 2022 PIP Submission Form. The PIP submission forms submitted provided detailed information about each health plan's PIP as it related to the protocol activities and associated steps HSAG reviewed and evaluated for the CY 2022 validation cycle.

Each section of the PIP submission form includes steps to be undertaken when conducting PIPs. The form presents instructions for documenting information related to each of the protocol steps. The health plans could also attach relevant supporting documentation with the PIP Submission Form. Each health plan completed the form for PIP activities conducted during the MY and submitted it to HSAG for validation.

Methodology and Technical Methods of Data Collection

In its PIP evaluation and validation, HSAG used CMS' EQR Protocol 1 cited earlier in this report to evaluate the following components of the QI process:

1. Evaluation of the technical structure of the PIP. This component ensures that the health plans design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's validation determines whether the PIP design (e.g., PIP question, population, PIP indicator[s], sampling techniques, and data collection methodology/processes) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring improvement.
2. Evaluation of the implementation of the PIP. Once a PIP is designed, its effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the health plans improve outcomes, and the quality of, access to, and timeliness of care provided to its members by implementing effective QI processes.

How Data Were Aggregated and Analyzed

HSAG obtained the data needed to conduct the PIP validation from the health plan's PIP Summary Form submitted in CY 2022. This form provided detailed information about the health plan's completed PIP activities.

To monitor, assess, and validate PIPs, HSAG uses an outcome-focused scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS' EQR Protocol 1. With DHHS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Step 1—Review the Selected PIP Topic

Step 2—Review the PIP Aim Statement

Step 3—Review the Identified PIP Population

Step 4—Review the Sampling Method

Step 5—Review the Selected PIP Variables and Performance Measures

Step 6—Review the Data Collection Procedures

Step 7—Review Data Analysis and Interpretation of PIP Results

Step 8—Assess the Improvement Strategies

Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred

How Conclusions Were Drawn

Each required protocol step is evaluated using one or more evaluations elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given protocol activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The HSAG PIP Review Team would give the health plan a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP activities were designed to evaluate the validity and quality of a health plan's processes for conducting valid PIPs. Therefore, HSAG determined that all PIPs had the potential impact the quality domain of care. Additionally, a health plan's particular PIP also may have also been associated with the timeliness or access domains, depending on the specific PIP topic. HSAG therefore analyzed each health plan's performance in conducting PIPs across the three domains of care based on those associations and the potential impact on member outcomes related to the domains of care.

Validation of Performance Measures

Objectives

The primary objectives of PMV were to:

- Evaluate the accuracy of the performance measure rates calculated by the health plans.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for each measure.

Description of Data Obtained

Medicaid ACOs, UMIC and CHIP MCOs, and Dental PAHPS

The ACOs, UMIC and CHIP MCOs, and dental PAHPs were required to calculate applicable HEDIS measures following the *HEDIS MY 2021 Technical Specifications*, undergo an NCQA HEDIS Compliance Audit[A-1] performed by an NCQA-certified auditor, and report the results of their HEDIS audit to DHHS. These health plans were also required to provide the HEDIS data, FARs, and a copy of the auditor's certification to DHHS. HSAG obtained the HEDIS FARs from DHHS and evaluated the FARs to assess the health plans' compliance with the NCQA HEDIS Compliance Audit standards.

PMHPs and HOME

The 11 PMHPs and HOME were required to calculate and report one measure, *Follow-Up After Hospitalization for Mental Illness (FUH)*, which was a modified version of NCQA's HEDIS MY 2021 *FUH* measure. The measure was based on claims/encounter data and data from the organization's care management tracking systems. DHHS required the PMHPs and HOME to maintain a data system that allowed for tracking, monitoring, calculating, and reporting this performance measure.

HSAG conducted PMV activities for the 11 PMHPs and HOME to assess the accuracy of performance measure rates reported and to determine the extent to which the calculated performance rates followed the measure specifications and reporting requirements. HSAG conducted virtual audits and reviewed these health plans' submitted documentation and performance measure rates.

Methodology and Technical Methods of Data Collection

Validation of Performance Measures

At the end of the NCQA HEDIS Compliance Audit season, the ACOs, UMIC plans, MCOs, and dental PAHPS submitted their FARs and final auditor-locked Interactive Data Submission System (IDSS) rate submissions to DHHS. HSAG obtained the HEDIS data and FARs from DHHS.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in CMS' EQR Protocol 2 cited earlier in this report. The CMS protocol activities for validation of performance measures includes the following methodology for data collection:

1. Conducted pre-virtual review activities including collecting and reviewing relevant documentation and rate review.
   - HSAG obtained a list of the indicators selected for validation as well as the indicator definitions from DHHS for the validation team to review.

[A-1] HEDIS Compliance Audit™ is a trademark of the NCQA.

- HSAG prepared a documentation request for the PMHPs and HOME, which included the Information Systems Capabilities Assessment Tool (ISCAT). HSAG customized the ISCAT to collect data consistent with Utah's service delivery model and forwarded the ISCAT to each organization with a timeline for completion and instructions for submission. HSAG responded to organizations' ISCAT-related questions during the pre-virtual phase.

2. Conducted virtual site visits using a webinar format with each organization.
   - HSAG collected information using several methods, including interviews with key staff, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports.
3. Conducted post-virtual-site visit activities including compiling and analyzing findings, and reporting results to DHHS.

How Data Were Aggregated and Analyzed

HSAG reviewed and evaluated the HEDIS 2021 FARs for the ACOs, UMIC plans, MCOs, and dental PAHPS to assess health plan compliance with the NCQA HEDIS Compliance Audit standards. The IS standards are:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry.
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry.
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry.
- IS 4.0—Medical Record Review Processes—Sampling, Abstraction, and Oversight.
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry.
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity.

HSAG then analyzed each health plan's performance based on measure rates by reviewing the certified HEDIS rates in comparison to MY 2021 NCQA Quality Compass rates for Medicaid Health Maintenance Organizations (HMOs) to identify strengths and opportunities for improvement.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in CMS' EQR Protocol 2 cited earlier in this report. The CMS protocol activities for validation of performance measures include aggregation and analysis of documentation submitted by the organization including the ISCAT and supporting documentation, interviews with key staff during the virtual review, systems demonstrations during the virtual review, review of data output files, PSV of records used for denominator and numerator identification, observation of data processing, and review of data reports.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care provided by the Utah's Medicaid and CHIP health plans, HSAG first ensured that each of the HEDIS performance measures reported was associated with one or more of the three domains of care (quality, timeliness, and access). Each measure may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance in comparison to MY 2021 NCQA Quality Compass rates for Medicaid HMOs to draw conclusions about the health plan's effectiveness in ensuring the quality and timeliness of, and access to care for its members.

Based on all validation activities with the PMHPs and HOME, HSAG determined results for each performance measure. As set forth in CMS' EQR Protocol 2, HSAG gave a validation finding of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported* (see Table A-1) to each performance measure. HSAG based each validation finding on how significant the errors were in each measure's evaluation elements, not by the number of elements determined to be noncompliant. For example, it was possible that a single error could result in a designation of *Do Not Report* if the impact of the error biased the rate by more than 5 percentage points. Conversely, even if multiple errors were identified, if the errors had little or no impact on the rate, the indicator was given a designation of *Reportable*.

After completing the validation process, HSAG prepared a report of the PMV findings and recommendations for each PMHP and HOME. HSAG forwarded these reports to DHHS and the appropriate health plan. Finally, HSAG analyzed each health plan's performance based on measure rates and reviewed the rates in comparison to the statewide average. Section 2 contains information about the health plan-specific performance measure rates and validation status.

Table A-1—Designation Categories for Performance Indicators

Reportable (R)	Measure was compliant with the State's specifications.
Do Not Report (DNR)	The PMHP rate was materially biased and should not be reported.
Not Applicable (NA)	The PMHP was not required to report the measure.
Not Reported (NR)	The measure was not reported because the PMHP did not offer the required benefit.

Compliance Monitoring

Objectives

The objective of the compliance review activities is to determine the extent to which the health plan complies with the standards set forth at 42 CFR Part 438 and with State contract requirements. In

addition, the compliance review process provides meaningful information to DHHS and the health plans regarding:

- The quality and timeliness of, and access to, health care furnished by the health plan.
- Corrective actions required and interventions needed to improve quality.
- Activities needed to enhance and sustain performance and processes.

Description of Data Obtained

During CY 2021, HSAG conducted an assessment of the Utah health plans' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. HSAG required that health plans complete a CAP to address requirements that were found to be out of compliance. For CY 2022, HSAG conducted a review of the implementation of each health plan's CAP as well as a review of pre-service authorization denial, appeal, grievance, initial credentialing, and recredentialing records.

Documents reviewed consisted of the following:

- The compliance monitoring tool with a portion completed by the health plan
- A document request form outlining the compliance review process where health plans added high-level organizational information and delegation information
- Policies and procedures
- Staff training materials
- Key committee meeting minutes
- Provider and member informational materials
- Paper and electronic UM and appeal determination records
- Correspondence related to NABDs and appeals
- Documentation of grievances, including the electronic record, correspondence, and grievance logs
- Records pertaining to credentialing activities

In addition, HSAG obtained data for assessing compliance with regulations through telephonic interviews with key health plan staff members during virtual site reviews.

Methodology and Technical Methods of Data Collection

To accomplish the stated objectives for the virtual site reviews, for assessing each health plan's compliance with Medicaid and CHIP managed care regulations HSAG collaborated with DHHS on the development of compliance monitoring tools and methods, document review and assessment

processes, schedules, agendas, and scoring methodology. HSAG completed document review and virtual interviews to assess all standards. Upon completion of each review, for each health plan, HSAG assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable* to each individual requirement reviewed and indicated where required actions existed, if appropriate. In addition, HSAG reviewed each health plan's administrative records related to adverse benefit determinations, grievances, appeals, and credentialing of providers. HSAG organized the Medicaid managed care regulations into nine standards as follows:

Table A-2—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 (Includes Confidentiality)	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 Selection and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610
Standard VII—Subcontractual Relationships and Delegation	438.230
Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems	438.236 438.330 438.242

Standard Number and Title	Regulations Included
Standard IX—Enrollment and Disenrollment	438.3(d) 438.56

HSAG conducted compliance review activities consistent with CMS' EQR Protocol 3 cited earlier in this report. The CMS protocol for assessing health plan compliance with regulations includes five protocol activities. To conduct compliance review activities, HSAG:

1. Collaborated with DHHS on the development of the compliance monitoring tool.
   - Collaborated with DHHS to determine review and scoring methods and thresholds.
   - Collaborated with the health plans and DHHS to determine schedules, agendas, and to explain the compliance monitoring processes and address questions.
2. Collected and reviewed data and documents and performed a preliminary review.
3. Conducted a virtual review using a telephonic or webinar strategy.
4. Compiled and analyzed and the data and information collected.
5. Prepared a report that delineated findings and required corrective actions (if applicable).
   - Submitted the health plan-specific draft reports to DHHS with a second draft to each health plan for review.
   - Submitted the final health plan-specific reports to the health plans and DHHS.

How Data Were Aggregated and Analyzed

HSAG assessed health plan compliance with the Medicaid managed care final rule, finalized November 9, 2020, through a proprietary compliance tool that itemized each of the regulations at 42 CFR Part 438, as noted in the Methodology and Technical Methods of Data Collection section of this report. Once the assessments were finalized, HSAG assigned scores (*Met*, *Partially Met*, *Not Met*, or *Not Applicable)* for each requirement and then assigned a point value, with *Met* equaling one point, *Partially Met* equaling one-half point, and *Not Met* equaling zero points. HSAG used this scoring methodology to determine scores for each requirement within the standards and then calculated a percent *Met* score for each standard. Finally, HSAG determined a weighted score for the entire assessment. With this information, HSAG was able to conduct analyses across standards; among health plan types (ACO, UMIC, CHIP, dental PAHP, and PMHP); and in the aggregate (statewide).

How Conclusions Were Drawn

HSAG assessed each requirement within the standards set forth at 42 CFR Part 438 and assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To make conclusions regarding the domains of care (quality, timeliness, and access) provided by each health plan, HSAG determined the requirements

within each standard that were associated with each domain. Each element may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance across the three domains of care based on those associations and potential impact on member outcomes related to the domains of care.

Validation of Network Adequacy

Objectives

Under the contract for EQR, DHHS requested that HSAG conduct NAV analyses including a network capacity analysis and a geographic network distribution analysis for the CHIP health plans during CY 2022.

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in 42 CFR §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. As of the writing of this report, CMS had not published this protocol. However, validation of the health plans' time/distance results, as described in HSAG's methodology, aligns with current federal regulations and will help prepare DHHS to meet the NAV requirements once the protocol is published.

The purpose of the network capacity and geographic distribution analyses was to determine the geographic distribution of the providers relative to member populations and to assess the capacity of a given provider network.

Description of Data Obtained

The CY 2022 NAV analyses included all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., health care facilities) contracted to provide care as of June 1, 2022, through one of Utah's Medicaid or CHIP managed care health plans.

Medicaid and CHIP Member Data Request

To complete the NAV analysis, HSAG obtained Medicaid and CHIP member eligibility, enrollment, and demographic information from DHHS. Key data elements requested included unique member identifier, gender, age, health plan in which the member is enrolled, and residential address as of June 1, 2022. Upon receiving the member data files from DHHS, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. HSAG collaborated with DHHS to resolve questions identified during the data review process.

Health Plan Data Request

HSAG submitted a detailed data requirements document to the health plans to request information about providers actively enrolled as June 1, 2022. HSAG supplied the health plans with the provider crosswalk that detailed the methods for classifying each provider category using provider type, specialty, taxonomy, and credentials. The health plans used the provider crosswalk to classify their providers to the appropriate provider categories. Key data elements requested included, but were not limited to, unique provider identifier, enrollment status with the health plans, provider category, provider type, provider specialty, and PCP indicator.

Methodology and Technical Methods of Data Collection

Under the contract for EQR, DHHS requested that HSAG conduct NAV analyses including a network capacity analysis and a geographic network distribution analysis for the Medicaid and CHIP health plans during CY 2022. As part of the analyses, HSAG refreshed the provider crosswalk developed in CY 2019 and updated in CY 2020 which the health plans used to classify providers into appropriate provider categories. HSAG then calculated the time/distance and provider ratio results for each health plan and validated each health plan's compliance with access standards. Additionally, for provider types that did not meet the time/distance requirements, a saturation analysis was completed to determine the degree to which each health plan's provider network reflects available providers.

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in 42 CFR §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. As of the writing of this report, CMS had not published this protocol. HSAG will collaborate with DHHS to modify and finalize this methodology upon release of the CMS EQR protocol. However, validation of the health plans' time/distance results, as described in this methodology, aligns with current federal regulations and will help prepare DHHS to meet the NAV requirements once the provisions go into effect. Figure A-1 describes HSAG's three main phases for the CY 2022 network adequacy tasks.

Figure A-1—Summary of CY 2022 Network Adequacy Tasks

CY 2022 Network Adequacy Tasks		
Data Collection	**Synthesis & Analysis**	**Reporting**
• Data request to DHHS and the health plans • Receive data from DHHS and the health plans	• Generate NAV analysis • Conduct saturation analysis • Conduct NAV analysis trending • Develop Tableau-based reporting dashboard	• Report on NAV analysis and saturation analysis • Deploy Tableau dashboard

How Data were Aggregated and Analyzed

Network Capacity Analysis

HSAG calculated the provider ratio for the provider categories defined in the provider crosswalks for the health plans. Specifically, the provider ratio measures the number of providers by provider category (e.g., PCPs, cardiologists) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations.

