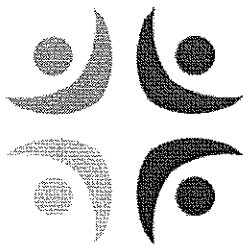


UTAH DEPARTMENT OF
HEALTH

Utah 1115 Demonstration Waiver

1115 Demonstration Waiver
Renewal Application pursuant to 1115 (f) of the Social Security Act

Demonstration Project No. 11- W-00145/8
21- W-00054/8

Renewal Period
July 1, 2013 through June 30, 2016

TABLE OF CONTENTS

Section 1: Extension Request

Utah is seeking a three-year extension of the Primary Care Network Demonstration Waiver pursuant to Section 1115(f) of the Social Security Act. While this includes extending the existing Terms and Conditions to the extent they are still necessary, the waiver extension also seeks to build upon the features of the Primary Care Network Plan that will allow Utah to expand health coverage to more individuals who are in need of health care, and support reform initiatives designed to improve health care in the State.

Letter from the Governor

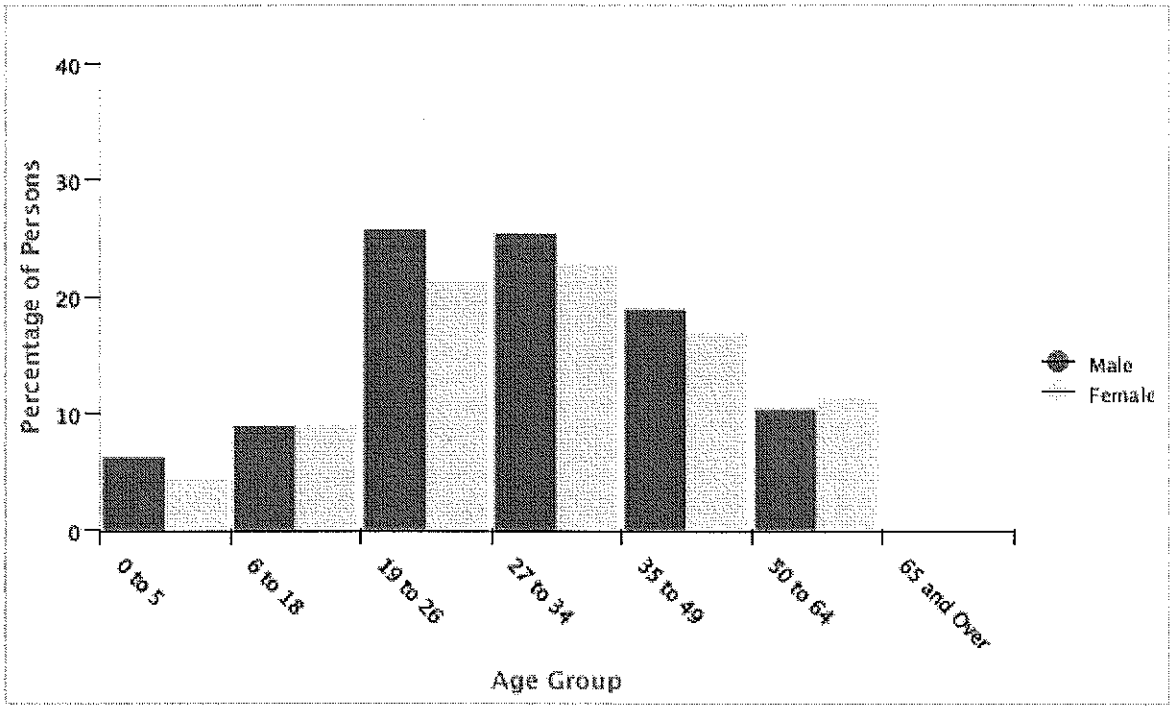
The State has included a letter from Governor Gary R. Herbert to Secretary Kathleen Sebelius, U.S. Department of Health and Human Services dated December 19, 2012, requesting an extension of Utah's 1115 waiver.

Section 2: History of Utah's 1115 Waiver

In the first few months of Governor Michael Leavitt's first term, Governor Leavitt introduced HealthPrint, a step by step incremental plan for reducing the rates of uninsured in Utah. Under HealthPrint, Utah implemented initiatives targeted at very specific populations to increase coverage for children, seniors and the disabled. These initiatives were very successful in reducing the uninsured in Utah. However, there was still a need to address the health care access needs of thousands of low income working adults who had no health care coverage at all. These Utahns may be working in some cases but have no access to health care through their employer. In some cases these are individuals with health issues not severe enough to qualify them as disabled for purposes of Medicaid, but clearly significant enough to interfere with their ability to find and maintain employment at a level that would also provide them with access to health care coverage. Many of them are seasonal employees.

The 2011 Utah Health Status Survey indicates that 13.4% of Utahns (377,700 individuals) remained uninsured. Of those uninsured 50.41% (190,400) are adults between the ages of 19 and 64. With regards to income, approximately 150,600 uninsured individuals are above 133% of the FPL.

Percentage of Persons Who Lacked Health Insurance Coverage by Age and Sex, Utah, 2011



Forty Eight (47.7%) of Utah adults ages 19-64 who are uninsured are employed either full or part time.

Data and Confidence Limits for No Health Insurance Coverage by Employment Status, Utahns Ages 19-64, 2010

You are Here: IBIS-PH > Indicator Reports > current page

Employment Status	Percentage of Persons Aged 19-64	Lower Limit	Upper Limit	Note
Employed	9.2%	7.6%	11.1%	
Self-employed	23.9%	18.3%	30.6%	
Out of Work >1 Yr	41.0%	28.9%	54.3%	
Out of Work <1 Yr	50.8%	39.0%	62.4%	
Homemaker	14.0%	10.2%	18.9%	
Student	13.0%	6.4%	24.6%	*
Retired	2.6%	1.0%	6.6%	*
Unable to Work	10.9%	5.9%	19.2%	*

Among the whole population of the uninsured, 53.2% had graduated high school but not completed college. More than two-thirds (70.2%) of the total uninsured population are people living below 200% of the federal poverty level.

A lack of coverage also impacts the likelihood of receiving preventative care. Results from the 2008 Healthcare Access Survey showed that uninsured persons were significantly less likely to have had a routine medical check-up in the past 12 months (56.6%) compared to insured persons (73.3%).

The intent of Utah 's original waiver is to allow up to 25,000 previously uninsured adults whose income is below 150% of the federal poverty level to access a limited health care benefit focused on preventative care. The Primary Care Network provides these individuals with ongoing access to primary care, pharmacy (up to four prescriptions per month) and emergency room coverage as well as other limited services.

In order to fund the cost of providing services to this new and very needy population of adults who are parents of children on Medicaid or who are receiving both Medicaid and TANF were given a reduced benefit package. While reduced, the benefit package is still comprehensive and is comparable to the Children's Health Insurance Program (CHIP) benefit package or comparable to employer sponsored plans.

Previous Demonstration Waivers and Amendments

- The Utah PCN 1115 demonstration waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.

- **Amendment #1 -** This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those age 19 and above who are eligible through sections 1925 and 1931) in the demonstration who become pregnant get the full Medicaid State plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform to changes to the benefits available under the State plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the State plan. (Approved on August 20, 2002, effective on July 1, 2002.)

- **Amendment #2 -** This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the State subsidizes the employee's portion of the premium for up to 5 years. The employer-sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over 5 years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer-sponsored plan. With this amendment, the State was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the State reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003.)

- **Amendment #3 -** This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from $50 to $25. (Approved on July 6, 2004, effective on July 6, 2004.)

- **Amendment #4 -** This changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the "Current Eligibles" ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the State provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005.)

- **Amendment #5** - This amendment implemented the adult dental benefit for the "Current Eligibles" population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005.)

- **Amendment #6** - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #7** - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from $2.00 per prescription to $3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #8** - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #9** - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (ESI) (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this amendment suspends Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006.)