Geographic Network Distribution Analysis

The second dimension of this study evaluated the geographic distribution of providers relative to the health plans' members. While the network capacity analysis identifies whether the network infrastructure is sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluates whether the provider locations in a health plan's provider network are proportional to the health plans' Medicaid and/or CHIP population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider specialties identified in the provider crosswalks:

- **Percentage of members within predefined access standards:**[A-2] A higher percentage of members meeting access standards indicates better geographic distribution of a health plan's providers in relation to its Medicaid or CHIP members.
- **Average travel distance (in miles) and travel time**[A-3] **(in minutes) to the nearest one to three providers:** A smaller distance or shorter travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care.

HSAG used GeoAccess software to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to three providers for all provider categories identified in the provider crosswalks. All study results were stratified by health plan.

[A-2] The percentage of members within predefined standards was calculated for provider categories with predefined access standards.

[A-3] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid or CHIP members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times were estimated based on the following drive speeds: urban areas were estimated at a drive speed of 30 miles per hour, suburban areas were estimated at a drive speed of 45 miles per hour, and rural areas were estimated at a drive speed of 55 miles per hour.

Provider Saturation Analysis

Based on the time/distance validation results, HSAG identified the provider categories for which each health plan failed to meet the established standard at the county level. For each time/distance standard in which a health plan did not meet the time/distance requirements, HSAG determined the extent to which deficiencies in the health plan provider network resulted from the failure to contract with available providers versus a lack of available providers for the provider type and/or geographic area. HSAG collaborated with DHHS to determine any limitations that should be applied when assessing potentially available providers. For example, HSAG worked with DHHS to determine if providers in adjacent counties should be included when determining potential network deficiencies.

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each EQR-related activity conducted in CY 2022. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality or timeliness of, or access to care and services provided by each health plan as well as related to potential statewide improvement. To accomplish this analysis, HSAG used the following three step process:

Step 1: HSAG analyzed the quantitative results obtained from each EQR-related activity, for each health plan, to identify strengths and weaknesses (opportunities for improvement) in each domain of care (quality and timeliness of, and access to care and services).

Step 2: From the information collected, HSAG identified common themes and salient patterns that emerged for each domain of care and drew conclusions about the quality and timeliness of, and access to care and services furnished by the health plans

Step 3: From the analysis identifying common themes and patterns related to the domains of quality, timeliness, and access, HSAG evaluated the patterns and determined whether statewide recommendations may be appropriate.

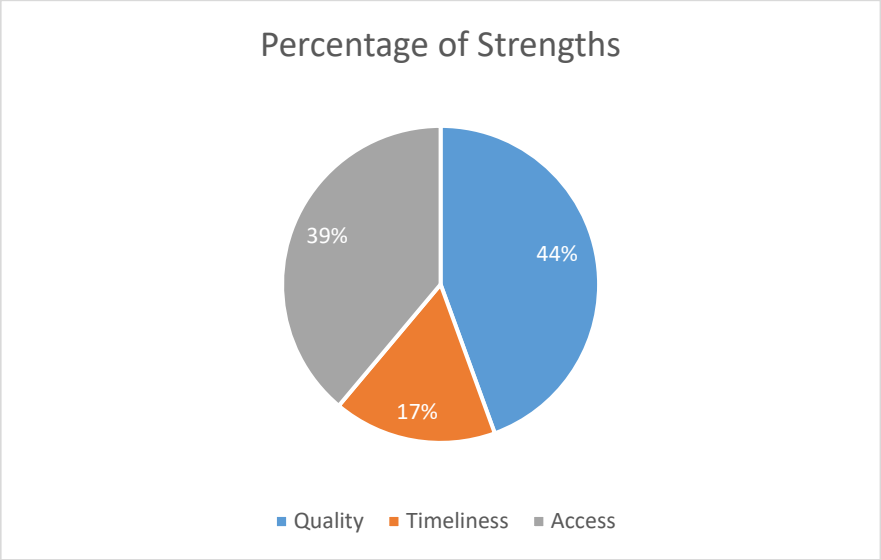
How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about health plan performance related to the quality and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Medicaid and CHIP member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the health plans' ability to track and monitor their respective provider networks.

Statewide Strengths, Opportunities for Improvement, and Recommendations Across External Quality Review Activities

Figure B-1 and Figure B-2 provide an overall assessment of the percentages of strengths and weakness (opportunities for improvement) that HSAG assessed to likely impact each of the care domains—quality, timeliness, and access. These percentages were derived from the results of all mandatory and optional EQR-related activities conducted during CY 2022. The information in these figures is also provided in Section 1—Executive Summary, Figure B-1 and Figure B-2.

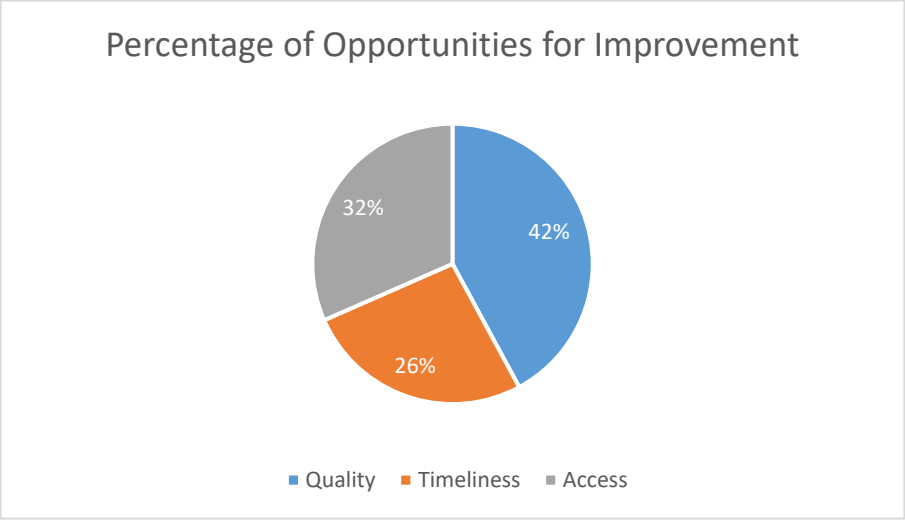
Figure B-1—Percentage of Strengths by Care Domain*



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

Figure B-2 presents the percentage of statewide opportunities for improvement that HSAG assessed are likely to impact the quality and timeliness of, and access to care and services.

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



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

Statewide Strengths Related to All Activities

Across all plans and all activities, HSAG identified the following statewide strengths:

- Utah health plans demonstrated a thorough application of the PIP design principles and appropriate QI activities to support improvement of PIP outcomes.
- Based on a validation review of IS standards, HSAG and external HEDIS compliance auditors determined that nearly all of Utah ACO, HOME, UMIC, and dental health plans' IS and processes were compliant with IS standards. HSAG found that the performance indicators calculated by the PMHPs had a status of "Reportable" based on the reporting requirements for MY 2021 PMV.
- The majority of members enrolled in a Utah PMHP that were hospitalized for mental health treatment received outpatient follow-up care within 30 days of hospital discharge.
- Utah health plans scored notably well in the Coordination and Continuity of Care, Subcontractual Relationships and Delegation, and Enrollment and Disenrollment standards.
- Overall, the Utah CY 2022 NAV results suggest that the health plans have comprehensive provider networks.

Statewide Opportunities Related to All Activities

Across all plans and all activities, HSAG identified the following statewide opportunities for improvement:

- All Utah Medicaid plans demonstrated opportunities for improvement in the areas of preventive and follow-up care for women and children.
- HSAG identified ongoing issues pertaining to the Member Rights and Information (Includes Confidentiality) standard in 21 of the 25 plans reviewed.
- Many of the ongoing issues pertaining to compliance across plans continue to relate to inaccuracies noted in policies and procedures.

Statewide Recommendations Related to All Activities

For all activities, HSAG offers the following statewide recommendations:

- Consider integrated topical focus groups among the health plans to share best practices and determine strategies for addressing ongoing issues pertaining to performance measure scores that are low across plans.
- Consider an integrated policy and member-facing document review group among the health plans to ensure that policies and documents align with federal and State contract requirements and share best practices for policy writing, procedures for ensuring that desktop procedures and member-facing documents reflect policies, and strategies for conducting an ongoing internal executive review.
- Review areas cited in this report that most consistently present opportunities for improvement and consider conducting a root cause analysis followed by a quality improvement intervention. Consider having the health plans share interventions and results (both successes and challenges).
- Consider a review patient satisfaction survey results and grievance and appeal data to evaluate the degree to which members are satisfied with the care they have received, as it related to all EQR activities.
- Seek technical assistance from HSAG, as needed.

Validation of Performance Improvement Projects

Statewide Comparative Results

For CY 2022, each health plan submitted one PIP for validation for a total of 25 PIPs. For a breakdown of statewide strengths, opportunities for improvement, and recommendations for PIPs, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activates—Validation of Performance Improvement Projects.

ACO, MCO, and UMIC Plans

MEDICAID ACOS

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

UTAH MEDICAID INTEGRATED CARE (UMIC) PLANS

Three of the four UMIC plans received an overall *Met* validation status for their PIP. SelectHealth CC UMIC received an overall *Partially Met* validation status, with an 85 percent *Met* score on all the applicable evaluation elements.

Table B-1 lists the PIP topics and validation scores for each ACO, MCO, and UMIC health plan.

Table B-1—CY 2022 PIP Topics Selected by Medicaid ACO, MCO, and UMIC Plans
Summary of Each Medicaid Health Plan's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Health Choice	*Well-Child Visits in the First 30 Months of Life*	100%	100%	M
Health Choice UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	M
Healthy U	*Well-Child Visits in the First 30 Months of Life*	100%	100%	M
Healthy U Integrated	*Improving Adults' Access to Preventive/Ambulatory Care Services*	95%	100%	M
Molina	*Well-Child Visits in the First 30 Months of Life*	100%	100%	M
Molina UMIC	*Follow-Up After Hospitalization for Mental Illness*	95%	100%	M
SelectHealth CC	*Well-Child Visits in the First 30 Months of Life*	100%	100%	M
SelectHealth CC UMIC	*7-day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members*	85%	90%	PM

PMHPs AND HOME

Seven of the 11 PMHPs received an overall *Met* validation status for their PIP. Bear River, Healthy U Behavioral, Salt Lake, and Weber received an overall *Partially Met* validation status.

HOME

Table B-2 lists the PIP topics and validation scores for HOME.

Table B-2—CY 2022 PIP Topic Selected by HOME
Summary of HOME's PIP Validation Scores and Status

PIP	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic	100%	100%	M

PMHPs

Table B-3 lists the PIP topics and validation scores for each PMHP.

Table B-3—CY 2022 PIP Topics Selected by PMHPs
Summary of Each PMHP's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Bear River	*YOQ/OQ*	92%	86%	PM
Central	*Inpatient Readmission Rates*	100%	100%	M
Davis	*Access to Care*	100%	100%	M
Four Corners	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	95%	100%	M
Healthy U Behavioral	*Improving Follow-up After Hospitalization for Mental Illness*	84%	89%	PM
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	100%	100%	M
Optum/Tooele	*Increasing Youth Engagement in Treatment Services in Tooele County*	93%	100%	M
Salt Lake	*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*	80%	89%	PM
Southwest	*Increased Number of PMHP Clients Receiving Peer Support Services*	100%	100%	M
Wasatch	*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*	100%	100%	M

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Weber	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	68%	78%	PM

CHIP MCOs

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

Table B-4 lists the PIP topics and validation scores for each CHIP.

Table B-4—CY 2022 PIP Topics Selected by CHIP Health Plans
Summary of Each CHIP Health Plan's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Molina CHIP	*Weight Assessment and Counseling for Nutrition and Physician Activity—BMI Screening*	96%	100%	M
SelectHealth CHIP	*Well-Child Visits for CHIP Members*	100%	100%	M

MEDICAID AND CHIP DENTAL PAHPS

For CY 2022, HSAG validated one PIP for each of the two Medicaid dental PAHPs and the CHIP dental PAHP. All three dental PAHPs received an overall *Met* validation status for their PIP.

Table B-5 lists the PIP topics and validation scores for each dental PAHP.

Table B-5—CY 2022 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%	M
Premier Access	*School Based Care for Medicaid Members*	100%	100%	M
Premier Access CHIP	*School Based Care for CHIP Members*	100%	100%	M

Validation of Performance Measures

Statewide Comparative Results

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for performance measures, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activates—Validation of Performance Measures.

ACO Plans

VALIDATION FINDINGS

The Medicaid ACOs' HEDIS compliance auditors determined that three of the health plans' IS and processes were fully compliant and that one health plan's IS and processes was partially compliant with the applicable IS standards and reporting requirements for HEDIS MY 2021.

PERFORMANCE MEASURE RESULTS

All four ACOs exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for URI—3 Months–17 Years*

Three of the four ACOs exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Controlling High Blood Pressure*
- *Use of Imaging Studies for Low Back Pain*

The following performance indicators demonstrated the most need for improvement, as all four ACOs fell below the MY 2021 NCQA Quality Compass average:

- *Breast Cancer Screening*
- *Child and Adolescent Well-Care Visits—3–11 Years*

In addition, three of the four ACOs fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life*

Based on performance measure outcomes:

- At least three out of four ACOs exceeded the MY 2021 NCQA Quality Compass average for six (37.50 percent) of the 16 performance indicators collected.
- At least three of the four ACOs fell below the MY 2021 NCQA Quality Compass average for six (37.50 percent) of the 16 performance indicators collected.

Table B-6 shows the ACOs' HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table B-6—ACOs' HEDIS MY 2021 Results

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth CC	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services					
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	**73.81%**	77.46%	77.89%	81.03%	75.81%
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)	69.09%	**59.86%**	NA	70.18%	60.80%
Appropriate Treatment for URI					
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	95.63%	95.71%	94.62%	96.91%	93.22%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**36.88%**	**38.30%**	**35.60%**	**47.76%**	51.00%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth CC	MY 2021 NCQA Quality Compass Average
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**41.61%**	**48.66%**	**46.47%**	60.80%	56.26%
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)	63.26%	66.18%	**56.45%**	71.78%	63.03%
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)	**80.54%**	86.37%	86.37%	92.53%	85.28%
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)	**44.04%**	**50.12%**	**47.45%**	64.18%	50.81%
Controlling High Blood Pressure					
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	68.80%	71.05%	**48.91%**	66.77%	58.63%
Immunizations for Adolescents					
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 2)	**26.76%**	37.23%	**26.28%**	36.63%	36.11%
Prenatal and Postpartum Care					
The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. (Timeliness of Prenatal Care)	**62.78%**	84.97%	**66.91%**	94.27%	83.53%
The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**64.30%**	**71.31%**	**69.59%**	86.02%	76.18%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth CC	MY 2021 NCQA Quality Compass Average
Use of Imaging Studies for Low Back Pain					
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	78.02%	**70.34%**	75.23%	75.27%	74.53%
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)	**57.18%**	80.40%	**57.42%**	86.61%	76.11%
Well-Child Visits in the First 30 Months of Life					
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	**48.15%**	**42.57%**	**44.72%**	58.07%	54.10%
Child and Adolescent Well-Care Visits					
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**44.47%**	**48.77%**	**46.90%**	**52.05%**	57.13%

*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.

UMIC Plans

VALIDATION FINDINGS

The UMIC plans' HEDIS compliance auditors determined that the health plans' IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS MY 2021.