  This amendment provides the option of ESI premium assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least 5 percent of the household's countable income. The State subsidizes premium assistance through a monthly subsidy of up to $150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is $140 per month; otherwise, it drops to $120 per month. If dental benefits are not provided by a child's ESI plan, the State offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the title XXI out-of-pocket cost sharing limit of 5 percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well-baby/well child care services, age appropriate immunizations, dental services, physician visits, hospital inpatient, and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so that they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

- **Amendment #10-** This amendment enables the State to provide premium assistance to children and adults for coverage obtained under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of employer-based group health coverage at group rates. COBRA coverage becomes available following the loss of employer-sponsored health insurance (ESI) due to specified qualifying events, such as an end of employment (voluntary or involuntary); divorce or legal separation; death of employee; entitlement to Medicare; reduction in hours of employment; and loss of dependent-child status. Through this amendment, Utah will provide premium assistance to programmatically-eligible adults and children (as differentiated from individuals who are COBRA-eligible but not otherwise eligible for the Utah COBRA premium assistance program) toward the purchase of COBRA coverage, in a manner similar to the provision of premium assistance for the purchase ESI coverage. (Medicare-eligible individuals who are also COBRA-eligible would be ineligible for the Utah COBRA Premium Assistance Program (CPAP) based on age or the State's standard processes of cross-matching with SSI/SSDI eligibility files).

During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) will work in tandem with the subsidy provided under the American Recovery and Reinvestment Act of 2009 (ARRA) for the purchase of COBRA coverage. Specifically, ARRA provides a Federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008 through December 31, 2009. As long as the individual receives the ARRA subsidy, the State would provide the family with premium assistance based on the number of programmatically-eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the State under these STCs.

The ARRA COBRA subsidy is of limited duration and eligibility is scheduled to end February 28, 2010. The ARRA COBRA subsidy can last for up to 9 months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA subsidy ends, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP will continue to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to a family will be based on the number of programmatically-eligible individuals in the household. However, as with the existing ESI program, the State will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

The Utah CPAP program will provide premium assistance to programmatically-eligible individuals and families with existing COBRA coverage, whether or not the individual qualifies for the ARRA COBRA subsidy. Individuals and families, who are COBRA-eligible but, uninsured, may also apply for enrollment in the Utah CPAP. Once the Utah CPAP has been implemented, the State may provide premium assistance for up to three months of retroactive eligibility, but the first date of retroactive eligibility may not pre-date the first day the State was approved to amend the section 1115 PCN Demonstration. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the State under these STCs. The State plans to implement CPAP on or about November 1, 2009.

- **Amendment #11**-This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA) from 150% of the FPL to 200 % of the FPL. This amendment was approved by CMS on September 28, 2012.

Section 1115(e) Extension - On June 23, 2006, the State of Utah formally requested an extension of their PCN 1115 demonstration waiver under the authority of Section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.

Section 1115(f) Extension- On February 3, 2010 the State of Utah formally requested an extension of their PCN 1115 Demonstration waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a 3-year extension from July 1, 2010, through June 30, 2013.

Section 3: Program Description and Objectives

Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration to expand Medicaid coverage to certain able-bodied adults who are not eligible for State plan services and to offer these adults and children eligible for CHIP an alternative to traditional direct coverage public programs. For State plan eligibles who are categorically or medically needy parents or other caretaker relatives, the Demonstration provides a reduced benefit package and requires increased cost-sharing. Savings from this State plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 to 64 with family incomes up to 150 percent of the Federal Poverty Level (FPL). This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also high-risk pregnant women, whose resources made them ineligible under the State plan, are covered under the Demonstration for the full Medicaid benefits package. The PCN Demonstration was amended in October 2006 to also use Demonstration savings to offer assistance with payment of ESI premiums through Utah's Premium Partnership for Health Insurance (UPP). The UPP program uses Title XIX funds to provide up to $150 per month in ESI premium assistance to each uninsured adult in families with income up to 150 percent FPL. UPP also uses Title XXI funds to provide premium assistance up to $120 per month per child for CHIP eligible children with family income up 200 percent FPL. UPP children receive dental coverage through direct CHIP coverage or they receive an additional $20 per month if they receive dental coverage through the ESI. Effective December 18, 2009, the PCN Demonstration was further amended to enable the State to provide premium assistance to children and adults for coverage obtained under the provisions of COBRA. Effective September 2012, the waiver was further amended to allow adults up to 200% of the FPL be eligible for premium assistance for ESI or COBRA continuation coverage.

Section 4: Compliance with Special Terms and Conditions

Utah has successfully completed all deliverables required by the Primary Care Network Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements. The State maintains comprehensive administrative rules, eligibility policies, and provider manuals that are regularly updated to reflect the most current operational policies and procedures of the Primary Care Network demonstration waiver.

Utah has complied with all applicable Federal statues relating to nondiscrimination.

Utah has complied with all applicable requirements of the Medicaid and CHIP expressed in laws, regulations, and policy statements, not expressly waived or identified as non applicable in the Special Terms and Conditions (STCs), apply to Utah's 1115 Demonstration Waiver, Primary Care Network.

Utah has complied with and has come into compliance with all changes in Federal law affecting the Medicaid or CHIP program that have occurred after the approval of the demonstration award date.

Utah's 1115 Demonstration Waiver adheres to all requirements of the approved 1115 waiver.

Utah has remained within the budget neutrality expenditure cap for all populations.

Section 6: Compliance with Budget Neutrality Requirements

See Attachment 1

Section 7: Program Evaluation

See Attachment 2

Section 8: Public Notice and Tribal Consultation

Public Notice of the State's request for renewal and amendment was published in the Utah State Bulletin on December 1, 2012 (**Attachment 3**). The public has until March 15, 2010 to provide comment.

On December 7, 2012 the State held a public hearing from 4:00 PM to 6:00 PM to take public comment on the extension request. (**Attachment 4**)

On December 7, 2012, a presentation regarding the request for renewal of Utah's 1115 Waiver and amendments was provided to the Utah Indian Health Advisory Board. (**Attachment 5**) This is the first step in our approved consultation process. The Tribes did not request additional consultation.

On December 11, 2012, the State held a special meeting of the Medical Care Advisory Committee from 3:30 PM to 5:30 PM to tale public comment on the PCN Demonstration Waiver extension request. (**Attachment 6**)

Section 9: Quality Initiatives

State plan eligibles in a four county area receive many physical health services through managed care plans. Mental health services for this population are also provided

through a managed care arrangement. A copy of the State's latest External Quality Review Organization report is included with this request for renewal. (**Attachment 7**)

A copy of Utah's most current Consumer Assessment of Health Plans Survey (CAHPS) is included with this request for renewal. (**Attachment 8**)

Attachment G
Utah 1115 Budget Neutrality 09302012

ATTACHMENT 1

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)											
									Budget		Budget
Medicaid	SFY 2001				Member Months				Neutrality		Neutrality
Eligibility	PM/PM	Trend	DY #1						Limit DY 1	Effective	Limit DY 1
Group	(Base Year)	Rate	PM/PM	QE 9/02	QE 12/02	QE 3/03	QE 6/03	Total	(TF)	FMAP	(FF)
Current eligibles	$333.55	1.08	$389.05					223,729	$87,042,676	70.93%	$61,739,157.29
1902(r)(2) - PCN	n/a	1.08	$54.00					62,978	$3,400,812	70.93%	$2,412,195.95
							Total BN Limit		$90,443,488	70.93%	$64,151,353.24
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #2						Limit DY 2	Effective	Limit DY 2
			PM/PM	QE 9/03	QE 12/03	QE 3/04	QE 6/04	Total	(TF)	FMAP	(FF)
Current eligibles		1.08	$420.18					251,558	$105,698,870	71.60%	$75,680,390.97
1902(r)(2) - PCN		1.08	$58.32					115,212	$6,719,164	71.60%	$4,810,921.31
							Total BN Limit		$112,418,034	71.60%	$80,491,312.28
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #3						Limit DY 3	Effective	Limit DY 3
			PM/PM	QE 9/04	QE 12/04	QE 3/05	QE 6/05	Total	(TF)	FMAP	(FF)
Current eligibles		1.08	$453.79					269,541	$122,315,305	72.04%	$88,115,945.64
1902(r)(2) - PCN		1.08	$62.99					138,562	$8,727,411	72.04%	$6,287,226.67
							Total BN Limit		$131,042,716	72.04%	$94,403,172.32
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #4						Limit DY 4	Effective	Limit DY 4
			PM/PM	QE 9/05	QE 12/05	QE 3/06	QE 6/06	Total	(TF)	FMAP	(FF)
Current eligibles		1.08	$490.09					264,052	$129,410,401	71.11%	$92,023,736.32
1902(r)(2) - PCN		1.08	$68.02					116,364	$7,915,597	71.11%	$5,628,780.93
							Total BN Limit		$137,325,998	71.11%	$97,652,517.25

BN Ceiling Calculation

Attachment G
Utah 1115 Budget Neutrality 09302012

									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #5						Limit DY 5	Effective	Limit DY 5
			PM/PM	QE 9/06	QE 12/06	QE 3/07	QE 6/07	Total	(TF)	FMAP	(FF)
Current eligibles		1.08	$529.30					214,792	$113,689,820	70.30%	$79,923,943.63
1902(r)(2) - PCN		1.08	$73.47					133,813	$9,830,760	70.30%	$6,911,024.21
1902(r)(2) - HIFA*		6.02%	$150.00					1,169	$175,350	70.30%	$123,271.05
							Total BN Limit		$123,695,930	70.30%	$86,958,238.89
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #6						Limit DY 6	Effective	Limit DY 6
		Inflation	PM/PM	QE 9/07	QE 12/07	QE 3/08	QE 6/08	Total	(TF)	FMAP	(FF)
Current eligibles		1.066	$564.24					194,914	$109,977,468	71.26%	$78,369,943.69
1902(r)(2) - PCN		1.066	$78.32					148,028	$11,592,840	71.26%	$8,261,058.09
1902(r)(2) - HIFA		1.066	$159.90					2,498	$399,430	71.26%	$284,633.96
							Total BN Limit		$121,969,739	71.26%	$86,915,635.74
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #7						Limit DY 7	Effective	Limit DY 7
			PM/PM	QE 9/08	QE 12/08	QE 3/09	QE 6/09	Total	(TF)	FMAP	(FF)
Current eligibles		1.066	$601.48					231,636	$139,323,861	70.94%	$98,835,992.59
1902(r)(2) - PCN		1.066	$83.48					143,979	$12,019,941	70.94%	$8,526,946.30
1902(r)(2) - HIFA		1.066	$170.45					2,875	$490,054	70.94%	$347,643.97
							Total BN Limit		$151,833,856	70.94%	$107,710,582.86
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #8						Limit DY 8	Effective	Limit DY 8
			PM/PM	QE 9/09	QE 12/09	QE 3/10	QE 6/10	Total	(TF)	FMAP	(FF)
Current eligibles		1.066	$641.17					278,979	$178,873,747	71.44%	$127,787,405.04
1902(r)(2) - PCN		1.066	$88.99					124,731	$11,100,302	71.44%	$7,930,055.85
1902(r)(2) - HIFA		1.066	$181.70					3,290	$597,804	71.44%	$427,071.13

BN Ceiling Calculation

Attachment G
Utah 1115 Budget Neutrality 09302012

							Total BN Limit		$190,571,853	71.44%	$136,144,532.02
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #9						Limit DY 9	Effective	Limit DY 9
			PM/PM	QE 9/10	QE 12/10	QE 3/11	QE 6/11	Total	(TF)	FMAP	(FF)
Current eligibles		1.066	$683.49					321,691	$219,872,648	71.27%	$156,703,236.45
1902(r)(2) - PCN		1.066	$94.87					128,540	$12,194,273	71.27%	$8,690,858.02
1902(r)(2) - HIFA		1.066	$193.70					3,079	$596,389	71.27%	$425,046.58
							Total BN Limit		$232,663,310	71.27%	$165,819,141.05
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #10						Limit DY 10	Effective	Limit DY 10
			PM/PM	QE 9/11	QE 12/11	QE 3/12	QE 6/12	Total	(TF)	FMAP	(FF)
Current eligibles		1.066	$728.60					382,634	$278,787,347	71.03%	$198,022,652.64
1902(r)(2) - PCN		1.066	$101.13					101,403	$10,254,763	71.03%	$7,283,957.84
1902(r)(2) - HIFA		1.066	$206.48					2,153	$444,551	71.03%	$315,764.37
							Total BN Limit		$289,486,660	71.03%	$205,622,374.86
									Budget		Budget
					Member Months				Neutrality		Neutrality
			DY #11						Limit DY 11	Effective	Limit DY 11
			PM/PM	QE 9/12	QE 12/12	QE 3/13	QE 6/13	Total	(TF)	FMAP	(FF)
Current eligibles		1.066	$776.69	97,726				390,904	$303,610,523	69.96%	$212,405,922.17
1902(r)(2) - PCN		1.066	$107.80	24,833				101,403	$10,931,577	69.96%	$7,647,731.19
1902(r)(2) - HIFA		1.066	$220.11	395				2,153	$473,891	69.96%	$331,534.19
							Total BN Limit		$315,015,991	69.96%	$220,385,187.55
									Budget		Budget
					Member Months				Neutrality		Neutrality

BN Ceiling Calculation

Attachment G
Utah 1115 Budget Neutrality 09302012

		DY #12						Limit DY 12	Effective	Limit DY 12
		PM/PM	QE 9/13	QE 12/13	QE 3/14	QE 6/14	Total	(TF)	FMAP	(FF)
Current eligibles	1.066	$827.95					390,904	$323,648,818	69.96%	$226,424,713.04
1902(r)(2) - PCN	1.066	$114.92					101,403	$11,653,061	69.96%	$8,152,481.45
1902(r)(2) - HIFA	1.066	$234.63					2,153	$505,168	69.96%	$353,415.44
						Total BN Limit		$335,807,047	69.96%	$234,930,609.93

* - Enrollment in HIFA amendment began in December 2006

= Neutrality Limit without waiver ceiling

= Actual Member Months

= Estimated Member Months

= Inflation percentage submitted in HIFA Amendment

Membership Assumptions:

Current Eligible enrollment remains flat

PCN enrollment averages 19,000 members per month or a total of 228,000 member months per year

- 143,640 (19,000*(0.63)*12) Parents with Children and 84,360 Childless Adults

UPP averages 1,000 members per month

Assume UPP enrollment % parents

80%

II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)

		EXPENDITURES (FF)							
		Current Eligibles	Demo Population I - PCN		Demo Population II	Demo Population III - HIFA			
			Adults w/Children	Childless Adults		Adults w/Children	Childless Adults		
	BUDGET	(Sections 1925 and	(Section 1902(r)(2)	(PCN		(Section 1902(r)(2)	(HIFA		
	NEUTRALITY	1931 Adults and	Adults; also Known	Adults in Demo	(High-Risk Pregnant	Adults; also Known	Adults in Demo		
	LIMIT (FF)	Medically Needy	as Hypothetical	Population I = 1115	Women = 1115	as Hypothetical	Population III = 1115	TOTAL	VARIANCE
		Adults)	State Plan Eligibles)	Expansion Group)	Expansion Group)	State Plan Eligibles)	Expansion Group)		
SFY 03	$64,151,853.24	$61,595,233	$2,809,194	$4,115,233				$68,519,660	-$4,368,307
SFY 04	$80,491,812.28	$64,047,444	$5,102,354	$7,856,860				$77,006,658	$3,484,654
SFY 05	$94,403,172.32	$75,766,088	$5,025,695	$8,945,075	$604,159			$90,341,017	$4,062,155
SFY 06	$97,652,517.25	$73,867,419	$5,003,894	$7,830,419	$679,517			$87,381,249	$10,271,268
SFY 07	$86,958,238.89	$69,226,869	$6,689,112	$8,423,719	$640,957	$58,159	$4,406	$85,043,222	$1,915,017
SFY 08	$86,915,635.74	$64,034,510	$7,816,235	$10,288,582	$695,696	$185,045	$22,970	$83,043,038	$3,872,598
SFY 09	$107,710,582.86	$80,074,470	$7,678,231	$9,135,441	$908,465	$231,658	$10,444	$98,038,709	$9,671,874
SFY 10	$135,144,532.02	$89,319,799	$6,671,035	$9,805,585	$1,216,309	$303,669	$19,733	$107,336,130	$28,808,402
SFY 11	$165,819,141.05	$71,898,700	$5,045,086	$5,369,817	$1,601,557	$172,847	$7,362	$84,095,369	$81,723,772
SFY 12	$205,622,374.86	$88,992,655	$3,924,164	$5,156,017	$1,964,229	$179,859	$4,213	$100,221,137	$105,401,238
QE 9/12	$55,035,189.96	$24,949,124	$1,018,742	$1,563,872	$519,334	$30,973	$1,116	$28,083,161	$26,952,029
QE 12/12								$0	$0
QE 3/13								$0	$0
QE 6/13								$0	$0
SFY 13	$220,385,187.55	$99,796,000	$4,183,000	$6,255,000	$2,094,000	$192,000	$4,000	$112,524,000	$107,861,188
TOTAL	$1,346,254,048.06							$993,550,189	$352,703,859
QE 9/13								$0	$0
QE 12/13								$0	$0
QE 3/14								$0	$0
QE 6/14								$0	$0
SFY 14	$234,930,609.93	$106,383,000	$4,459,000	$6,668,000	$2,232,000	$205,000	$4,000	$119,951,000	$114,979,610