PERFORMANCE MEASURE RESULTS

All four MCOs exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence —7-Day Follow-Up—Total*

- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence — 30-Day Follow-Up—Total*

Three of the four MCOs exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Controlling High Blood Pressure*
- *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*

The following performance indicators demonstrated the most need for improvement, as all four MCOs fell below the MY 2021 NCQA Quality Compass average:

- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

In addition, three of the four MCOs fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*
- *Use of Imaging Studies for Low Back Pain*

Based on performance measure outcomes:

- At least three out of four MCOs exceeded the MY 2021 NCQA Quality Compass average for four (21.05 percent) of the 19 performance indicators collected.

- At least three of the four MCOs fell below the MY 2021 NCQA Quality Compass average for 10 (52.63 percent) of the 19 performance indicators collected.

Table B-7 shows the UMIC plans' HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates.

Table B-7—UMIC Plans' HEDIS MY 2021 Results

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	MY 2021 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services					
The percentage of members 20 years and older who had an ambulatory or preventive care visit.	**59.90%**	**68.52%**	**66.85%**	75.83%	75.81%
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	**60.00%**	**40.00%**	**59.49%**	60.80%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	NA	**47.12%**	**36.36%**	57.35%	51.00%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	NA	NA	NA	NA	74.92%
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**31.39%**	**39.90%**	**35.77%**	57.95%	56.26%
Comprehensive Diabetes Care					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing. (HbA1c Testing)	**74.70%**	87.35%	**83.94%**	88.32%	85.28%
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)	**31.14%**	**44.04%**	**36.98%**	53.77%	50.81%
Controlling High Blood Pressure					
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose	60.10%	62.03%	**43.55%**	68.33%	58.63%

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	MY 2021 NCQA Quality Compass Average
blood pressure was adequately controlled during the measurement year.					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	**71.33%**	NA	NA	80.81%	79.20%
Diabetes Monitoring for People With Diabetes and Schizophrenia					
The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	NA	NA	NA	NA	67.13%
Follow-Up After Emergency Department Visit for Mental Illness					
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (7-Day Follow-Up–Total)	**14.89%**	**24.43%**	**20.12%**	**34.73%**	40.08%
The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. (30-Day Follow-Up–Total)	**24.47%**	**31.82%**	**29.88%**	**46.86%**	53.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence					
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (7-Day Follow-Up–Total)	22.81%	13.48%	16.29%	13.51%	13.35%
The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. (30-Day Follow-Up–Total)	28.9%	23.51%	26.82%	23.42%	19.79%
Follow-Up After Hospitalization for Mental Illness					
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (7-Day Follow-Up—Total)	**24.44%**	**29.54%**	**28.52%**	**38.24%**	38.44%

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	MY 2021 NCQA Quality Compass Average
Assesses adults 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. (30-Day Follow-Up—Total)	**40.44%**	**50.18%**	**49.10%**	**56.72%**	58.73%
Initiation and Engagement of AOD Dependence Treatment					
Initiation of AOD Treatment: Adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of diagnosis. (Initiation of AOD Treatment—Total)	45.86%	44.63%	**40.21%**	44.97%	44.16%
Engagement of AOD Treatment: Adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. (Engagement of AOD Treatment—Total)	14.55%	**12.40%**	**13.37%**	**13.53%**	13.87%
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.	76.52%	**68.98%**	**71.14%**	**71.61%**	74.53%

*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.

PMHPs and HOME

VALIDATION FINDING

HSAG determined that all 12 PMHPs' IS and processes were compliant with IS standards and that the performance indicators calculated by the PMHPs had a status of "Reportable" based on the reporting requirements for MY 2021 PMV.

PERFORMANCE MEASURE RESULTS

For MY 2021, 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. The results were compared to a calculated statewide average. This measure helps PMHPs and HOME monitor and

ensure that members receive timely follow-up outpatient services after hospital discharge. Timely follow-up can help reduce the risk of rehospitalizations.

Based on performance measure outcomes, four PMHPs exceeded the statewide PMHP average for both *FUH* measure indicators, while six PMHPs fell below the statewide average for both measure indicators. HOME was not included in or compared to the statewide PMHP average.

HOME

Table B-8 presents the findings reported by HOME for the *Follow-Up After Hospitalization for Mental Illness* (*FUH-UT*) measure.

Table B-8—HOME MY 2021 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	36.67%
Follow-Up Within 30 Days	90.00%

PMHPs

Table B-9 presents the findings reported by the PMHPs for the *Follow-Up After Hospitalization for Mental Illness* (*FUH-UT*) measure.

Table B-9—PMHPs MY 2021 *FUH* Results

PMHP	Follow-Up Within 7 Days	Follow-Up Within 30 Days
Statewide PMHP Average	**53.92%**	**70.68%**
Bear River	60.30%	74.37%
Central	79.10%	92.54%
Davis	**51.64%**	78.69%
Four Corners	**49.09%**	**60.00%**
Healthy U Behavioral	**36.36%**	**68.18%**
Northeastern	60.47%	73.26%
Optum/Tooele	**47.52%**	**58.42%**
Salt Lake	**47.88%**	**64.84%**
Southwest	**51.95%**	**64.50%**
Wasatch	61.59%	77.17%
Weber	**47.22%**	**65.48%**

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

CHIP MCO

VALIDATION FINDINGS

The CHIP MCOs' HEDIS compliance auditors determined that the health plans' IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS MY 2021.

PERFORMANCE MEASURE RESULTS

Both CHIP MCOs exceeded the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for URI*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

One CHIP MCO fell below the MY 2021 NCQA Quality Compass average for the following performance indicators:

- *Child and Adolescent Well-Care Visits—3–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

Based on performance measure outcomes:

- Both CHIP MCOs exceeded the MY 2021 NCQA Quality Compass average for four (66.7 percent) of the six performance indicators collected.
- One of the CHIP MCOs fell below the MY 2021 NCQA Quality Compass average for two (33.3 percent) of the six performance indicators collected.

Table B-10 shows CHIP MCOs' HEDIS MY 2021 results as compared to the MY 2021 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table B-10—CHIP MCO HEDIS MY 2021 Results

HEDIS Measure	Molina CHIP	SelectHealth CHIP	MY 2021 NCQA Quality Compass Average
Appropriate Treatment for URI			
The percentage of children 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months–17 years)	96.44%	95.39%	93.22%
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)	67.61%	73.83%	63.03%
Immunizations for Adolescents			
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	83.92%	90.11%	77.68%
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)	**59.85%**	88.52%	76.11%
Well-Child Visits in the First 30 Months of Life			
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Well-Child Visits in the First 15 Months)	69.57%	74.70%	54.10%
Child and Adolescent Well-Care Visits			
The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. (3 to 11 years)	**53.38%**	61.11%	57.13%

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

Medicaid and CHIP Dental PAHPs

VALIDATION FINDINGS

Two dental PAHPs (Premier Access and MCNA) contracted with DHHS to serve the Medicaid population, while DHHS contracted with Premier Access to also serve the CHIP population. The PAHPs' HEDIS compliance auditors determined that both PAHPs' IS and processes were compliant with the applicable IS standards and reporting requirements for MY 2021.

PERFORMANCE MEASURE RESULTS

Both Medicaid dental PAHPs exceeded the MY 2021 NCQA Quality Compass average for all of the performance indicators:

- *Annual Dental Visit—2–3 Years*
- *Annual Dental Visit—4–6 Years*
- *Annual Dental Visit—7–10 Years*
- *Annual Dental Visit—11–14 Years*
- *Annual Dental Visit—15–18 Years*
- *Annual Dental Visit—19–20 Years*
- *Annual Dental Visit—Total*

Premier Access' performance for the CHIP population also exceeded the MY 2021 NCQA Quality Compass average for all of the *Annual Dental Visit* performance indicators.

Table B-11 shows the HEDIS MY 2021 results for the dental PAHPs serving the Medicaid population as compared to the MY 2021 NCQA Quality Compass average rates.

Table B-11—Medicaid Dental PAHPs HEDIS MY 2021 Results

HEDIS Measure	MCNA	Premier Access	MY 2021 NCQA Quality Compass Average
Annual Dental Visit			
2–3 Years	39.24%	44.49%	36.00%
4–6 Years	59.60%	64.08%	55.01%
7–10 Years	63.54%	66.84%	57.69%
11–14 Years	58.29%	61.75%	53.18%
15–18 Years	50.44%	52.08%	46.49%

HEDIS Measure	MCNA	Premier Access	MY 2021 NCQA Quality Compass Average
19–20 Years	31.66%	35.67%	31.09%
Total	55.04%	58.89%	47.26%

Table B-12 shows the HEDIS MY 2021 results for the dental PAHP serving the CHIP populations compared to the MY 2021 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP PAHP measure rates to these averages should be interpreted with caution.

Table B-12—CHIP Dental PAHP HEDIS MY 2021 Results

HEDIS Measure	Premier Access CHIP	MY 2021 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years	60.77%	36.00%
4–6 Years	76.24%	55.01%
7–10 Years	81.94%	57.69%
11–14 Years	78.67%	53.18%
15–18 Years	66.30%	46.49%
19–20 Years	64.29%	31.09%
Total	75.29%	47.26%

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Comparative Results

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for compliance activities, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activates—Compliance Monitoring.

ACOs

For the CY 2021 compliance reviews, HSAG conducted an assessment of the four Medicaid ACOs' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2022, HSAG conducted a review of each ACO's implementation of interventions to address CY 2021 required corrective actions. In addition, HSAG conducted a review of a sample of pre-service authorization denials, appeals, grievances, initial credentialing, and recredentialing.

Table B-13 presents the standard scores and overall compliance scores for each Medicaid ACO. Shading indicates that HSAG found the standard to be in full compliance during the CY 2021 compliance review. HSAG did not conduct a further review of these standards in CY 2022. Statewide averages from CY 2021 and CY 2022 are included for comparison.

Table B-13—Statewide ACO Compliance Scores

Standard	Health Choice	Healthy U	Molina	SelectHealth CC	CY 2021 Statewide Average	CY 2022 Statewide Average
Standard I—Coverage and Authorization of Services	96%	93%	96%	100%	91%	96%
Standard II—Access and Availability	96%	100%	100%	96%	86%	98%
Standard III—Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%
Standard IV—Member Rights and Information (Includes Confidentiality	100%	96%	98%	98%	93%	98%
Standard V—Grievance and Appeal System	88%	91%	100%	98%	89%	94%
Standard VI—Provider Selection and Program Integrity	98%	98%	98%	100%	93%	99%
Standard VII—Subcontractual Relationships and Delegation	100%	100%	100%	88%	72%	97%
Standard VIII—Quality Assessment and Performance Improvement Program, Practice Guidelines, and Health Information Systems	94%	100%	100%	100%	94%	99%
Standard IX—Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%
Total Weighted Score*	**96%**	**96%**	**99%**	**99%**	**91%**	**98%**

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

HSAG identified trends when comparing the findings for these four organizations. Across all ACOs, statewide average scores for the standards reviewed in CY 2022 improved from CY 2021. In CY 2022, statewide average scores were highest for Standard VI—Provider Selection and Program Integrity, which improved from 93 percent in CY 2021 to 99 percent in CY 2022, and Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems, which improved from 94 percent to 99 percent. Additionally, statewide average scores for all standards except Standard V—Grievance and Appeal System were above 95 percent, indicating strong compliance with State and federal regulations. Overall, HSAG found that all four ACOs had implemented the majority of CY 2021 required corrective actions and had fully compliant systems for credentialing network providers, as evidenced by the record review.

Regarding coverage and authorization of services, all four ACOs implemented CY 2021 CAP findings related to policies and procedures. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 denial record reviews. HSAG found that three ACOs (Health Choice, Healthy U, and Molina) had continued required actions related to NABD content required at 42 CFR §438.404(b).

Regarding access to care, HSAG found that three out of four ACOs (Healthy U, Molina, and SelectHealth CC) implemented planned interventions related to required corrective actions to update health plan policies and processes to reflect correct time and distance standards outlined by the State. Further, two ACOs (Healthy U and Molina) increased their cumulative compliance score for Standard II—Access and Availability to 100 percent.

HSAG found that all four ACOs had implemented interventions to address required actions related to ensuring member handbooks include required information; however, only one ACO (Health Choice) successfully addressed all required actions. HSAG found that three ACOs (Healthy U, Molina, and SelectHealth CC) had not made revisions to member handbooks available to members on ACO websites, resulting in continued required actions.

The statewide average score for the ACOs was lowest for Standard V—Grievance and Appeal System, with Molina being the only ACO that implemented successfully addressed all CY 2021 required actions. Most ACOs had grievance and appeal policies and procedures that were compliant with Medicaid managed care regulations and State contract requirements for accepting, reviewing, and responding to appeals and grievances.

For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 appeal and grievance record reviews. For three ACOs (Health Choice, Healthy U, and SelectHealth CC), HSAG found that many appeal and grievance records lacked full compliance. For example, records did not include complete documentation to provide evidence of compliance with requirements related to sending acknowledgment and resolution letters.

In CY 2022, HSAG found that three ACOs (Health Choice, Molina, and SelectHealth CC) had successfully addressed most required actions related to providing required information to providers and subcontractors when they enter a contract. Further, HSAG found that three ACOs (Health Choice, Molina, and SelectHealth CC) had updated their compliance programs to contain required provisions. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 initial credentialing and recredentialing record reviews. HSAG found full compliance with the initial credentialing and recredentialing files reviewed across all four ACOs.

Regarding Standard VII—Subcontractual Relationships and Delegation, HSAG found that three ACOs (Health Choice, Healthy U, and Molina) had successfully addressed all required corrective actions,

resulting in full compliance and the ACO statewide average score changing from 72 percent in CY 2021 to 97 percent in CY 2022. One ACO had continued required actions related to this standard.

UMIC and HOME Plans

For the CY 2021 compliance reviews, HSAG conducted an assessment of the four UMIC plans' and HOME's compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2022, HSAG conducted a review of each MCO's implementation of interventions to address CY 2021 required corrective actions. In addition, HSAG conducted a review of a sample of pre-service authorization denials, appeals, grievances, initial credentialing, and recredentialing records.

Table B-14 provides the standard scores and overall compliance scores for each Medicaid UMIC plan and HOME (MCOs). Shading indicates that HSAG found the standard to be in full compliance during the CY 2021 compliance review. HSAG did not conduct a further review of these standards in CY 2022. Statewide averages from CY 2021 and CY 2022 are included for comparison.

Table B-14—Standard Compliance Scores by MCO

Standard	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	HOME	CY 2021 Statewide Average	CY 2022 Statewide Average
Standard I—Coverage and Authorization of Services	96%	95%	96%	100%	100%	92%	97%
Standard II—Access and Availability	96%	100%	100%	100%	100%	89%	99%
Standard III—Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
Standard IV—Member Rights and Information (Includes Confidentiality	100%	96%	98%	96%	98%	93%	98%
Standard V—Grievance and Appeal System	88%	91%	100%	95%	91%	86%	93%
Standard VI—Provider Selection and Program Integrity	98%	98%	98%	100%	100%	94%	99%
Standard VII—Subcontractual Relationships and Delegation	100%	100%	100%	88%	100%	75%	98%

Standard	Health Choice UMIC	Healthy U Integrated	Molina UMIC	SelectHealth CC UMIC	HOME	CY 2021 Statewide Average	CY 2022 Statewide Average
Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems	94%	100%	100%	100%	100%	95%	99%
Standard IX—Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%	100%
Total Weighted Score*	**96%**	**96%**	**99%**	**98%**	**98%**	**92%**	**97%**

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

Across all MCOs, statewide average scores for the standards reviewed in CY 2022 improved from CY 2021. In CY 2022, statewide average scores were highest for Standard II—Access and Availability, which improved from 89 percent in CY 2021 to 99 percent in CY 2022; Standard VI—Provider Selection and Program Integrity, which improved from 94 percent to 99 percent; and Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems, which improved from 95 percent to 99 percent. Additionally, statewide average scores for all standards except Standard V—Grievance and Appeal System were above 95 percent, indicating strong compliance with State contract requirements and Medicaid managed care regulations. Overall, HSAG found that MCOs had implemented planned interventions to address the majority of CY 2021 CAP require corrective actions and had fully compliant systems for credentialing network providers, as evidenced by the CY 2022 credentialing and recredentialing record review.