Attachment G
Utah 1115 Budget Neutrality 09302012

TOTAL	$1,581,184,657.99							$1,113,501,189	$467,683,469
		= Estimated Figures							
		= Neutrality Limit without waiver ceiling							
		= Actual Expenditures 1115 Waivers							

Attachment G
Utah 1115 Budget Neutrality 09302012

III. SUMMARY BY DEMONSTRATION YEAR AND CUMULATIVELY (Federal Funds)								
	Budget Neutrality Limit	Waiver Costs on CMS-64	Annual Variance	Variance As % of Annual BN Limit	Cumulative Budget Neutrality Limit	Cumulative Waiver Costs on CMS-64	Cumulative Variance	Variance As % of Cumulative BN Limit
DY #1 (SFY 2003)	$64,151,353	$68,519,660	-$4,368,307	-6.81%	$64,151,353	$68,519,660	-$4,368,307	-6.81%
DY #2 (SFY 2004)	$80,491,312	$77,006,658	$3,484,654	4.33%	$144,642,666	$145,526,318	-$883,652	-0.61%
DY #3 (SFY 2005)	$94,403,172	$90,341,017	$4,062,155	4.30%	$239,045,838	$235,867,335	$3,178,503	1.33%
DY #4 (SFY 2006)	$97,652,517	$87,381,249	$10,271,268	10.52%	$336,698,355	$323,248,584	$13,449,771	3.99%
DY #5 (SFY 2007)	$86,958,239	$85,043,222	$1,915,017	2.20%	$423,656,594	$408,291,806	$15,364,788	3.63%
DY #6 (SFY 2008)	$86,915,636	$83,043,038	$3,872,598	4.46%	$510,572,230	$491,334,844	$19,237,386	3.77%
DY #7 (SFY 2009)	$107,710,583	$98,038,709	$9,671,874	8.98%	$618,282,813	$589,373,553	$28,909,260	4.68%
DY #8 (SFY 2010)	$136,144,532	$107,336,130	$28,808,402	21.16%	$754,427,345	$696,709,683	$57,717,662	7.65%
DY #9 (SFY 2011)	$165,819,141	$84,095,369	$81,723,772	49.28%	$920,246,486	$780,805,052	$139,441,434	15.15%
DY #10 (SFY 2012)	$205,622,375	$100,221,137	$105,401,238	51.26%	$1,125,868,861	$881,026,189	$244,842,672	21.75%
DY #11 (SFY 2013)	$220,385,188	$112,524,000	$107,861,188	48.94%	$1,346,254,048	$993,550,189	$352,703,859	26.20%
DY #12 (SFY 2014)	$234,930,610	$119,951,000	$114,979,610	48.94%	$1,581,184,658	$1,113,501,189	$467,683,469	29.58%
	= Estimated Figures							
	= Neutrality Limit without waiver ceiling QTD Amount							
	= Actual Expenditures 1115 Waivers QTD Amount							

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds

	DY #3 FFY 2005	DY #4 FFY 2006	DY #5 FFY 2007	DY #6 FFY 2008	DY #7 FFY 2009	DY #8 FFY 2010	DY #9 FFY 2011	DY #10 FFY 2012	DY #11 FFY 2013
State's Allotment	$31,699,161	$32,207,704	$40,485,868	$41,291,966	$65,264,100	$ 69,925,931	$ 63,915,866	$ 67,820,283	$ -
Funds Carried Over From Prior Year(s)	$48,784,806	$51,794,787	$38,752,157	$40,381,700	$31,420,653	$ 41,070,648	$ 51,486,312	$ 63,915,866	$ 72,120,111
SUBTOTAL (Allotment + Funds Carried Over)	$80,483,967	$84,002,491	$79,238,025	$81,673,666	$96,684,753	$ 110,996,579	$ 115,402,178	$ 131,736,149	$ 72,120,111
Reallocated Funds (Redistributed or Retained that are Currently Available)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL (Subtotal + Reallocated funds)	$80,483,967	$84,002,491	$79,238,025	$81,673,666	$96,684,753	$ 110,996,579	$ 115,402,178	$ 131,736,149	$ 72,120,111
State's Enhanced FMAP Rate	80.50%	79.53%	79.10%	80.14%	79.50%	80.18%	79.79%	79.69%	79.50%
State's Blended SFY FMAP Rate	80.42%	79.77%	79.21%	79.88%	79.66%	80.01%	79.89%	79.72%	79.66%

COST PROJECTIONS OF APPROVED SCHIP PLAN	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Benefit Costs									
Managed care	$38,157,940	$48,249,026	$48,763,736	$51,665,693	$66,289,295	$ 68,759,279	$ 68,617,616	$ 66,371,695	$ [illegible]
Estimated Average Number In Direct Coverage	28,579	35,186	31,895	32,021	38,019	41,641	38,506	37,630	[illegible]
Per Member/Per Month Rate	$ 111.26	$ 114.27	$ 127.41	$ 134.46	$ 145.30	$ 137.60	$ 148.50	$ 146.98	$ [illegible]
Total Benefit Costs	$38,157,940	$48,249,026	$48,763,736	$51,665,693	$66,289,295	$ 68,759,279	$ 68,617,616	$ 66,371,695	$ [illegible]
(Offsetting beneficiary cost sharing payments)	$ (663,617)	$ (789,861)	$ (790,622)	$ (1,690,334)	$ (1,749,354)	$ (2,092,548)	$ (1,418,355)	$ (1,948,229)	$ [illegible]
Net Benefit Costs	**$37,494,323**	**$47,459,165**	**$47,973,114**	**$49,975,359**	**$64,539,942**	**$ 66,666,731**	**$ 67,199,261**	**$ 64,423,466**	$ [illegible]
Administration Costs									
Personnel	$ 430,170	$ 519,094	$ 1,073,122	$ 884,073	$ 896,114	$ 909,904	$ 772,634	$ 1,095,884	$ [illegible]
General administration	$ 18,332	$ 51,760	$ 51,803	$ 49,596	$ 42,146	$ 26,030	$ 95,458	$ 59,993	$ [illegible]
Contractors/Brokers (e.g., enrollment contractors)	$ 1,924,878	$ 2,754,711	$ 2,213,125	$ 3,570,127	$ 4,490,595	$ 6,187,049	$ 5,550,646	$ 5,519,426	$ [illegible]
Outreach/marketing costs	$ 304,738	$ 272,891	$ 248,521	$ 855,897	$ 548,353	$ 363,799	$ -	$ -	$ [illegible]
Total Administration Costs	**$ 2,678,118**	**$ 3,598,456**	**$ 3,586,571**	**$ 5,359,693**	**$ 5,977,208**	**$ 7,486,782**	**$ 6,418,739**	**$ 6,675,303**	$ [illegible]
10% Administrative Cap	$ 4,166,036	$ 5,273,241	$ 5,330,346	$ 5,552,818	$ 7,171,105	$ 7,407,415	$ 7,466,585	$ 7,158,163	$ [illegible]
Federal Title XXI Share	$32,306,677	$40,730,451	$40,838,622	$44,201,640	$56,173,961	$ 59,330,226	$ 58,813,420	$ 56,679,939	$ [illegible]
State Share	$ 7,865,764	$10,327,170	$10,721,063	$11,133,412	$14,343,188	$ 14,823,287	$ 14,804,580	$ 14,418,830	$ [illegible]
TOTAL COSTS OF APPROVED SCHIP PLAN	**$40,172,441**	**$51,057,621**	**$51,559,685**	**$55,335,052**	**$70,517,150**	**$ 74,153,513**	**$ 73,617,999**	**$ 71,098,769**	$ [illegible]
CHIP Member Months	342,948	422,226	382,742	384,250	456,225	499,693	462,070	451,562	[illegible]
Estimated Inflation		2.70%	11.49%	5.54%	8.06%	-5.30%	7.92%	-1.02%	[illegible]
Managed Care PMPM	$ 111.26	$ 114.27	$ 127.41	$ 134.46	$ 145.30	$ 137.60	$ 148.50	$ 146.98	$ [illegible]
Administration PMPM	$ 7.81	$ 8.52	$ 9.37	$ 13.95	$ 13.10	$ 14.98	$ 13.89	$ 14.78	$ [illegible]
	$ 119.07	$ 122.80	$ 136.78	$ 148.41	$ 158.40	$ 152.59	$ 162.39	$ 161.77	$ 155.92

COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL									
Benefit Costs for Demonstration Population #1 (e.g., children)			94.90068493						
Pop. 1		Growth							
Estimated Average Number Enrolled in HIFA		[illegible]	73	235	352	407	331	310	[illegible]
Per Member/Per Month Rate		[illegible]	$ 94.90	$ 115.60	$ 74.61	$ 122.77	$ 133.40	$ 112.84	$ [illegible]
Total Benefit Costs for Waiver Population #1			$ 83,133	$ 325,985	$ 315,164	$ 599,624	$ 529,855	$ 420,121	$ [illegible]
(Offsetting beneficiary cost sharing payments)			0	0	0	0	0	0	[illegible]
Net Benefit Costs			**$ 83,133**	**$ 325,985**	**$ 315,164**	**$ 599,624**	**$ 529,855**	**$ 420,121**	$ [illegible]
Administration Costs									
Personnel			$ -	$ 97	$ 21,710	$ 25,481	$ 53,604	$ 43,335	$ [illegible]
General administration			$ -	$ -	$ -	$ -	$ -	$ -	$ [illegible]
Contractors/Brokers (e.g., enrollment contractors)			$ 75,262	$ 171,404	$ 268	$ -	$ 4,763	$ 160	$ [illegible]
Outreach/marketing costs			$ -	$ -	$ -	$ -	$ -	$ -	$ [illegible]
Total Administration Costs			**$ 75,262**	**$ 171,501**	**$ 21,978**	**$ 25,481**	**$ 58,367**	**$ 43,495**	$ [illegible]
10% Administrative Cap			$ 9,237	$ 36,221	$ 35,018	$ 66,625	$ 58,873	$ 46,680	$ [illegible]
Federal Title XXI Share			$ 125,459	$ 397,392	$ 268,567	$ 500,147	$ 469,930	$ 369,595	$ [illegible]
State Share			$ 32,936	$ 100,094	$ 68,575	$ 124,958	$ 118,291	$ 94,021	$ [illegible]
TOTAL COSTS FOR DEMONSTRATION			**$ 158,395**	**$ 497,486**	**$ 337,142**	**$ 625,105**	**$ 588,222**	**$ 463,616**	$ [illegible]
TOTAL PROGRAM COSTS (State Plan + Demonstration)			$51,718,080	$55,832,538	$70,854,292	$ 74,778,618	$ 74,206,221	$ 71,562,385	$ [illegible]
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)			$79,238,025	$81,673,666	$96,684,753	$ 110,996,579	$ 115,402,178	$ 131,736,149	$ [illegible]
Total Federal Title XXI Program Costs (State Plan + Demonstration)			$40,964,081	$44,599,031	$56,442,529	$ 59,830,372	$ 59,283,350	$ 57,049,534	$ [illegible]
Unused Title XXI Funds Expiring (Allotment or Reallocated)			$ -	$ -	$ -	$ -	$ -	$ -	$ [illegible]
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)			$38,273,944	$37,074,635	$40,242,224	$ 51,166,207	$ 56,118,828	$ 74,686,615	$ [illegible]
Source of Funds: Tobacco Settlement Funds	$40,836,058	$51,847,482	$52,508,702	$57,522,872	$72,603,645	$ 76,871,166	$ 75,624,576	$ 73,510,615	$ 77,347,900

IX. Member Month Reporting
Enter the member months for each of the EG's for the quarter

A. For Use in Budget Neutrality Calculations Eligibility Group

	Month 1 July 2012	Month 2 August 2012	Month 3 September 2012	Total for Quarter Ending 09/12
Current Eligibles	32,628	32,740	32,358	97,726
PCN DP #1	16,119	15,677	15,282	47,078
High Risk Pregnancy DP #2	234	224	219	677
HIFA DP #3	118	116	109	343
HIFA COBRA DP #5	45	41	41	127

B. Not Used in Budget Neutrality Calculations Eligibility Group

	Month 1 July 2012	Month 2 August 2012	Month 3 September 2012	Total for Quarter Ending 09/12
CHIP Current Eligibles	36,864	36,583	36,318	109,765
CHIP HIFA COBRA DP #6	290	277	254	821

ATTACHMENT 2

UTAH DEPARTMENT OF HEALTH

Evaluation of Utah's 1115 Demonstration Waiver

Primary Care Network, High-Risk Pregnancy, and Utah's Premium Partnership

Information about the Demonstration

Title: Primary Care Network
Awardee: Utah Department of Health
Timeline:

December 11, 2001	Waiver submitted
February 8, 2002	Approved
July 1, 2002	Implemented
June 30, 2007	Original expiration date
June 30, 2010	Extension expiration date
June 30, 2013	Extension expiration date

A Brief History of the Demonstration

Utah's 1115 waiver is a statewide demonstration to cover previously uninsured individuals through alternative benefit packages. This demonstration uses increased flexibility with current State plan eligibles to fund a Medicaid expansion for uninsured adults age 19 and older with incomes up to 150 percent of the Federal poverty level (FPL). It is known as the Primary Care Network (PCN). The waiver also includes coverage for High-Risk pregnant women whose assets exceed the current Medicaid asset limit.

The demonstration also provides an employer-sponsored health insurance option for uninsured adults with incomes up to 150 percent of the FPL and for children with family incomes up to 200 percent of the FPL. This option is known as Utah's Premium Partnership for Health Insurance (UPP). Children eligible for the Children's Health Insurance Program (CHIP) can elect to enroll in UPP if a parent has a qualified plan through work.

In addition the demonstration includes an insurance subsidy option for uninsured adults (up to 150% FPL) and children (up to 200%FPL) who are eligible for coverage under COBRA.

The original Utah 1115 waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007. On December 21, 2006, the waiver was extended through June 30, 2010. On June 23, 2010, the waiver was extended through June 30, 2013.

Prior to the demonstration, Utah was providing a limited-benefit program for otherwise uninsured adults through the Utah Medical Assistance Program (UMAP). Coverage for UMAP adults was generally provided with 100% state funds. At the time of the waiver's implementation, the UMAP adults were enrolled in PCN and UMAP was discontinued.

Population Groups impacted

Current Eligibles: This demonstration includes some modifications to benefits received by currently eligible "Non-Traditional Medicaid" clients

Demonstration Population #1 – PCN enrollees: Previously uninsured parents and adults without dependent children who enroll in this limited benefit program.

Demonstration Population #2 – Pregnant women with High-Risk pregnancies: Previously uninsured women who face a $5,000 asset co-pay to enroll in traditional Medicaid.

Demonstration Population #3 – UPP adults: Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

Current eligible CHIP Children (Formally Demonstration Population #4): UPP children - Previously uninsured children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

Demonstration Population #5 – UPP adults: Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in COBRA continuation coverage.

Demonstration Population #6 – COBRA eligible children: previously insured children who use a premium subsidy to enroll in COBRA continuation coverage.