Regarding coverage and authorization of services, all five Integrated MCOs implemented planned interventions to address CY 2021 CAP findings related to policies and procedures. Two MCOs (SelectHealth CC UMIC and HOME) improved their compliance scores to 100 percent. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 denial record reviews. HSAG found that three MCOs (Health Choice UMIC, Healthy U Integrated, and Molina UMIC) had continued required actions related to missing NABD content required at 42 CFR §438.404(b).

Regarding access to care, HSAG found that four out of five MCOs (Healthy U Integrated, Molina UMIC, SelectHealth CC UMIC, and HOME) implemented planned interventions related to required corrective actions to update policies and processes to reflect correct time and distance standards outlined by the State. Further, these four MCOs increased their cumulative compliance score for Standard II—Access and Availability to 100 percent.

HSAG found that all five MCOs had implemented interventions to address required actions related to ensuring member handbooks include required information; however, only one MCO (Health Choice UMIC) successfully addressed all required actions. HSAG found that four MCOs (Healthy U Integrated,

Molina UMIC, SelectHealth CC UMIC, and HOME) had not revised member handbooks available to members on MCO websites, resulting in continued required actions.

The statewide average score for the Integrated MCOs was lowest for the Grievance and Appeal system standard, with Molina UMIC being the only MCO that addressed all CY 2021 required actions. Most MCOs had grievance and appeal policies and procedures that were compliant with Medicaid managed care regulations and State contract requirements regarding accepting, reviewing, and responding to appeals and grievances. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 grievance and appeal record reviews. For four MCOs (Health Choice UMIC, Healthy U Integrated, SelectHealth CC UMIC, and HOME), HSAG found that many appeal and grievance records lacked full compliance. For example, records did not include complete documentation to provide evidence of compliance with requirements related to sending acknowledgement and resolution letters.

In CY 2022, HSAG found that three MCOs (Health Choice UMIC, Molina UMIC, and SelectHealth CC UMIC) had successfully addressed most required actions related to providing required information to providers and subcontractors when they enter a contract. Further, HSAG found that four MCOs (Health Choice UMIC, Molina UMIC, SelectHealth CC, and HOME) had updated their compliance programs to contain required provisions. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 initial credentialing and recredentialing record reviews. HSAG found full compliance with the initial credentialing and recredentialing files reviewed across all five MCOs.

Regarding Standard VII—Subcontractual Relationships and Delegation, HSAG found that four MCOs (Health Choice UMIC, Healthy U Integrated, Molina UMIC, and HOME) had successfully implemented planned interventions to address all CY 2022 required actions, resulting in full compliance. The MCO statewide average score changed from 75 percent in CY 2021 to 98 percent in CY 2022.

PMHPs

For the CY 2021 compliance reviews, HSAG conducted an assessment of the PMHPs' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2022, HSAG conducted a review of each PMHP's implementation of interventions to address CY 2021 required corrective actions. In addition, HSAG conducted a review of a sample of pre-service authorization denials, appeals, grievances, initial credentialing, and recredentialing records.

Table B-15 provides the standard scores and overall compliance scores for each Medicaid PMHP. Shading indicates that HSAG found the standard to be in full compliance curing the CY 2021 compliance review. HSAG did not conduct a further review of these standards in CY 2022. Statewide averages from CY 2021 and CY 2022 are included for comparison.

Table B-15—Standard Compliance Scores by PMHP

Standard	Bear River	Central	Davis	Four Corners	Healthy U Behavioral	North-eastern	Optum Tooele	Salt Lake	South-west	Wasatch	Weber	CY 2021 State-wide Avg	CY 2022 State-wide Avg
Standard I—Coverage and Authorization of Services	98%	100%	100%	100%	94%	100%	100%	100%	100%	100%	98%	96%	99%
Standard II—Access and Availability	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	96%	100%
Standard III—Coordination and Continuity of Care	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	99%
Standard IV—Member Rights and Information (Includes Confidentiality	94%	98%	98%	98%	96%	100%	98%	98%	100%	92%	98%	84%	97%
Standard V—Grievance and Appeal System	93%	95%	100%	95%	91%	100%	100%	96%	100%	95%	96%	90%	96%
Standard VI—Provider Selection and Program Integrity	95%	97%	97%	95%	97%	97%	100%	100%	100%	95%	100%	94%	98%
Standard VII—Subcontractual Relationships and Delegation	NA	NA	NA	NA	100%	NA	75%	100%	NA	NA	NA	54%	92%
Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	97%	100%
Standard IX—Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Weighted Score*	**96%**	**98%**	**99%**	**98%**	**96%**	**100%**	**99%**	**99%**	**100%**	**96%**	**98%**	**93%**	**98%**

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

Although the 11 PMHPs were spread across the State and continued to have different needs and challenges within their member populations and regional service areas, HSAG was able to identify trends by comparing findings across these 11 organizations. Across all PMHPs, statewide average scores for the standards reviewed in CY 2022 improved from CY 2021. In CY 2022, statewide average scores were highest for Standard II—Access and Availability, which improved from 96 percent in CY 2021 to 100 percent in CY 2022, and Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems, which improved from 97 percent to 100 percent. Additionally, statewide average scores for all standards except Standard VII—Subcontractual Relationships and Delegation were above 95 percent, indicating strong compliance with Medicaid managed care regulations and State contract requirements. Overall, HSAG found that MCOs had implemented planned interventions to address the majority of CY 2021 required corrective actions.

In CY 2021, three PMHPs (Central, Northeastern, and Davis) achieved full compliance in Standard I—Coverage and Authorization of Services. Following the review in CY 2022, HSAG found that five additional PMHPs (Four Corners, Optum/Tooele, Salt Lake, Southwest, and Wasatch) had improved their scores for Standard I to 100 percent, indicating full compliance with requirements. Two remaining PMHPs (Bear River and Healthy U Behavioral) had continued required actions related to ensuring policies include accurate and complete information. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 denial record reviews. Most PMHPs (Bear River, Central, Davis, Four Corners, Optum/Tooele, Salt Lake, Southwest, and Wasatch) did not report any pre-service authorization denials for the period under review. HSAG found full compliance with pre-service authorization denial records reviewed for Northeastern. The two remaining PMHPs (Healthy U Behavioral and Weber) received required actions based on HSAG's review of pre-authorization denial records that related to ensuring member notices are sent in a timely manner, include required content, and meet language and format requirements of 42 CFR §438.10(c).

In CY 2021, four PMHPs (Central, Northeastern, Optum, and Salt Lake) demonstrated full compliance with requirements in Standard II—Access and Availability. Following the review in CY 2022, HSAG found that six additional PMHPs (Bear River, Davis, Four Corners, Healthy U Behavioral, Southwest, and Weber) had improved their compliance scores for Standard II to 100 percent. Only one PMHP (Wasatch) had continued required actions related to Standard II.

In CY 2021, HSAG found that eight PMHPs (Davis, Four Corners, Healthy U Behavioral, Northeastern, Optum/Tooele, Salt Lake, Southwest, and Wasatch) were in full compliance with the requirements in Standard III—Coordination and Continuity of Care. In CY 2022, Central and Weber implemented required actions, which improved their compliance scores to 100 percent. Only one PMHP (Bear River) had continued required actions related to Standard III.

Regarding Standard IV—Member Rights and Information, in CY 2022 HSAG found that all PMHPs had implemented interventions to address required actions, and that two PMHPs (Northeastern and Southwest) had achieved full compliance. HSAG found that six PMHPs (Bear River, Central, Four

Corners, Healthy U Behavioral, Wasatch, and Weber) did not have an up-to-date member handbook with all required information present on their websites. Further, HSAG found that three PMHPs (Healthy U Behavioral, Optum/Tooele, and Salt Lake) had continued required actions related to ensuring provider directories are readily accessible (i.e., 508 compliant) as required by 42 CFR §438.10.

In CY 2022, four PMHPs (Davis, Northeastern, Optum/Tooele, and Southwest) achieved full compliance with the grievance and appeal systems standard. These four PMHPs and two additional PMHPs (Salt Lake and Weber) demonstrated grievance and appeal policies that met full requirements. Three PMHPs (Bear River, Central, and Wasatch) had policies that contained inaccurate information. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 grievance and appeal record reviews. Ten MCOs (Bear River, Central, Davis, Four Corners, Northeastern, Optum/Tooele, Salt Lake, Southwest, Wasatch, and Weber) reported that they did not have any prior-authorization denial decisions that were appealed during the period under review; therefore, HSAG did not review appeal records for these PMHPs. HSAG reviewed appeal records for one PMHP (Healthy U Integrated) and found that most appeal resolution notices did not meet the language and format requirements of §438.10. Two PMHPs (Healthy U Behavioral and Optum) reported that they did not receive any grievances from members during the period under review; therefore, HSAG did not review grievance records for these PMHPs. Four PMHPs (Central, Davis, Northeastern, and Southwest) achieved full compliance with the grievance record review requirements. HSAG found that across the five remaining PMHPs (Bear River, Four Corners, Salt Lake, Wasatch, and Weber), grievance records lacked full compliance related to grievance acknowledgment and resolution.

In CY 2022, four PMHPs (Optum/Tooele, Salt Lake, Southwest, and Weber) achieved full compliance in the provider selection and program integrity standard. HSAG found that eight PMHPs (Bear River, Central, Davis, Northeastern, Optum/Tooele, Salt Lake, Southwest, and Weber) had implemented interventions to address CY 2021 required corrective actions. HSAG found that these eight PMHPs had revised policies, provider and subcontract agreements, and/or compliance programs to meet requirements. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 initial credentialing and recredentialing record reviews. Six PMHPs (Bear River, Healthy U Behavioral, Optum/Tooele, Salt Lake, Southwest, and Weber) were in full compliance with initial credentialing record review requirements. HSAG found that five PMHPs (Davis, Healthy U Behavioral, Optum/Tooele, Salt Lake, and Weber) were in full compliance with the recredentialing record review requirements. Three PMHPs (Central, Four Corners, and Southwest) reported that they did not recredential any providers during the period under review. For the remaining PMHPs (Bear River, Northeastern, and Wasatch), HSAG found that initial credentialing and recredentialing records did not include evidence that the PMHP verified the provider's license prior to hire.

In CY 2022, the statewide average score was lowest for Standard VII—Subcontractual Relationships and Delegation; however, eight PMHPs did not delegate any administrative services; therefore, this standard was not applicable for these PMHPs. One PMHP (Healthy U Behavioral) improved its score to

100 percent based on the CY 2022 review, while one PMHP (Optum/Tooele) had continued required actions related to missing specific provisions within subcontracts. Optum/Tooele did, however, provide evidence that the required contract revisions were in progress.

Regarding Standard VIII—QAPIP, Practice Guidelines, and Health Information Systems, in CY 2022, HSAG found that Bear River, Central, Davis, Four Corners, Northeastern, and Southwest had implemented interventions to address CY 2021 required corrective actions and improved their scores in Standard VIII to 100 percent.

CHIP MCOs

For the CY 2021 compliance reviews, HSAG conducted an assessment of the CHIP MCOs' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2022, HSAG conducted a review of each CHIP MCO's implementation of planned interventions to address CY 2021 required corrective actions. In addition, HSAG conducted a review of a sample of pre-service authorization denials, appeals, grievances, initial credentialing, and recredentialing records.

Table B-16 provides the standard scores and overall compliance scores for each CHIP MCO. Shading indicates that HSAG found the standard to be in full compliance curing the CY 2021 compliance review. HSAG did not conduct a further review of these standards in CY 2022. Statewide averages from CY 2021 and CY 2022 are included for comparison.

Table B-16—Standard Compliance Scores by CHIP MCO

Standard	Molina CHIP	SelectHealth CHIP	CY 2021 Statewide Average	CY 2022 Statewide Average
Standard I— Coverage and Authorization of Services	96%	100%	93%	98%
Standard II— Access and Availability	96%	96%	89%	96%
Standard III— Coordination and Continuity of Care	100%	100%	100%	100%
Standard IV— Member Rights and Information (Includes Confidentiality	96%	96%	94%	96%
Standard V— Grievance and Appeal System	98%	100%	97%	99%
Standard VI— Provider Selection and Program Integrity	98%	100%	94%	99%
Standard VII— Subcontractual Relationships and Delegation	100%	88%	81%	94%
Standard VIII—	100%	100%	100%	100%

Standard	Molina CHIP	SelectHealth CHIP	CY 2021 Statewide Average	CY 2022 Statewide Average
Quality Assessment and Performance Improvement Program, Practice Guidelines, and Health Information Systems				
Standard IX—Enrollment and Disenrollment	100%	100%	100%	100%
Total Weighted Score*	**98%**	**99%**	**95%**	**99%**

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

HSAG identified commonalities when comparing the findings in these two organizations. The CY 2022 average scores for the two CHIP organizations improved from CY 2021. In CY 2022, the CHIP MCO average scores were highest for Standard V—Grievance and Appeal System, which improved from 97 percent in CY 2021 to 99 percent in CY 2022, and Standard VI—Provider Selection and Program Integrity, which improved from 94 percent to 99 percent. Additionally, the CHIP average scores for all standards except Standard VII—Subcontractual Relationships and Delegation were above 95 percent, indicating strong compliance with State and federal regulations. Overall, HSAG found that both CHIP MCOs had implemented planned interventions to address the majority of CY 2021 required corrective actions and had fully compliant systems for credentialing and recredentialing network providers, as evidenced by the initial credentialing and recredentialing record reviews.

Regarding coverage and authorization of services, both CHIP MCOs implemented interventions to address CY 2021 required corrective actions related to revising policies and procedures. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 denial record reviews. Although HSAG found that Molina CHIP's NABDs were missing required content at 42 CFR §438.404(b), both CHIP MCOs submitted denial records which included NABD letters that were easy to understand, with medical terms explained using easy to understand language.

Regarding access to care, in CY 2022, HSAG found that both CHIP MCOs had implemented interventions related to updating health plan policies, documents, and processes to reflect correct time and distance standards outlined by the State. However, HSAG found that neither CHIP MCO had made revised information available to members, resulting in continued required corrective actions.

Regarding member rights and information, HSAG found that both CHIP MCOs implemented interventions to address required corrective actions related to ensuring member handbooks include required information. Although required revisions were completed, neither CHIP MCO had made final versions of the handbooks available to members on its website, resulting in continued required actions.

HSAG found that both CHIP MCOs had updated grievance and appeal policies and procedures to ensure compliance with Medicaid managed care regulations and State contract requirements for accepting, reviewing, and responding to appeals and grievances. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 grievance and appeal record reviews. HSAG found that both CHIP MCOs' appeals and grievance records contained evidence that appeals and grievances were acknowledged and resolved in a timely manner and met requirements for this standard.

In CY 2022, HSAG found that the CHIP MCOs had successfully addressed most required actions related to providing required information to providers and subcontractors when they enter a contract. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 initial credentialing and recredentialing record reviews. HSAG found the two CHIP MCOs to be in full compliance with the initial credentialing and recredentialing files reviewed.

The CHIP MCOs' average score was lowest for Standard VII—Subcontractual Relationships and Delegation. While both CHIP MCOs had updated delegation agreements to include most requirements, HSAG found that there was one provision missing from SelectHealth CHIP's delegated agreements related to administrative services. Although SelectHealth CHIP had continued required actions related to this standard, improved scores for both CHIP MCOs improved the CHIP MCO average score from 81 percent in CY 2021 to 94 percent in CY 2022.

Medicaid and CHIP Dental PAHPs

For the CY 2021 compliance reviews, HSAG conducted an assessment of the Medicaid and CHIP dental PAHPs' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2022, HSAG conducted a review of each dental PAHP's implementation of planned interventions to address CY 2021 required corrective actions. In addition, HSAG conducted a review of a sample of pre-service authorization denials, appeals, grievances, initial credentialing, and recredentialing records.

Table B-17 provides the standard scores and overall compliance scores for the Medicaid and CHIP PAHPs. Shading indicates that HSAG found the standard to be in full compliance during the CY 2021 compliance review. HSAG did not conduct a further review of these standards in CY 2022. Statewide averages from CY 2021 and CY 2022 are included for comparison.

Table B-17—Standard Compliance Scores by Dental PAHP

Standard	Premier Medicaid	Premier CHIP	MCNA	CY 2021 Statewide Average	CY 2022 Statewide Average
Standard I— Coverage and Authorization of Services	95%	95%	100%	96%	97%

Standard	Premier Medicaid	Premier CHIP	MCNA	CY 2021 Statewide Average	CY 2022 Statewide Average
Standard II—Access and Availability	96%	96%	100%	94%	97%
Standard III—Coordination and Continuity of Care	100%	100%	100%	100%	100%
Standard IV—Member Rights and Information (Includes Confidentiality	93%	93%	98%	79%	95%
Standard V—Grievance and Appeal System	89%	88%	100%	82%	92%
Standard VI—Provider Selection and Program Integrity	88%	88%	98%	85%	91%
Standard VII—Subcontractual Relationships and Delegation	NA	NA	100%	75%	100%
Standard VIII—Quality Assessment and Performance Improvement Program, Practice Guidelines, and Health Information Systems	81%	81%	100%	85%	87%
Standard IX—Enrollment and Disenrollment	100%	100%	100%	100%	100%
Total Weighted Score*	**91%**	**91%**	**99%**	**87%**	**94%**

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

HSAG identified commonalities when comparing the findings for these two programs (Premier Access' and MCNA's Medicaid lines of business, and Premier Access CHIP line of business). For the Medicaid and CHIP dental PAHPs, statewide average scores for the standards reviewed in CY 2022 improved from CY 2021. In CY 2022, statewide average scores were highest for Standard I—Coverage and Authorization of Services, which improved from 96 percent in CY 2021 to 97 percent in CY 2022, and Standard II—Access and Availability, which improved from 94 percent to 97 percent. Additionally, statewide average scores for four out of seven standards reviewed in CY 2022 were above 95 percent, indicating improvement in compliance with State and federal regulations. Overall, HSAG found both Medicaid and CHIP dental PAHPs had implemented the majority of CY 2021 CAP findings and had fully compliant systems for credentialing network providers, as evidenced by the record review.

Regarding coverage and authorization of services, HSAG found that both Medicaid PAHPs and the CHIP PAHP had implemented planned interventions that addressed most CY 2021 required corrective

actions related to updating policies and NABD letter templates. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 denial record reviews. Although HSAG found that Premier Access Medicaid and Premier Access CHIP had required actions related to missing required content within NABDs, both Medicaid PAHPs and the CHIP PAHP submitted denial records which included NABD letters that were easy to understand and scored at or below a sixth-grade reading level using the Flesch-Kincaid readability test.

Regarding access to care, HSAG found that both Medicaid and CHIP dental PAHPs had implemented interventions that addressed most required actions to update health plan policies, documents, and processes to reflect and monitor accurate time and distance standards outlined by the State. Premier Access Medicaid and Premier Access CHIP had one continued required corrective action to ensure that the PAHP's access policies were complete. Regarding the member rights and information standard, HSAG found that both Medicaid PAHPs and the CHIP PAHP implemented required actions to ensure member handbooks include required information, such as taglines. However, although many required revisions were completed, both Medicaid PAHPs and the CHIP PAHP had continued required actions related to updating the member handbooks for completeness.

Across the Medicaid and CHIP dental PAHPs, HSAG found that the PAHPs had updated grievance and appeal policies and procedures to successfully address most required corrective actions to ensure compliance with Medicaid managed care regulations and State contract requirements for accepting, reviewing, and responding to appeals and grievances. Premier Access Medicaid and Premier Access CHIP, however, had continued required actions related to updating the policies and letter templates with accurate information regarding continuation of benefits during an appeal. For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 grievance and appeal record reviews. HSAG found that both Medicaid PAHPs and the CHIP PAHP acknowledged and resolved grievances and appeals in a timely manner and that member letters were written in easy-to-understand language, at a sixth-grade reading level, according to the Flesch-Kinkaid readability scale. However, HSAG found that Premier Access Medicaid and Premier Access CHIP did not document all grievances received, resulting in required corrective actions. As MCNA reported that it did not have any grievances for the period under review, HSAG recommended that the Medicaid and CHIP dental PAHPs ensure members are aware of the processes for submitting grievances and that member services staff are knowledgeable that any expression of dissatisfaction should be recorded as a grievance.

In CY 2022, HSAG found that the Medicaid PAHPs and CHIP PAHP had successfully addressed most required actions related to providing required information to providers and subcontractors when they enter a contract. Both Medicaid PAHPs and the CHIP PAHP received continued required corrective actions that related to updating the provider manual (MCNA) and developing well-publicized disciplinary guidelines pertaining to FWA (Premier Access Medicaid and Premier Access CHIP). For this standard, CY 2022 compliance scores represent results of a follow-up review of CY 2021 *Partially Met* and *Not Met* scores as well as results of the CY 2022 initial credentialing and recredentialing record

reviews. HSAG found all three dental PAHPS to be in full compliance with the initial credentialing and recredentialing record review requirements.

In CY 2022, Premier Access did not delegate any administrative services; therefore, Standard VII—Subcontractual Relationships and Delegation was not applicable to Premier Access Medicaid or Premier Access CHIP. MCNA successfully addressed all required corrective actions and improved its score for Standard VII from 75 percent in CY 2021 to 100 percent in CY 2022.

In CY 2022, while Premier Access Medicaid and Premier Access CHIP implemented interventions to address some required corrective actions for Standard VIII—QAPI, Practice Guidelines, and Health Information Systems, both PAHPs had continued required corrective actions related to ensuring their QAPIPs include information regarding PIPs, performance measures, quality measures, mechanisms to detect under- and over-utilization, and mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

Validation of Network Adequacy

Statewide Comparative Results

Table B-18 displays the number of provider categories meeting the time/distance standards by health plan statewide and by urbanicity. Health plans had to meet the standard for each urbanicity (i.e., urban, rural, and frontier) to meet the statewide time/distance standard for a provider category. UMIC plans operate only in urban areas. Since most PMHPs are inherently regional, statewide results are not presented for those regional health plans.

Overall, the Utah CY 2022 NAV results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider categories. Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards.

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for NAV, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activates—Validation of Network Adequacy.

Table B-18—Compliance With Time/Distance Standards by Health Plan, Statewide, and Urbanicity

		Statewide*		Frontier		Rural		Urban	
Health Plan	Number of Provider Categories	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard
ACOs									
Health Choice	56	58.9%	33	96.4%	54	78.6%	44	62.5%	35
Healthy U	56	75.0%	42	83.9%	47	76.8%	43	92.9%	52
Molina	56	71.4%	40	71.4%	40	78.6%	44	82.1%	46
SelectHealth CC	56	66.1%	37	67.9%	38	67.9%	38	76.8%	43
UMIC Plans and HOME MCO									
Health Choice UMIC	43	88.4%	38	NA	NA	NA	NA	88.4%	38
Healthy U Integrated	43	95.3%	41	NA	NA	NA	NA	95.3%	41
Home	55	94.5%	52	94.5%	52	94.5%	52	94.5%	52
Molina	43	86.0%	37	NA	NA	NA	NA	86.0%	37
SelectHealth CC UMIC	43	83.7%	36	NA	NA	NA	NA	83.7%	36
CHIP MCOs									
Molina CHIP	41	31.7%	13	34.1%	14	56.1%	23	56.1%	23
SelectHealth CHIP	41	26.8%	11	26.8%	11	46.3%	19	41.5%	17
PMHPs									
Bear River	10	30.0%	3	30.0%	3	30.0%	3	NA	NA
Central	12	25.0%	3	25.0%	3	25.0%	3	NA	NA
Davis	12	25.0%	3	NA	NA	NA	NA	25.0%	3
Four Corners	12	25.0%	3	25.0%	3	33.3%	4	NA	NA
Healthy U Behavioral	12	100.0%	12	NA	NA	100.0%	12	NA	NA
Northeastern	12	16.7%	2	16.7%	2	NA	NA	NA	NA

		Statewide*		Frontier		Rural		Urban	
Health Plan	Number of Provider Categories	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard
Optum/Tooele	12	91.7%	11	91.7%	11	NA	NA	NA	NA
Salt Lake	12	83.3%	10	NA	NA	NA	NA	83.3%	10
Southwest	12	41.7%	5	41.7%	5	41.7%	5	NA	NA
Wasatch	12	8.3%	1	NA	NA	NA	NA	8.3%	1
Weber	12	75.0%	9	NA	NA	75.0%	9	75.0%	9
PAHPs									
MCNA	2	50.0%	1	50.0%	1	100.0%	2	100.0%	2
Premier	2	100.0%	2	100.0%	2	100.0%	2	100.0%	2
CHIP PAHP									
Premier CHIP	2	100.0%	2	100.0%	2	100.0%	2	100.0%	2

NA refers to areas outside the serviced counties for each health plan or indicates that statewide results are not presented for PMHPs because they are regional.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Assessment of Health Plan Follow-Up on Prior Year's Recommendations

Medicaid ACOs Providing Physical Health Services

Health Choice Utah

Validation of Performance Improvement Projects

In CY 2022, Health Choice submitted a new PIP, *Well-Child Visits in the First 30 Months of Life*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG recommended that Health Choice focus its improvement efforts on the following:

- Reducing barriers for members to attend office visits for women's health services and well-child visits (e.g., member incentives such as gift cards for completing annual preventive services, ensure access to transportation for parents with multiple children, seamless access to interpreter services, offer home-based services or mobile clinics).
- Educational campaigns that focus on member/parents' concerns about disease control procedures in provider offices during the COVID-19 pandemic, and the impact of health care on the physical and social development of children and adolescents.
- Provider incentives for partnering with Health Choice on outreach to members with missing preventive services, such as VBR payment structures that reward higher performance on targeted HEDIS measures.

Health Choice Utah reported the following initiatives designed to address HSAG's CY 2021 recommendations:

- Health Choice reported working collaboratively with DHHS and other ACOs on a well-child visit PIP. Health Choice also reported active participation to offer suggestions for initiatives based on feedback from in-network PCPs during monthly QI meetings.
- To facilitate women receiving a mammogram for breast cancer screenings, Health Choice Utah reported that it will be offering a $50 gift card incentive for members in the eligible population for the *BCS* [*Breast Cancer Screening*] measure, who had a mammogram performed by the end of 2022.
- Health Choice Utah's chief medical officer has created an educational video to be shared through social media and with provider offices to either play in their offices or share with their patients on

well-child visits, what to expect, and the impact of health care on the physical and social development of children and adolescents. Dr. Ferguson has also created a Member Focus Group composed of several Medicaid members in order to seek insight directly from members on barriers to care, patient satisfaction, among other health care related topics.

- Health Choice has contracted with Welltok to help with member outreach campaigns. The initial campaign will focus on members who are not established with a PCP. It will offer resources to help them establish with a PCP in an effort to improve members' overall health by encouraging the completion of preventive screenings.
- Health Choice has hired community health workers to connect with members on a more personal level. The goal will be to address and overcome barriers for members that may prevent them from seeking appropriate care.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- QAPIP, Practice Guidelines, and Health Information Systems

Following the CY 2021 compliance review, Health Choice submitted a CAP to address requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Health Choice had successfully implemented interventions to address outstanding required actions related to the Member Rights and Information, and Subcontractual Relationships and Delegation standards. HSAG identified 13 ongoing required corrective actions related to the Coverage and Authorization; Access and Availability; Grievance and Appeal System; Provider Selection and Program Integrity; and QAPIP, Practice Guidelines, and Health Information standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Health Choice's provider network and identified network inadequacies compared to DHHS' minimum time and

distance network standards. Regarding Health Choice's provider network, HSAG recommended that Health Choice conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Health Choice, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Health Choice reported that Network Adequacy reports will be run quarterly to compare the Health Choice Network to DHHS requirements. Additionally, Health Choice reported that any counties found to be inadequate in primary care or specialty providers were discussed at Health Choice's quarterly QMUM (Quality Management/Utilization Management) meeting, of which the Contracting Committee is a subcommittee. Each quarter, network service representatives were tasked with outreach and contracting with providers as necessary to bring each county into compliance with network adequacy standards.

In CY 2022, HSAG reevaluated Health Choice's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy U

Validation of Performance Improvement Projects

In CY 2022, Health Choice submitted a new PIP, *Well-Child Visits in the First 30 Months of Life*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG recommended that Healthy U focus improvement efforts on the following:

- Reducing barriers for members to attend office visits for women's health services and well-child visits (e.g., member incentives such as gift cards for completing annual preventive services, ensure access to transportation for parents with multiple children, seamless access to interpreter services, offer home-based services or mobile clinics).
- Educational campaigns that focus on member/parents' concerns about disease control procedures in provider offices during the COVID-19 pandemic, and the impact of health care on the physical and social development of children and adolescents.
- Provider incentives to partner on outreach to members with missing preventive services, such as VBR payment structures that reward higher performance on targeted HEDIS measures.

In response to HSAG's recommendations, Healthy U reported that it continues to conduct outreach to members and providers to increase compliance rates on multiple measures, and it offers member incentives for completing well-child visits. Healthy U reported it is developing VBP arrangements with select provider groups which will include provider incentives for closing care gaps. Healthy U is also

launching a new text messaging campaign to help members select an in-network PCP. Healthy U is also collaborating with Center for Hope on a text message campaign wherein children 9 to 14 years of age on Medicaid will receive a text message if they are due for their HPV vaccination. Healthy U has also developed educational materials for our providers on appropriate diabetic care which have been distributed through provider newsletters. Healthy U has adopted clinical practice guidelines in support of appropriate use of imaging for low back pain, which were distributed to providers through the newsletter and are available on Healthy U's website.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the CY 2021 compliance review, Healthy U submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Healthy U had successfully implemented interventions to address all outstanding required corrective actions related to the Access and Availability and Subcontractual Relationships and Delegation standards. HSAG identified 12 ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U's provider network, HSAG recommended that Healthy U conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Healthy U, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Healthy U did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Healthy U's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Molina Healthcare of Utah

Validation of Performance Improvement Projects

In CY 2022, Molina submitted a new PIP, *Well-Child Visits in the First 30 Months of Life*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG recommended that Molina focus improvement efforts on the following:

- Reducing barriers for members to attend office visits for women's health services and well-child visits (e.g., member incentives such as gift cards for completing annual preventive services, ensure access to transportation for parents with multiple children, seamless access to interpreter services, offer home-based services or mobile clinics).
- Educational campaigns that focus on member/parents' concerns about disease control procedures in provider offices during the COVID-19 pandemic, and the impact of health care on the physical and social development of children and adolescents.
- Provider incentives to partner on outreach to members with missing preventive services, such as VBR payment structures that reward higher performance on targeted HEDIS measures.