Evaluation Requirements in Special Terms and Conditions

1. The State shall conduct an end-of-demonstration evaluation that incorporates any amendments during the period of the demonstration.

2. The State must submit a draft evaluation design for an overall evaluation of the Demonstration by August 31, 2011. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus on the target population for the Demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly the target population. It shall discuss the data sources and sampling methodology for assessing theses outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct and evaluation or select an outside contractor for evaluation.

3. The State shall submit to CMS for approval an amendment to the Evaluation Plan referenced in section XIII.1 (Submission of a draft Evaluation Plan) no later than 120 days after CMS's approval of the COBRA Premium Assistance Program.

Purposes, aims, objectives, and goals of the demonstration

Overarching strategy, principles, goals, and objectives

The primary strategy for this demonstration is to provide valuable benefits to a greater population by slightly reducing benefits to some currently covered populations. The demonstration is founded on the principle that the highest value health care comes from coverage for primary and preventive care. The goal of the demonstration is to reduce the number of uninsured as well as the rate of uninsurance for Utahns while improving the quality, value and access of care received by beneficiaries.

To show that value can be added to the system without increasing costs by shifting some resources from fully indemnified populations to populations that currently have no health care coverage. In addition, the demonstration seeks to increase health insurance coverage without directly providing the coverage through government-managed programs.

State's hypotheses on outcomes of the demonstration

There are five hypotheses in this demonstration that will be evaluated

Hypothesis #1: The demonstration will not negatively impact the overall health well-being of Current Eligibles who experience reduced benefits and increased cost sharing.

Hypothesis #2: The demonstration will improve well-being in Utah by:

a. Reducing the number of Utahns without coverage for primary health care.

b. Improving PCN enrollees' access to primary care.

c. Improving the overall well-being in the health status of PCN enrollees.

Hypothesis #3: The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.

Hypothesis #4: The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.

Hypothesis #5: The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.

Hypothesis #6: The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.

Key interventions planned

Implementation and administration of the Primary Care Network program PCN Expansion

Implementation and administration of the Utah's Premium Partnership for Health Insurance Program (UPP) for both employer-sponsored insurance and COBRA continuation coverage.

Implementation and administration of the High-Risk Pregnancy Program

Evaluation Design

General Approach to Evaluation

Data Sources

Claims Data: The State has access to claims data for PCN and High-Risk pregnancy enrollees through the State's fee for service system. We will use that data to monitor utilization patterns and costs. The State also has access to claims data for Current Eligibles who are affected by this demonstration. However, it should be noted that Current eligibles in Weber, Davis, Salt Lake and Utah counties are enrolled in managed care. Therefore some data on Current Eligibles may not be immediately comparable to that in the State's system.

Outcome Tracking Data: Specialty, charitable care is not an included benefit in the PCN demonstration. Primary care providers may contact PCN administration and request a referral for specialty care. Charitable Care Coordinators endeavor to fill this gap by seeking donated charitable care from providers and institutions. Outcomes of these endeavors are tracked and summarized.

Comparison groups

Where possible, the State will compare PCN enrollee utilization and health status to similar populations within traditional Medicaid and Non-Traditional Medicaid.

Timelines for Completing and Delivering Elements of the Evaluation

Draft Evaluation Report: December 31, 2012.

Final Evaluation Report: Within 60 days after receipt of CMS feedback on the Draft Report.

Plan for Analysis

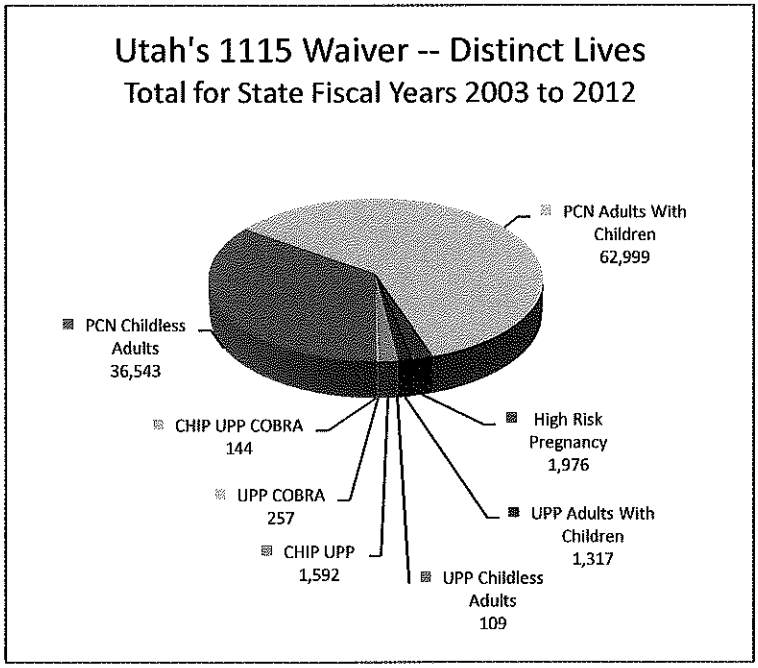
1. Evaluation of performance of the demonstration,
2. Report outcomes,
3. Identify limitations, challenges and opportunities,
4. Identify successes and best practices,
5. Revise strategies or goals,
6. Develop recommendations and implication at the state and federal levels.

Introduction

Historically, Utahns age 19 to 64 have the highest rate of uninsurance in the state. The rate of uninsurance is highest among adults with family incomes below 150 percent of the Federal Poverty Level (FPL)—the working poor—a group that, even though employed, is not able to acquire or afford health insurance through their employers.[1]

In 2011, 18.7 percent of all Utahns age 19-64 declared that they were uninsured. During that same year (2011), 13.2 percent of Utahns employed full-time were uninsured while 41.3 percent of Utahns with a household income below 150 percent FPL were uninsured. It is this group that Utah's Primary Care Network (PCN) was designed to serve by offering limited benefits to cover their day-to-day needs and to encourage them to appropriately use the health care system. The basic goal of PCN is to serve a larger percentage of this income group with basic benefits than could be served if the coverage were more comprehensive.

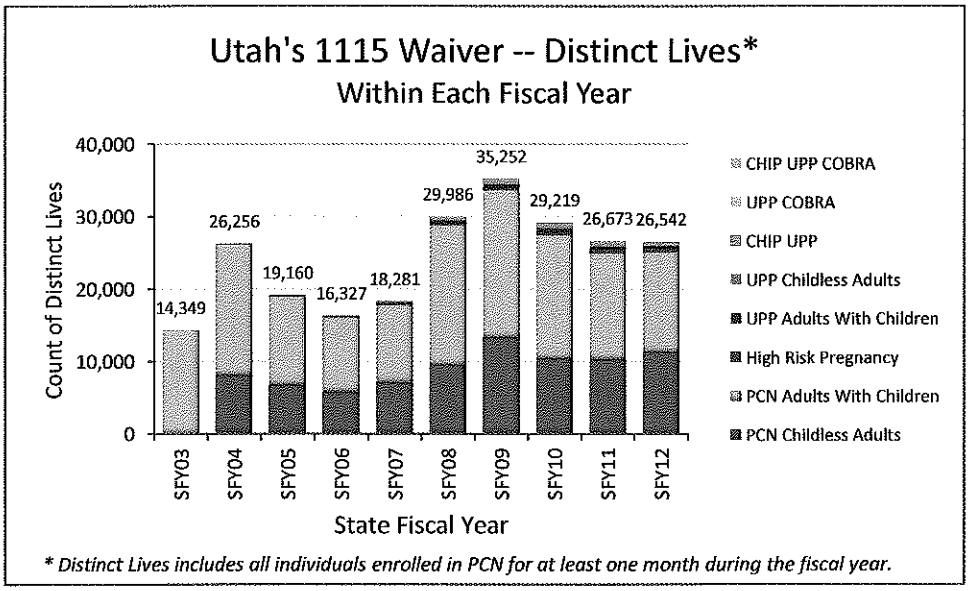
Since its inception in July 2002 through the end of Utah state fiscal year 2012 (June 30, 2012), Utah's Primary Care Network has served a total of 104,937 individuals, with an average of 24,200 unique lives being served in each fiscal year.