In response to HSAG's recommendations, Molina reported several performance improvement efforts underway:

- A pay-for-quality program in which providers receive quarterly bonus payments (97 groups in 2021; 34 opt-in groups in 2022)
- An in-home postpartum follow-up examination through the Care Connections program
- Omnichannel communication to educate and inform members regarding services, benefits, programs, etc.
- Provider EHR messaging to identify missed services
- Outbound scheduling by a vendor to close service gaps
- Pregnant members receive an incentive (gift box) for providing early pregnancy notification to the ACO
- Prenatal Food Box with prepared meals delivered to members completing an early prenatal visit

- Postpartum Farm Box with fresh produce delivered to members completing postpartum care
- Health fair for Molina members where immunizations and well-care visits were provided

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, Molina submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Molina had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards. HSAG identified four ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina's provider network, HSAG recommended that Molina conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Molina, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Molina reported that it will be implementing a new proprietary network adequacy monitoring solution, Quest Analytics, to enhance Molina's ability to monitor provider networks and health care accessibility.

In CY 2022, HSAG reevaluated Molina's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

SelectHealth Community Care

Validation of Performance Improvement Projects

In CY 2022, SelectHealth CC submitted a new PIP, *Well-Child Visits in the First 30 Months of Life*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG recommended that SelectHealth CC focus targeted improvement efforts on the following:

- Reducing barriers for parents to attend office visits for women's health services and well-care visits (e.g., member incentives such as gift cards for completing annual preventive services, ensure access to transportation for parents with multiple children, seamless access to interpreter services, offer home-based services or mobile clinics).
- Educational campaigns that focus on member/parents' concerns about disease control procedures in provider offices during the COVID-19 pandemic, and the impact of health care on the physical and social development of children and adolescents.
- Provider incentives to partner on outreach to members with missing preventive services, such as VBR payment structures that reward higher performance on targeted HEDIS measures.

In response to HSAG's recommendations SelectHealth CC reported several quality initiatives such as the following:

- Intermountain Healthcare reported that it has a mobile mammography unit that decreases barriers by improving access.
- Participating in a workgroup with Intermountain Healthcare, R1 Revenue Cycle Management (R1 RCM), and Castell, which works to increase access, improve scheduling, and coordinate efforts to maximize screenings.
- The Medical Home program includes incentive measures for which providers must achieve targeted screening rates. Clinics enrolled in the program are able to track gaps in care through a provider portal which helps them to monitor performance and educate patients.
- SelectHealth has built a Quality Ribbon Program to publicly report certain HEDIS results by provider in the format of comparing to the national benchmarks. The goal of this program is to allow members to see quality information on providers and to promote quality care by providers by publishing ratings.
- SelectHealth employs the Choosing Wisely campaign launched by Intermountain Healthcare for members and providers, which uses national guidelines and recommendations for care process models in addition to providing resources for decision making at the point of care. This model helps

members and providers avoid unnecessary imaging tests for low back pain unless red flags exist for serious pathology or injury.

- SelectHealth conducts member outreach for Medicaid members through a vendor that performs IVR calls, email, and text reminders.
- SelectHealth has updated the time frame policy for pediatric well visits to remove the every-12-month limitation on scheduling these visits. The hope is that this will assist providers in getting pediatric patients in for well visits as it allows for some flexibility to help shift patients back to normal schedules following the pandemic.
- SelectHealth reported working on a pilot project that focuses on members not affiliated with a PCP (i.e., kids without a PCP are less likely to receive well care). This project will include live phone outreach to parents to help find a provider and schedule a well exam.
- SelectHealth conducts immunization incentive and reminder programs that also encourage parents to schedule well visits.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, SelectHealth CC submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that SelectHealth CC had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services and Provider Selection and Program Integrity standards. HSAG identified four ongoing required corrective actions related to the Access and Availability, Member Rights and Information, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate SelectHealth's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding SelectHealth's provider network, HSAG recommended that SelectHealth conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with SelectHealth, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

SelectHealth did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated SelectHealth's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

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

Health Choice UMIC

Validation of Performance Improvement Projects

Health Choice UMIC's *Follow-Up After Hospitalization for Mental Illness* PIP received a *Met* score for 76 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG identified opportunities for improvement related to the documentation of the causal barrier analysis process and evaluation data for the interventions. In the CY 2022 submission, the health plan addressed the identified deficiencies.

Validation of Performance Measures

In CY 2021, HSAG recommended that Health Choice UMIC focus its improvement efforts on the following:

- Educational campaigns that focus on member concerns about disease control procedures in provider offices during the COVID-19 pandemic.
- Encourage providers with low performance to offer text reminders to members about scheduled appointments and help providers through care coordination for members who need transportation or help with other barriers to treatment.

- Provider incentives, such as VBR payment structures that reward higher performance, targeted toward:
  - Behavioral health providers that treat members with severe and persistent mental illness (SPMI) or SUDs such as community mental health agencies or SUD treatment facilities that can partner on outreach to members.
  - Providers who offer integrated physical and behavioral health care for members with SPMI or SUD conditions who have common co-occurring chronic medical conditions that require treatment (e.g., diabetes, hypertension, chronic pain).

Health Choice UMIC reported the following initiatives designed to address performance:

- All ACOs are working collaboratively with DHHS on a well-child visit PIP, and Health Choice UMIC has been vocal in that participation to offer suggestions for initiatives based on feedback from in-network PCPs during monthly QI meetings.
- To facilitate women receiving a mammogram for breast cancer screenings, Health Choice UMIC will be offering a $50 gift card incentive for members currently eligible for the *BCS* measure, who have a mammogram performed by the end of 2022.
- Health Choice UMIC's chief medical officer has created a Member Focus Group composed of several Medicaid members, in order to seek insight directly from our members on barriers to care, patient satisfaction, among other health care related topics.
- Health Choice UMIC has contracted with Welltok to help with member outreach campaigns. The initial campaign will focus on members who are not established with a PCP. It will offer resources to help them establish with a PCP in an effort to improve our member's overall health by encouraging the completion of preventive screenings.
- Health Choice UMIC has hired community health workers to connect with members on a more personal level. The goal will be to address and overcome barriers for members that may prevent them from seeking appropriate care.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Health Choice UMIC submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Health Choice UMIC had successfully implemented interventions to address all outstanding required actions related to the Member Rights and Information, and Subcontractual Relationships and Delegation standards. HSAG identified 13 ongoing required corrective actions related to the Coverage and Authorization; Access and Availability; Grievance and Appeal System; Provider Selection and Program Integrity; and QAPIP, Practice Guidelines, and Health Information standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Health Choice UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Health Choice UMIC's provider network, HSAG recommended that Health Choice UMIC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Health Choice UMIC, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To accommodate HSAG's NAV recommendations, Health Choice UMIC reported that Network Adequacy reports will be run quarterly to compare the Health Choice UMIC Network to DHHS requirements. Additionally, any counties found to be inadequate in primary care or specialty providers will be reported at Health Choice UMIC's quarterly QMUM meeting, of which the Contracting Committee is a subcommittee. Each quarter, network service representatives will be tasked with outreach and contracting with providers as necessary to bring each county into compliance with network adequacy standards.

In CY 2022, HSAG reevaluated Health Choice UMIC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy Outcomes Medical Excellence (HOME)

Validation of Performance Improvement Projects

In CY 2022, HOME submitted a new PIP*, Impact of Interventions on Improving Rate of Annual Physical Examinations Performed in the Clinic*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG recommended that HOME conduct additional validation on the data entered into its Microsoft Excel spreadsheet used for reporting to ensure there are no errors. Although the errors noted during PSV did not impact numerator compliance in this instance, these types of errors could potentially impact compliance in the future, causing rates to be reported incorrectly.

In response to HSAG's recommendations, HOME reported that its data and UM team introduced an additional step of data validation to ensure compliance with rate reporting. Before final calculation of the *FUH* rates, a UM member cross-checks the compiled data for the accuracy of information and to identify the level and source of error (hospital tracking sheet; claims data; and patient medical records) from Epic, the EHR system, if any. Any discrepancy found is discussed with associated HOME staff member(s) to eliminate errors for future reporting.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, HOME submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that HOME had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards. HSAG identified six ongoing required corrective actions related to the Member Rights and Information and Grievance and Appeal System standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate HOME's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding HOME's provider network, HSAG recommended that HOME conduct ongoing assessments of its provider network to identify those providers, if any, who chose not

to contract with HOME, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

HOME did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated HOME's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy U Integrated

Validation of Performance Improvement Projects

Healthy U Integrated's *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP received a *Met* score for 93 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG identified an opportunity for improvement related to the documentation of the barrier prioritization process. In the CY 2022 submission, the health plan addressed the identified deficiency.

Validation of Performance Measures

In CY 2021, HSAG recommended that Healthy U Integrated focus improvement efforts on the following:

- Educational campaigns that focus on member concerns about disease control procedures in provider offices during the COVID-19 pandemic.
- Encourage providers with low performance to offer text reminders to members about scheduled appointments and help providers through care coordination for members who need transportation or help with other barriers to treatment.
- Provider incentives, such as VBR payment structures that reward higher performance, targeted toward:
  - Behavioral health providers that treat members with SPMI or SUDs such as community mental health agencies or SUD treatment facilities that can partner on outreach to members.
  - Providers who offer integrated physical and behavioral health care for members with SPMI or SUD conditions who have common co-occurring chronic medical conditions that require treatment (e.g., diabetes, hypertension, chronic pain).

In response to HSAG's recommendations, Healthy U Integrated reported that it continues to conduct outreach to members and providers to increase compliance rates on multiple measures, and it offers member incentives for completing well-child visits. Healthy U reported that it is developing VBP arrangements with select provider groups which will include provider incentives for closing care gaps.

Healthy U Integrated is also launching a new text messaging campaign to help members select an in-network PCP. Healthy U Integrated is also collaborating with Center for Hope on a text message campaign wherein children 9 to 14 years of age on Medicaid will receive a text message if they are due for their HPV vaccination. Healthy U Integrated has also developed educational materials for our providers on appropriate diabetic care which have been distributed through provider newsletters. Healthy U Integrated has adopted clinical practice guidelines in support of appropriate use of imaging for low back pain, which were distributed to providers through the newsletter and are available on Healthy U Integrated's website. Finally, Healthy U Integrated care managers work with discharge planners in finding in-network providers and timely follow-up appointments for members who are hospitalized due to mental illness.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, Healthy U Integrated submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Healthy U Integrated had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, and Subcontractual Relationships and Delegation standards. HSAG identified 13 ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U Integrated's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U Integrated's provider network, HSAG recommended that Healthy U Integrated conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Healthy U Integrated, and to

investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Healthy U Integrated did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Healthy U Integrated's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Molina UMIC

Validation of Performance Improvement Projects

Molina UMIC's *Follow-Up After Hospitalization for Mental Illness* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG recommended that Molina UMIC focus improvement efforts on the following:

- Educational campaigns that focus on member concerns about disease control procedures in provider offices during the COVID-19 pandemic.
- Encourage providers with low performance to offer text reminders to members about scheduled appointments and help providers through care coordination for members who need transportation or help with other barriers to treatment.
- Provider incentives, such as VBR payment structures that reward higher performance, targeted toward:
  - Behavioral health providers that treat members with SPMI or SUD such as community mental health agencies or SUD treatment facilities that can partner on outreach to members.
  - Providers who offer integrated physical and behavioral health care for members with SPMI or SUD conditions who have common co-occurring chronic medical conditions that require treatment (e.g., diabetes, hypertension, chronic pain).

In response to HSAG's recommendations, Molina UMIC reported several performance improvement efforts underway:

- A pay-for-quality program in which providers receive quarterly bonus payments (97 groups in 2021; 34 opt-in groups in 2022)
- Omnichannel communication to educate and inform members regarding services, benefits, programs, etc.

- Provider EHR messaging to identify missed services.
- Outbound calls/in-person visits by licensed behavioral health providers to members discharged with behavioral health or substance use diagnosis to complete follow-up services.
- Pregnant members receive an incentive (gift box) for providing early pregnancy notification.
- Prenatal Food Box with prepared meals delivered to members completing early prenatal visit.
- Postpartum Farm Box with fresh produce delivered to members completing postpartum care.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, Molina UMIC submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Molina UMIC had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards. HSAG identified four ongoing required corrective actions related to the Coverage and Authorization, Member Rights and Information, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina UMIC's provider network, HSAG recommended that Molina UMIC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Molina UMIC, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Molina UMIC reported they will be implementing a new proprietary network adequacy monitoring solution, Quest Analytics, to enhance Molina UMIC's ability to monitor provider networks and health care accessibility.

In CY 2022, HSAG reevaluated Molina UMIC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

SelectHealth CC UMIC

Validation of Performance Improvement Projects

SelectHealth CC UMIC's *Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG recommended that SelectHealth CC UMIC focus targeted improvement efforts on the following:

- Educational campaigns that focus on member concerns about disease control procedures in provider offices during the COVID-19 pandemic.
- Encourage providers with low performance to offer text reminders to members about scheduled appointments and help providers through care coordination for members who need transportation or help with other barriers to treatment.
- Provider incentives, such as VBR payment structures that reward higher performance, targeted toward:
  - Behavioral health providers that treat members with SPMI or SUD such as community mental health agencies or SUD treatment facilities that can partner on outreach to members.
  - Providers who offer integrated physical and behavioral health care for members with SPMI or SUD conditions who have common co-occurring chronic medical conditions that require treatment (e.g., diabetes, hypertension, chronic pain).

In response to HSAG's recommendations SelectHealth CC UMIC reported several quality initiatives such as the following:

- Intermountain Healthcare has a mobile mammography unit that decreases barriers by improving access.

- SelectHealth CC UMIC participates in a workgroup with Intermountain Healthcare, R1 RCM, and Castell which works to increase access, improve scheduling, and coordinate efforts to maximize screenings.
- The Medical Home program includes incentive measures that must hit targeted screening rates. Clinics enrolled in the program are able to track gaps in care through a provider portal which helps them to monitor performance and educate patients about the importance of screening.
- SelectHealth CC UMIC has built a Quality Ribbon Program to publicly report certain HEDIS results by provider in the format of comparing to the national benchmarks. The goal of this program is to allow members to see quality information on providers and to promote quality care by our providers by publishing ratings.
- SelectHealth CC UMIC employs the Choosing Wisely campaign launched by Intermountain Healthcare for members and providers which uses national guidelines and recommendations for care process models in addition to providing resources for decision making at the point of care. This model helps members and providers avoid unnecessary imaging tests for low back pain unless red flags exist for serious pathology or injury.
- SelectHealth CC UMIC reported that it conducts member outreach for Medicaid members through a vendor that performs IVR calls, email, and text reminders.
- SelectHealth CC UMIC reported that it has updated the time frame policy for pediatric well visits to remove the every-12-month limitation on scheduling these visits. The hope is that this will assist providers in getting pediatric patients in for well visits as it allows for some flexibility to help shift patients back to normal schedules following the pandemic.
- SelectHealth CC UMIC is currently working on a pilot project that focuses on members not affiliated with a PCP (i.e., kids without a PCP are less likely to receive well care). This project will include live phone outreach to parents to help find a provider and schedule a well exam.
- SelectHealth CC UMIC conducts immunization incentive and reminder programs that also encourage parents to schedule well visits.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, SelectHealth CC UMIC submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that SelectHealth CC UMIC had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, and Provider Selection and Program Integrity standards. HSAG identified six ongoing required corrective actions related to the Member Rights and Information, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate SelectHealth CC UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding SelectHealth CC UMIC's provider network, HSAG recommended that SelectHealth CC UMIC conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with SelectHealth CC UMIC, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

SelectHealth CC UMIC did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated SelectHealth CC UMIC's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

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

Bear River Mental Health Services

Validation of Performance Improvement Projects

Bear River's *Suicide Prevention* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

To ensure the accuracy of its performance measure rates, HSAG recommended that Bear River select a sample of compliant, noncompliant, and excluded cases for review to confirm proper categorization for future reporting. HSAG also recommended that Bear River closely monitor and compare overall performance year by year to ensure data anomalies are identified and addressed and ensure Bear River can monitor access to and timeliness of care for its members and can take prompt action if necessary.