Total enrollment fluctuates as applications are only accepted during open enrollment periods, which are held when sufficient resources are available to cover more people. The federal government requires PCN to enroll more adults with children than people without children. Because of this, PCN may schedule separate enrollment times for parents and those without children. To qualify as a parent, the applicant must have children age 18 or younger living at home. Enrollment can be held at any time throughout the year as space becomes available.

The primary source for applicants to learn about Utah's Primary Care Network is from the Department of Workforce Services Eligibility Workers, as applicants are seeking public assistance.

During state fiscal year (SFY) 2008 and into SFY 2009, the Utah Department of Health increased the marketing, and subsequently the awareness, of PCN resulting in peak enrollment during SFY 2009. During that peak (SFY 2009), a total of over 35,242 distinct lives were served for at least one month during the year. Moreover, the all-time monthly peak enrollment occurred in June of 2009, with 24,405 individuals participating in the Primary Care Network.[2]



PCN offers primary care services which include: primary care provider visits; four prescriptions per month; dental exams, dental x-rays, cleanings, and fillings; immunizations; an eye exam (no glasses or contacts); routine lab services and x-rays; limited emergency department visits; emergency medical transportation; and birth control.

Overnight hospital stays, MRIs, CT scans, and similar services, as well as visits to specialists such as orthopedists or cardiologists are not covered under PCN. To assist PCN clients who may be in need of non-covered services, a written request may be made by a participant's primary care provider for a PCN Specialty Care Coordinator to assist in finding providers who are willing to donate services or provide treatment for a minimal co-pay.

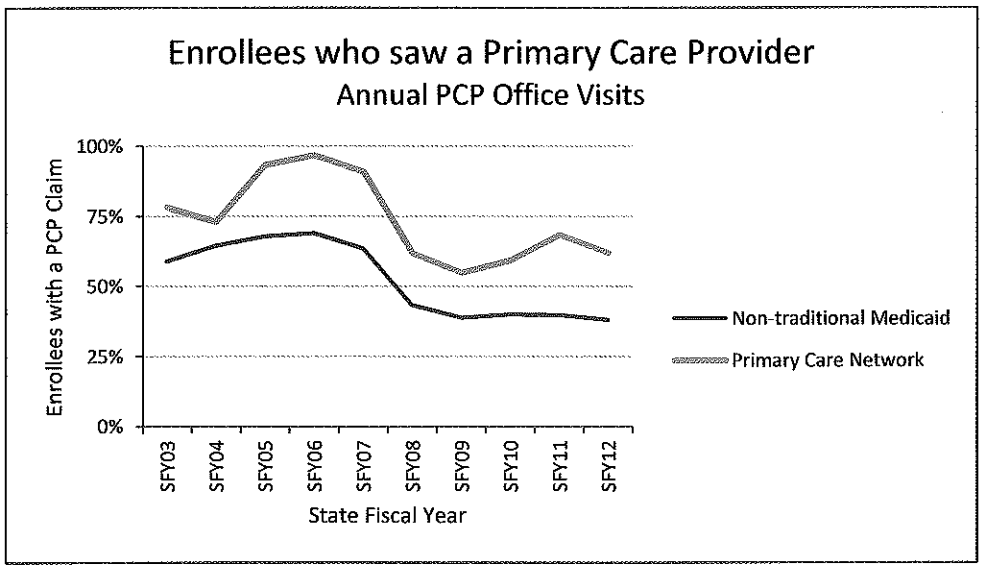
Evaluation of Hypotheses

Hypothesis 1: *The demonstration will not negatively impact the overall well-being, in relation to health status, of Current Eligibles (Non-Traditional Medicaid) who experience reduced benefits and increased cost sharing.*

According to insurance claims filed with Utah medical assistance programs, during the first five years the PCN program was in existence, many enrollees took advantage of the ability to see a primary care provider (PCP) as they had not access to basic health care for many years. The rate of individuals who accessed PCP care increased to a peak of 97 percent of enrollees in SFY 2006. During this same time period, Non-Traditional Medicaid (NTM) participants also increased their visits to PCPs to a peak of 69 percent in SFY 2006.[3]

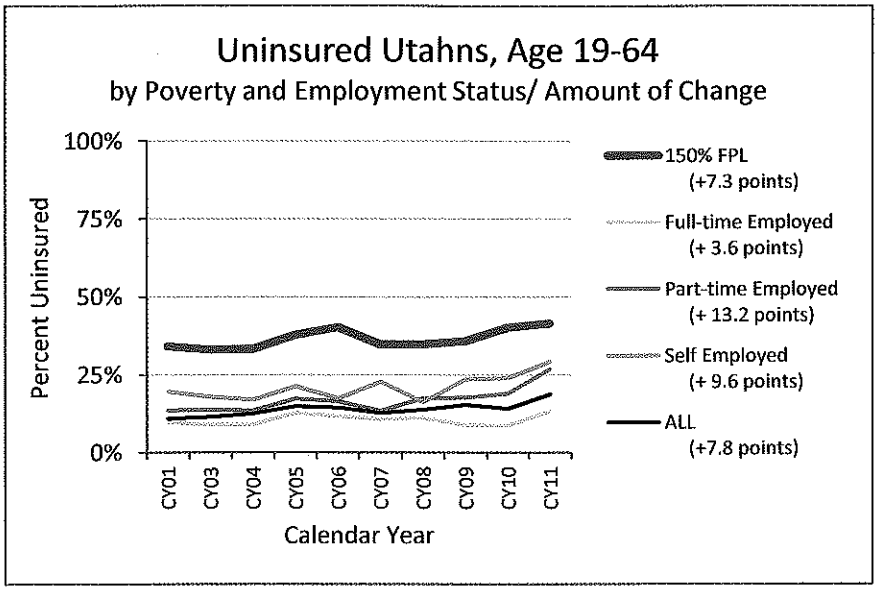
Rates of accessing a PCP diminished for both PCN and NTM from SFY 2006 to SFY 2009. However, with similar rates of decrease for both, one did not adversely affect the other.

During SFY 2009 and 2010, the Utah converted to a new eligibility enrollment system and PCN again experienced an increase in participants accessing a PCP, although not the degree experienced with the implementation of the PCN program (up to 68 percent in SFY 2011). At the same time, access to a PCP among NTM enrollees maintained an even rate between 38 percent and 40 percent. Again, there was no negative impact to the NTM group by increase of PCN enrollees seeking PCP care.



Hypothesis 2a: *The demonstration will improve well-being in Utah by reducing the number of Utahns without coverage for primary health care.*

Between 2001 and 2011, the percent of Utahns without health insurance increased among all adults age 19 to 64. This increase in uninsurance affected not only the PCN target group—those at 0-150-percent of the Federal Poverty Level (FPL)—but the three major employment groups as well: full-time, part-time, and self-employed.[4]



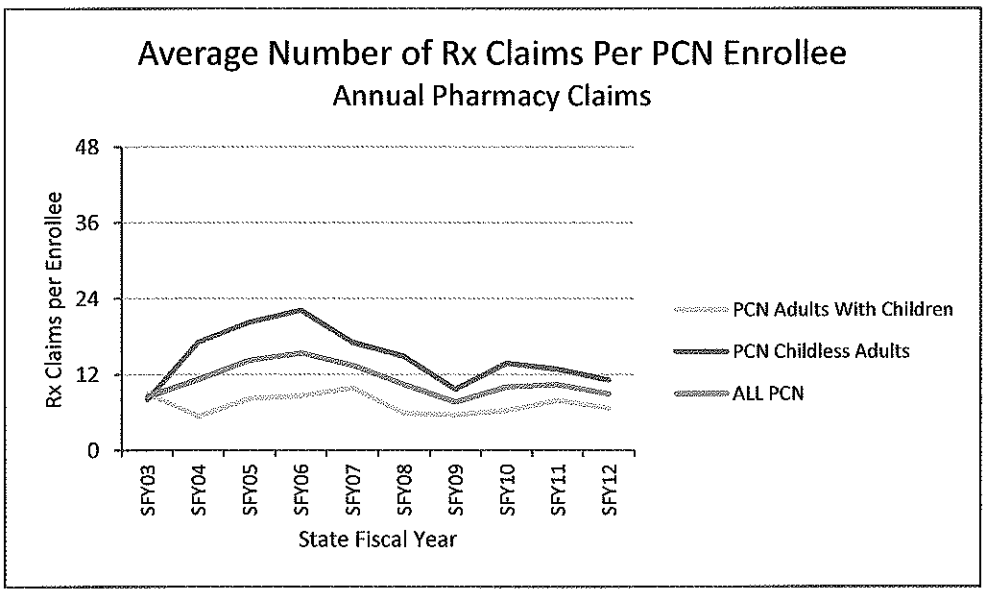
The PCN target group continues to have the highest rate of uninsurance, but the increase in the rate of uninsurance in the PCN target group is lower than for all of the employment groups except for adults employed full time. The PCN target group experienced an increase of 7.3 percentage points in uninsurance between 2001 (34.0 percent) to 2011 (41.3 percent), while the self-employed-adults group increased 9.6 points (2001: 19.5 percent to 2011: 29.1 percent), and the rate of uninsurance for the part-time-employed group nearly doubled, increasing 13.2 points (2001: 13.4 percent to 2011: 26.6 percent uninsured). Even the employed-full-time group experienced an increase in uninsurance, up 3.6 points (2001: 9.6 percent to 2011: 13.2 percent).