Bear River reported that in response to HSAG's recommendations, it hired an individual who tracks hospitalizations of all clients and performs follow-up.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Bear River submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Bear River had successfully implemented interventions to address outstanding required actions related to the Access and Availability and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified 11 ongoing required corrective actions related to the Coverage and Authorization of Services, Coordination and Continuity of Care, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Bear River's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Bear River's provider network, HSAG recommended that Bear

River conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Bear River, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Bear River did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Bear River's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Central Utah Counseling Center

Validation of Performance Improvement Projects

Central's *Inpatient Readmission Rates* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG recommended that Central continue to standardize the way it calculates and validates the performance measure and noted that a final verification of all discharges in the denominator against the member's discharge summary would help ensure the accuracy of the discharge dates used in the measure calculation.

Central reported that in response to HSAG's recommendations, it implemented the recommended additional fields in its tracking sheet for the performance measure, which was noted to eliminate errors in reporting.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coordination and Continuity of Care
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Central submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Central had successfully implemented interventions to address all outstanding required actions related to the Coordination and Continuity of Care and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified five ongoing required corrective actions related to the Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Central's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Central's provider network, HSAG recommended that Central conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Central, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Central did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Central's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Davis Behavioral Health

Validation of Performance Improvement Projects

Davis' *Access to Care* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for Davis during the PMV review.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Access and Availability

- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Davis submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Davis had successfully implemented interventions to address all outstanding required actions related to the Access and Availability; Grievance and Appeal System; and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified two ongoing required corrective actions related to the Member Rights and Information and the Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Davis' provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Davis' provider network, HSAG recommended that Davis conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Davis, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Davis did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Davis' provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Four Corners Community Behavioral Health

Validation of Performance Improvement Projects

Four Corners' *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder* PIP received a *Met* score for 67 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG identified opportunities for improvement related to the documentation of narrative interpretation of results, the causal barrier analysis process, and interventions evaluation data. In the CY 2022 submission, Four Corners addressed the identified deficiencies.

Validation of Performance Measures

In CY 2021, HSAG recommended that Four Corners perform additional validation on its numerator positive cases and eligible population in the denominator to reduce potential errors. The recommendation noted that validation could include checking the following:

- Age at the time of discharge
- That the follow-up and discharge do not occur on the same day
- For readmissions within 30 days that the date of discharge is not after December 1 of the MY.

Four Corners did not provide a response to the CY 2021 HSAG recommendations for PMV.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Four Corners submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Four Corners had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services; Access and Availability; and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified six ongoing required corrective actions related to the Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Four Corners' provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Four Corners' provider network, HSAG recommended that Four Corners conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Four Corners, and to investigate barriers to accurately reporting and

classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Four Corners did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Four Corners' provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Healthy U Behavioral

Validation of Performance Improvement Projects

Healthy U Behavioral's *Improving Follow-up After Hospitalization for Mental Illness* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for Healthy U Behavioral during the PMV review.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, Healthy U Behavioral submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess all outstanding required actions from CY 2021. HSAG found that Healthy U Behavioral had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, and Subcontractual Relationships and Delegation standards. HSAG identified 11 ongoing required corrective actions related

to the Coverage and Authorization of Services, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U Behavioral's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U Behavioral's provider network, HSAG recommended that Healthy U Behavioral conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Healthy U Behavioral, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Healthy U Behavioral did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Healthy U Behavioral's provider network and did not identify any ongoing network inadequacies, as detailed in Section 2 of this report.

Northeastern Counseling Center

Validation of Performance Improvement Projects

Northeastern's *Inpatient Post Discharge Engagement and Suicide Intervention* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for Northeastern during the PMV review.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Northeastern submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review, to assess outstanding required actions from CY 2021. HSAG found that Northeastern had successfully implemented interventions to address all outstanding required actions related to the Member Rights and Information; Grievance and Appeal System; and QAPIP, Practice Guidelines, and Health Information Systems standards. HSAG identified one ongoing required corrective action related to the Provider Selection and Program Integrity standard that was not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Northeastern's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Northeastern's provider network, HSAG recommended that Northeastern conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Northeastern, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Northeastern did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Northeastern's provider network and identified the ongoing network inadequacies detailed above Section 2 of this report.

Optum/Tooele

Validation of Performance Improvement Projects

Optum/Tooele did not submit a PIP for validation in 2021. Therefore, this section in *Not Applicable* for Optum/Tooele.

Validation of Performance Measures

In CY 2021, HSAG recommended that Optum/Tooele take an additional validation step and update potential source code to ensure data captured within myAvatar match future rate submissions to eliminate potential errors.

Optum/Tooele reported that it initiated the following efforts to address performance:

- The Optum/Tooele Utilization Management Team meets monthly to review the data related to inpatient utilization. The clinical manager includes information related to specific cases when appropriate to explore the potential impact of barriers to follow-up appointments.
- Optum/Tooele has added an Assertive Outreach Team to support adults in their transition to community-based treatment from inpatient services.
- Transportation costs have been evaluated and addressed to ensure youth have access to day treatment services.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, Optum/Tooele completed a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Optum/Tooele had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Grievance and Appeal System, and Provider Selection and Program Integrity standards. HSAG identified two ongoing required corrective actions related to the Member Rights and Information and the Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Optum/Tooele's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Optum/Tooele's provider network, HSAG recommended that Optum/Tooele conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Optum, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To accommodate HSAG's NAV recommendations, Optum/Tooele reported that it will be implementing an internal GeoAccess study. Optum/Tooele will also continue to pursue contracting opportunities with additional providers to expand network access in Toole County.

In CY 2022, HSAG reevaluated Optum/Tooele's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Salt Lake County Division of Behavioral Health Services

Validation of Performance Improvement Projects

Salt Lake's *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG identified opportunities for improvement related to achieving improvement in the performance indicator results. In the CY 2022 submission, Salt Lake indicated that it was unable to collect accurate performance indicator data and therefore discontinued the PIP.

Validation of Performance Measures

In CY 2021, due to undercounting Assertive Community Treatment (ACT) services provided after discharge because of monthly billing practices, HSAG recommended that Salt Lake implement updated source code logic once developed and fully tested to ensure that the ACT services provided were captured for numerator compliance.

Salt Lake reported that it put in place several efforts to address the CY 2021 recommendations:

- Salt Lake reported the ability to ensure an accurate count of ACT members receiving seven- and 30-day *FUH* appointments.
- Salt Lake conducts quarterly Provider Advisory Committee meetings where network providers are able to relay challenges, barriers, as well as solutions to timely follow-up visits for members. This feedback is also relayed to other quality committees to include Utilization Management and the Quality Assurance and Performance Improvement committees. The Salt Lake Division of Behavioral Health Services (DBHS) participates in all of these committees. Subsequently, data can be mined to better understand the extent of the challenges and possible solutions.
- Provider Satisfaction Surveys are offered annually, and results are reviewed with quality subcommittees, the Salt Lake QAPI Committee, DBHS, and all departments within Salt Lake County. Possible drivers for responses and plans to respond to provider concerns are included.
- Salt Lake is taking a deeper dive into the data related to *FUH* for a possible PIP. Year-over-year analysis indicates relatively stable rates in spite of the volume of members who are receiving inpatient services. We want to better understand the needs and nuances of the approximate 33 percent who struggle to connect with a provider in a timely manner.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity

Following the review, Salt Lake submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to address outstanding required actions from CY 2021. HSAG found that Salt Lake had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services, and the Provider Selection and Program Integrity standards. HSAG identified three ongoing required corrective actions related to the Member Rights and Information and the Grievance and Appeal System standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Salt Lake's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Salt Lake's provider network, HSAG recommended that Salt Lake conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Salt Lake, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To accommodate HSAG's NAV recommendations, Salt Lake reported that it will be implementing an internal GeoAccess study as well as analyzing timely access data to enhance network access monitoring.

In CY 2022, HSAG reevaluated Sale Lake's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Southwest Behavioral Health Center

Validation of Performance Improvement Projects

Southwest's *Outcome Questionnaire Project* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for Southwest during the PMV review.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Southwest submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Southwest had successfully implemented interventions to assess outstanding required actions related to all standard areas.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Southwest's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Southwest's provider network, HSAG recommended that Southwest conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Southwest, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Southwest did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Southwest's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Wasatch Behavioral Health

Validation of Performance Improvement Projects

Wasatch's *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for Wasatch during the PMV review.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity

Following the review, Wasatch submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Wasatch had successfully implemented interventions to address all outstanding required actions related to the Coverage and Authorization of Services standard. HSAG identified 10 ongoing required corrective actions related to the Access and Availability, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Wasatch's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Wasatch's provider network, HSAG recommended that Wasatch conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Wasatch, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Wasatch did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Wasatch's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

Weber Human Services

Validation of Performance Improvement Projects

Weber's *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG recommended that Weber:

- Continue to collaborate with providers conducting telehealth services and provide ongoing training when necessary.
- Closely monitor and compare overall performance year over year. This would ensure that Weber could identify and address data anomalies, monitor access and timeliness of care for its members, and take prompt action if necessary.

In response to HSAG's recommendations, Weber noted that:

- Clinicians continue to work on motivational interviewing skills by recording and getting feedback from supervisors. While telehealth sessions have decreased significantly over the past year, the same motivational interviewing skills that apply to in-person sessions also apply to telehealth sessions. Weber also uses a telehealth platform (Zoom) that is "user friendly" for both clients and clinicians.

- It works diligently to engage individuals in treatment who have been discharged from the inpatient unit. Weber has an inpatient coordinator who sends a daily list of admissions and discharges to all case managers and clinicians from the Adult Team. The inpatient coordinator ensures that clients who are on the inpatient unit have a scheduled outpatient appointment upon discharge.
- It assigned a case manager to follow up by phone with clients who are discharged from the inpatient unit and help motivate them to attend their scheduled follow-up appointment. A spreadsheet has been created to document all of the outreach and engagement attempts. If the client does not engage in services after two outreach attempts from the case manager, a referral will be made to the Managed Care Team to have someone reach out to the client in person.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Coordination and Continuity of Care
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- QAPIP, Practice Guidelines, and Health Information Systems

Following the review, Weber submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Weber had successfully implemented interventions to address all outstanding required actions related to the Access and Availability, Coordination and Continuity of Care, and Provider Selection and Program Integrity standards. HSAG identified four ongoing required corrective actions related to the Coverage and Authorization of Services; Member Rights and Information; Grievance and Appeal System; and QAPIP, Practice Guidelines, and Health Information Systems standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Weber's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Weber's provider network, HSAG recommended that Weber conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Weber, and to investigate barriers to accurately reporting and classifying individual

providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Weber did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Weber's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

CHIP MCOs Providing Both Physical and Mental Health Services

Molina Healthcare of Utah CHIP

Validation of Performance Improvement Projects

Molina CHIP's *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG indicated that Molina CHIP should consider:

- Reducing barriers for parents to attend office visits for well-child visits (e.g., member incentives such as gift cards for completing annual preventive services, ensure access to transportation for parents with multiple children, seamless access to interpreter services, offer home-based services or mobile clinics).
- Educational campaigns that focus on member/parents' concerns about disease control procedures in provider offices during the COVID-19 pandemic, and the impact of health care on the physical and social development of children and adolescents.
- Provider incentives to partner on outreach to members with missing preventive services, such as VBR payment structures that reward higher performance on targeted HEDIS measures.

In response to HSAG's recommendations, Molina reported several performance improvement efforts underway:

- A pay-for-quality program in which providers receive quarterly bonus payments (97 groups in 2021; 34 opt-in groups in 2022)

- Omnichannel communication to educate and inform members regarding services, benefits, programs, etc.
- Provider EHR messaging to identify missed services
- Outbound scheduling by a vendor to close service gaps
- Health fair for Molina CHIP members where immunizations and well-care visits were provided

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, Molina CHIP completed a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Molina CHIP had successfully implemented interventions to address all outstanding required actions related to the Subcontractual Relationships and Delegation standard. HSAG identified seven ongoing required corrective actions related to the Coverage and Authorization of Services, Access and Availability, Member Rights and Information, Grievance and Appeal System, and Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina CHIP's provider network, HSAG recommended that Molina CHIP conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Molina CHIP, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

To address HSAG's NAV recommendations, Molina CHIP reported that it will be implementing a new proprietary network adequacy monitoring solution, Quest Analytics, to enhance Molina CHIP's ability to monitor provider networks and health care accessibility.

In CY 2022, HSAG reevaluated Molina CHIP's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

SelectHealth CHIP

Validation of Performance Improvement Projects

In CY 2022, SelectHealth CHIP submitted a new PIP, *Well-Child Visits for CHIP Members*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG did not identify recommendations for SelectHealth CHIP related to HEDIS performance.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, SelectHealth CHIP submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that SelectHealth CHIP had successfully implemented its interventions to address all required actions related to the Coverage and Authorization of Services, Grievance and Appeal System, and Provider Selection and Program Integrity standards. HSAG identified four ongoing required corrective actions related to the Access and Availability, Member Rights and Information, and Subcontractual Relationships and Delegation standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate SelectHealth CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding SelectHealth CHIP's provider network, HSAG recommended that SelectHealth CHIP conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with SelectHealth CHIP, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

SelectHealth CHIP did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated SelectHealth CHIP's provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

PAHPs Providing Medicaid Dental Services

Premier Access

Validation of Performance Improvement Projects

In CY 2022, Premier Access submitted a new PIP, *School Based Care for Medicaid Members*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for Premier Access related to HEDIS performance.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity

Following the review, Premier Access submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to address outstanding required actions from CY 2021. HSAG found that Premier Access had not implemented interventions to address outstanding required actions related to any of the standard areas found to be not fully compliant in CY 2021. HSAG identified 21 ongoing required corrective actions related to the standards listed above that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Premier Access' provider network and did not identify any network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Premier Access' provider network, HSAG recommended that Premier Access continue to conduct ongoing assessments of its provider network to maintain compliance with DHHS' minimum time and distance network standards.

Premier Access did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Premier Access' provider network and did not identify any ongoing network inadequacies, as detailed in Section 2 of this report.

MCNA

Validation of Performance Improvement Projects

MCNA's *Annual Dental Visits* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2021 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2021.

Validation of Performance Measures

In CY 2021, HSAG did not identify opportunities for improvement or recommendations for MCNA related to HEDIS performance.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services

- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation

Following the review, MCNA completed a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to address outstanding required actions from CY 2021. HSAG found that MCNA had successfully implemented its interventions to address all outstanding required actions related to the Coverage and Authorization of Services, Access and Availability, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards. HSAG identified two ongoing required corrective actions related to the Member Rights and Information and the Provider Selection and Program Integrity standards that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate MCNA's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding MCNA's provider network, HSAG recommended that MCNA conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with MCNA, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

MCNA did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated MCNA provider network and identified the ongoing network inadequacies detailed in Section 2 of this report.

PAHP Providing CHIP Dental Services

Premier Access—CHIP

Validation of Performance Improvement Projects

In CY 2022, Premier Access CHIP submitted a new PIP, *School Based Care for CHIP Members*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2021, HSAG indicated that targeted improvement efforts could be focused on educational campaigns that focus on guardians' concerns about disease control procedures in provider offices during the COVID-19 pandemic and the impact of dental care on physical and social development of children and adolescents.

Premier Access CHIP did not provide a response to CY 2021 HSAG recommendations for HEDIS performance.

Compliance Monitoring

In CY 2021, HSAG conducted a virtual review of all standard areas of performance. During the review in CY 2021, HSAG identified required actions related to the following standard areas:

- Coverage and Authorization of Services
- Access and Availability
- Member Rights and Information
- Grievance and Appeal System
- Provider Selection and Program Integrity

Following the review, Premier Access CHIP submitted a CAP for all requirements found to be not fully compliant.

In CY 2022, HSAG conducted a virtual follow-up review to assess outstanding required actions from CY 2021. HSAG found that Premier Access CHIP had not implemented interventions to address outstanding required corrective actions related to the standard areas found to be not fully compliant in CY 2021. HSAG identified 22 ongoing required corrective actions related to the standards listed above that were not adequately addressed and required a continued CAP, as detailed in Section 2 of this report.

Validation of Network Adequacy

In CY 2021, HSAG conducted network capacity and geographic distribution analyses to evaluate Premier Access CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Premier Access CHIP's provider network, HSAG recommended that Premier Access CHIP conduct ongoing assessments of its provider network to identify those providers, if any, who chose not to contract with Premier Access CHIP, and to investigate barriers to accurately reporting and classifying individual providers and health facilities in the data using the standard definitions provided in the Provider Crosswalk document.

Premier Access CHIP did not report any specific activities to address recommendations from the 2021 Annual EQR Technical Report for NAV.

In CY 2022, HSAG reevaluated Premier Access CHIP's provider network and did not identify any ongoing network inadequacies, as detailed in Section 2 of this report.

Appendix D. Summary of PIP Interventions by Health Plan Type and PIP Topic

Table D-1 on the following page includes information about interventions each health plan implemented for PIP topics submitted for validation in CY 2022.

Table D-1—Health Plan Interventions by Health Plan Type and PIP Topic

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Medicaid ACOs Providing Physical Health Services			
Health Choice	*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 performance improvement coordinator (PIC) team used the Utah Health Information Network (UHIN) to obtain better contact information for members. • Implemented the PIC program to perform provider outreach, supply care gap reports, and work with practice quality champions to close gaps in care. • Partnered with a mobile mammography van to provide mammogram screenings to members in southern Utah. • The PIC team conducted member outreach to encourage members to obtain screenings once it was deemed appropriate to do so. Telehealth appointments were also encouraged for members.
Healthy U	*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*	1. The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	• Parents of Healthy U children in the target age group will receive a $25 gift card incentive for obtaining a well-child visit. • Healthy U will send PCPs a list of attributed members who are overdue for well-child visits. PCPs will be encouraged to call members to schedule appointments. • Healthy U plans to launch a new member portal in CY 2022. The member portal will allow members to access health plan information, including the ability to search for and select a PCP.
Molina	*Medicaid Comprehensive Diabetic Care—Eye Exams*	1. The percentage of members 18–75 years of age with diabetes (type 1 and type 2)	• Partnered with Care Connections, a vendor that completes in-home diabetic exams for members. • Mailed $40 Walmart gift cards as incentives for members upon completion of a retinal eye exam.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		who received a retinal eye exam.	• Partnered with VSP Vision Care (VSP) to increase diabetic member awareness by sending letters, including VSP contact information, so members can call and obtain benefit information and assistance with scheduling eye exams. • Dissemination of a monthly missing services gap list to VBC groups so they can encourage and assist members in obtaining an eye exam.
SelectHealth CC	*HPV Vaccine Prior to 13th Birthday for Medicaid Members*	1. The percentage of 13-year-old Medicaid members who had two doses of human papillomavirus (HPV) vaccine on or between the member's 9th and 13th birthdays.	• Work with State of Utah immunization registry staff members and SelectHealth CC data analyst team to improve data timeliness, availability, and accuracy. • Offer member incentive to encourage parents to have their child receive the HPV vaccine with other adolescent vaccines. • IVR well-exam call with email follow-up targeting parents of 12-year-olds who are missing one or more adolescent vaccines. • Member materials are routinely reviewed and updated with changes to dose recommendations or to clarify program requirements. Member materials are available in English and Spanish. • Member HPV second dose reminder letter informs parents of "next dose due date."
Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services			
Health Choice Utah	*Follow-Up After Hospitalization for Mental Illness*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days 2. Follow-Up After Hospitalization for Mental Illness within 30 Days	• The behavioral health case manager used discharge documents with face sheets and the clinical HIE to find better contact information for the member and made three attempts to reach out and encourage follow-up care.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
			• The PIC team works with the case management team to encourage outreach to the member or member's inpatient case manager prior to discharge to ensure a discharge plan is in place and also to update member contact information.
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.	• Adjust provider schedules to increase availability and timeliness of nutritional counseling. • Address member needs, such as prescribing metformin, referral to a nutritionist, and helping members understand pre-diabetes and how to manage it.
Healthy U Integrated	*Improving Adults' Access to Preventive/Ambulatory Care Services*	1. The percentage of members 20 year of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	• The health plan is conducting a phone and letter member outreach campaign to educate members on the importance of identifying a PCP and making an appointment to see that provider annually. Members who do not have an attributed PCP are the target of both the letter and phone outreach. – Letters will be mailed to active Healthy U Integrated members who do not have an attributed PCP in two phases. Phase 1 letters were mailed in March 2022. Phase 2 letters are planned to be mailed in August/September 2022. – Phone calls to active members who do not have an attributed PCP began in March 2022 and will continue throughout the year. • The health plan is launching a new member portal and online provider search (planned launch in May 2022). The member portal will allow members to access health plan information, including the ability to search and select an in-network PCP.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Molina Healthcare of Utah UMIC	*Follow Up After Hospitalization for Mental Illness*	1. The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.	• The health plan had not progressed to identifying barriers and interventions at the time of the PIP submission.
SelectHealth CC UMIC	*7-Day Follow-Up after Hospitalization for Mental Illness for Medicaid Integration Members*	1. Percentage of Medicaid Integration members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within 7 days after discharge.	• Care manager identifies admitted members and works with patient navigator to connect with member and to verify seven-day follow-up appointment has been scheduled before discharge. • Care manager confirms appointment and maintains contact with the member. • Care manager provides support and resources as needed, such as appointment rescheduling, transportation assistance, childcare services, and basic needs. This program has been implemented at one facility, and SelectHealth CC UMIC intends to roll it out to a second location and eventually to all the facilities.
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.	• Training to address that all members who need a safety plan receive one. This topic is addressed in ongoing training, and staff members are reminded of the requirement to create a safety plan for new admits. • Emphasis on making sure the same-day safety plans are created and recorded.

Health Plan Name	PIP Topic	Performance 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.	• Train/remind staff quarterly that all members should receive a C-SSRS screening at the time of intake.
Central	*Inpatient Readmission Rates*	1. The percentage of psychiatric discharges from the denominator that did not have a psychiatric readmission within 12 months.	• Implement a standardized care approach wherein all Medicaid enrollees will not only have a primary therapist assigned to the case, but an additional and specific case manager who will make frequent/weekly outreach to individuals discharged from inpatient settings for one year following discharge.
Davis	*Access to Care*	1. Percentage of initial appointments scheduled within 7 calendar days from first contact. 2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	• Intake and evaluating staff members have been informed of the seven-calendar-day requirement. • The Substance Treatment Program director is notified when a clinical staff member is unavailable and, if needed, assists in ensuring that the member is seen within 14 days. • Implemented electronic form access and telehealth protocols, platforms, and training. • RSS outreach members to attempt to schedule a follow-up appointment.
Four Corners	*Increasing the Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	1. Percentage of members diagnosed with F11 code, who received 20 or more services within 6 months of	• The health plan had not progressed to identifying barriers and interventions at the time of the PIP submission.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		admission into OUD treatment.	
Healthy U Behavioral	*Improving Follow-Up After Hospitalization for Mental Illness*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days 2. Follow-Up After Hospitalization for Mental Illness within 30 Days	• For members hospitalized at HMHI, the UUHP care management team reaches out to the HMHI discharge planner via Smart Web or email to ensure that a follow-up appointment has been scheduled within seven days after discharge. If needed, UUHP care managers assist the discharge planner in finding available in-network providers to see members. • Upon notification of hospital admission, UUHP will provide care management support to hospitalized members to ensure timely follow-up visits after discharge. Care management support involves identifying and mitigating the specific barriers for each member that may prevent the member from attending a follow-up visit.
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	1. Percentage of inpatient discharges where members received a formal covered service per the HEDIS [Healthcare Effectiveness Data and Information Set] protocol or a documented "Caring Contact" (i.e., documented "outreach") 1 to 3 business days post discharge. 2. Percentage of inpatient discharges where members received a personalized	• In-person training of all staff members that the three-business-day follow-up requirement applies to anyone being discharged from an inpatient unit and clinicians need to complete a safety plan and C-SSRS on the first service post-discharge from the inpatient unit. Email summary of the training is sent to the staff members three times per year. • Train clinicians and suicide prevention specialists regarding service and/or Caring Contact expectations (i.e., within 31 to 60 days) that include the following: – Tracking in Credible and on the tracking spreadsheet is required for 31- to-60-day follow-up and Caring Contacts. – Members who choose to follow up with providers other than Northeastern must still have Caring Contacts within the time frames of this project, including 31 to 60 days.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		Safety Plan 1–7 days post discharge with or through Northeastern Counseling. 3. Percentage of inpatient discharges where members received a Columbia Suicide Severity Risk Screening 1–7 days post inpatient discharge. 4. Percentage of inpatient discharges where members received a formal covered service or a documented "Caring Contact" (i.e., documented "outreach") 31 to 60 days post inpatient discharge.	– Members who do not show up for an appointment or who do not cancel the appointment with support staff members are to be contacted by the clinician or suicide prevention specialist within the time frames of this project and are to use the Caring Contact follow-up service in the EHR to document those actions 31 to 60 days post-inpatient discharge. • The clinical director, suicide prevention specialist, and back-up specialist have developed a spreadsheet to track inpatient discharges as they occur with daily follow-up. A marker in the EHR has also been added for inpatient discharge members, which remains in place for 60 days post-inpatient discharge. • The clinical services note used for hospital discharge follow-up has been altered to include, "Was this Individual just discharged from an Inpatient Psychiatric Hospital?" Answering "yes" brings up this reminder: – You must complete the following for this visit: 1. Columbia Suicide Severity Risk Screening 2. Safety Plan
Optum/Tooele	*In CY 2022, Optum/Tooele was instructed not to submit a PIP due to the effective date of Optum's contract with DHHS and the limited time to obtain baseline data.*		
Salt Lake	*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*	1. Percentage of members who have been diagnosed with an OUD and who may have received MAT services. 2. Percentage of members who received MAT services	• Provided two-hour MAT training on July 29, 2020, to PRCs offering services in the Optum Medical Network of SUD providers. • Provided training to provider administrative staff members (billing) to ensure the diagnoses for OUD are entered correctly. • Providers were allowed to deliver services via telehealth and telephonically based on the approval exceptions outlined by CMS and DHHS Medicaid.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		and remained in treatment longer than 6 months.	• Extended the MAT training to all staff members of three providers with the fewest number of members with an OUD diagnosis who were referred for MAT services.
Southwest	*Outcome Questionnaire Project*	1. The percentage of psychotherapy sessions during which the OQ is reviewed with a member who is age 18 or older at the time of service.	• A monthly OQ administration report is sent to the manager, which the manager reviews with the clinicians and the clinical director. • Online administration of OQ reviews wherein the front office staff will email OQ to the member or clinician/front office staff will complete OQ with the member over the phone or via Zoom. • Train all therapists providing psychotherapy to adults and discuss how to use the OQ in treatment.
Wasatch	*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*	1. The percentage of Y/OQ signal cases wherein CST was administered during a four-month window surrounding the signal event.	• Reports on CST usage will be provided monthly to program managers. Reports will contain: – The percentage of clinicians who administered CSTs within the last four months, indicated by the Y/OQ instruments. – Information on which clinicians are using the CSTs accurately and which clinicians are not. • Program managers will provide monthly reports to the executive director regarding improvement in the number of CSTs the clinics are collecting.
Weber	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	1. The percentage of members diagnosed with opioid use disorder, who received at least 6 case management or peer support services per year.	• Provided service code training; presented on the PIP Aim statement and ways to increase outreach during the COVID-19 pandemic. • Case manager/peer support placed in the MAT clinic for eight hours a week to readily assess member needs and provide assistance.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		2. The percentage of members diagnosed with opioid use disorder that were discharged from treatment and who successfully completed the treatment.	• Provided training to clinicians and case managers via Zoom on how to better engage members in treatment during the COVID-19 pandemic.
CHIP MCOs Providing Both Physical Health and Mental Health Services			
Molina CHIP	*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*	1. The percentage of members 3–17 years of age who had an outpatient visit with a PCP [primary care physician] or OB/GYN [obstetrician/gynecologist] and who had evidence of BMI percentile documentation during the measurement year.	• Conducted targeted outreach to six high-volume pediatric groups to disseminate monthly reports of children in need of well-child visits. • Disseminate a missing services list to VBC groups and conduct monthly discussions with providers for support. • Research billing code issue reasons. Collaborate with various health plan staff members to develop mitigation strategies. Educate providers regarding coding issues and resolutions
SelectHealth CHIP	*HPV Vaccine Prior to 13th Birthday for CHIP Members*	1. The percentage of 13-year-old CHIP members who had two doses of human papillomavirus (HPV) vaccine on or between the member's 9th and 13th birthdays.	• Work with State of Utah immunization registry staff members and SelectHealth CHIP data analyst team to improve data timeliness, availability, and accuracy. • Offer member incentive to encourage parents to have their child receive the HPV vaccine with other adolescent vaccines. • IVR well-exam call with email follow-up targeting parents of 12-year-olds who are missing one or more adolescent vaccines. • Member materials are routinely reviewed and updated with changes to dose recommendations or to clarify program

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
			requirements. Member materials are available in English and Spanish. • Member HPV second dose reminder letter informs parents of "next dose due date."
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.	• Outreach to providers as soon as normal business practices are resumed and encourage application of dental sealants through education. Seventy-two provider offices with 50 or more members and below-average dental sealant rates were provided education during CY 2020.
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.	• MCNA member service representatives (MSRs) offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls, which indicates the member is overdue for a preventive dental visit. • Send text messages once a month to members who have no claims history on file. • Provide monthly member rosters to high-volume providers of members who have not had a dental checkup in the current RY to a PCD/dental home. • Conduct outbound calls to members who have not had a dental checkup within the last six months to encourage them to schedule an appointment.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
PAHP Providing CHIP Dental Services			
Premier Access CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*	1. The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	• Outreach to providers as soon as normal business practices are resumed and encourage application of dental sealants through education. Seventy-two provider offices with 50 or more members and below-average dental sealant rates were provided education during CY 2020.