It is postulated that lower rate of increase in the target group is due, at least in part, to the availability of PCN insurance.

Hypothesis 2b: *The demonstration will improve well-being in Utah by improving PCN enrollees' access to primary care.*

The PCN benefit covers four prescriptions each month or a maximum of 48 per year. The number of prescriptions is not limited in the Medicaid and Non-Traditional Medicaid programs.

As reflected in Hypothesis 1 (PCP visits), the first few years of the PCN program ushered in a greater need to treat pent-up conditions among a group of people who had collectively been without health insurance for a number of years. Even so, with an allowable 48 prescription claims allowed per year, the highest average number of prescription claims filed among PCN enrollees is 15.3 in SFY 2006, including both PCN adults with children and PCN childless adults. As these initial needs were quelled, the average number of prescription claims per PCN enrollee has settled in at an average less than 12 per year.[5]



Through PCN, approximately 24,000 individual lives each year since July 1, 2002 have been improved by having access to basic primary medical care and a limited number of prescriptions. This is coverage that is not available through any other source for this group of people.

Hypothesis 2c: *The demonstration will improve well-being in Utah by improving the overall well-being in the health status of PCN enrollees.*

As a primary care program, PCN does not cover inpatient hospital services such as surgery or overnight hospital stays. If it is determined that a client needs to stay in the hospital for more than 24 hours, the client should contact the hospital's billing office to determine eligibility for the hospital's charity care program.

Likewise, specialty care services such as cardiology, gastroenterology, etc. are not a covered by PCN. However, with a written referral that includes clinical notes from a primary care provider (PCP), PCN is committed to assisting with a search for donated services at little or no cost to the client.

Between April 2005 and June 2011, PCN Specialty Care Coordinators received a total of 11,615 referrals from PCPs. The Care Coordinators voluntarily tracked and categorized the outcomes of these referrals. Those tracked outcomes have been summarized into four categories.[6]

Services Rendered: Successfully arranged specialty care, the requested service is a covered PCN benefit (specialty care was not required), clients arranged their own specialty service, and client obtained health insurance.

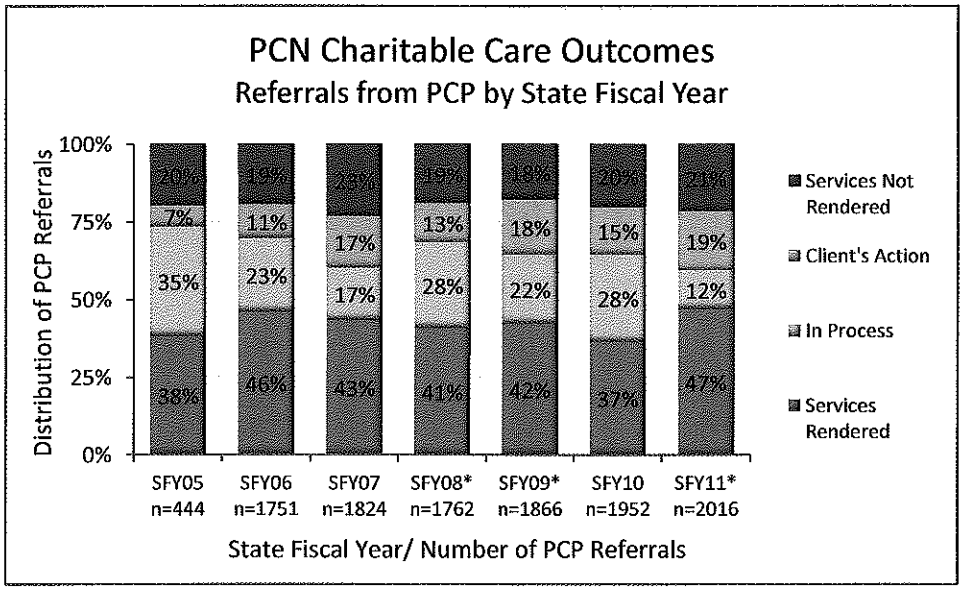
In Process: Outcome is pending, client is on the charitable-care waiting list at University Healthcare (U of U Medical Center), client has been contacted—awaiting a response, case was transferred, and duplicate referral.

Client's action: Client has not responded to communication, service was not required, client was not eligible for PCN, and client refused service.

Services Not Rendered: Client cannot pay fee, Intermountain Healthcare denied charity care, and service referral was unsuccessful/unavailable.

The plurality of outcomes (those with the greatest proportion) falls in the "Services Rendered" category. Indeed, Specialty Care Coordinators have been able to report 37 percent (SFY 2010) to 47 percent (SFY 2011) of the referrals they have received have resulted in services being rendered.

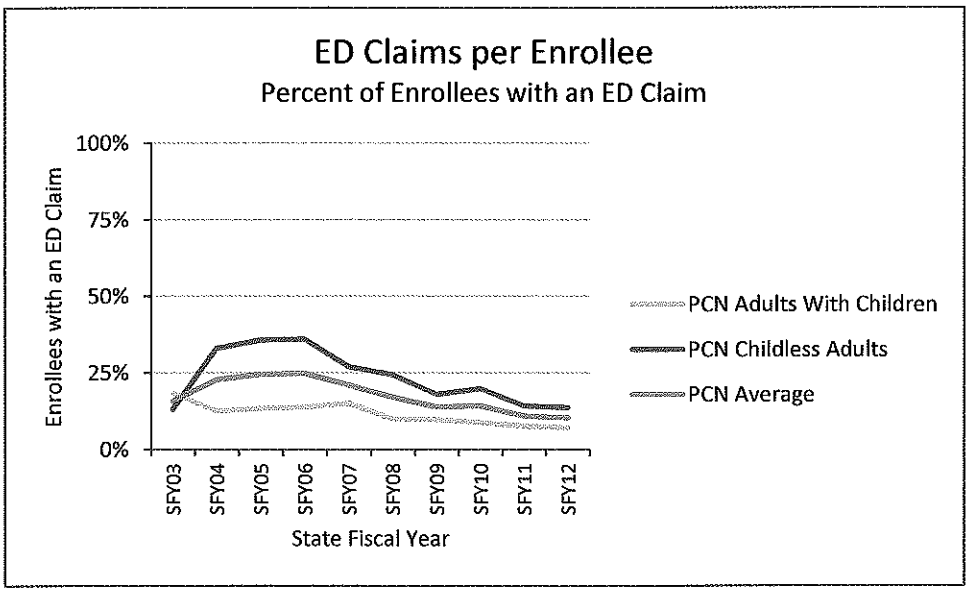
By comparison, "Services Not Rendered" outcomes range from 18 percent (SFY 2009) to 23 percent (SFY 2006)—roughly half of what the "Services Rendered" percentages are for each fiscal year.



Outcomes identified as "In Process" in most cases were resolved in the following quarter. The group of outcomes categorized as "Client's Action" were out of the Specialty Care Coordinator's control, with the majority of them being a non-response from the client, even after the Coordinator attempted to contact them at a variety of times and using all available contact information.

Hypothesis 3: *The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.*

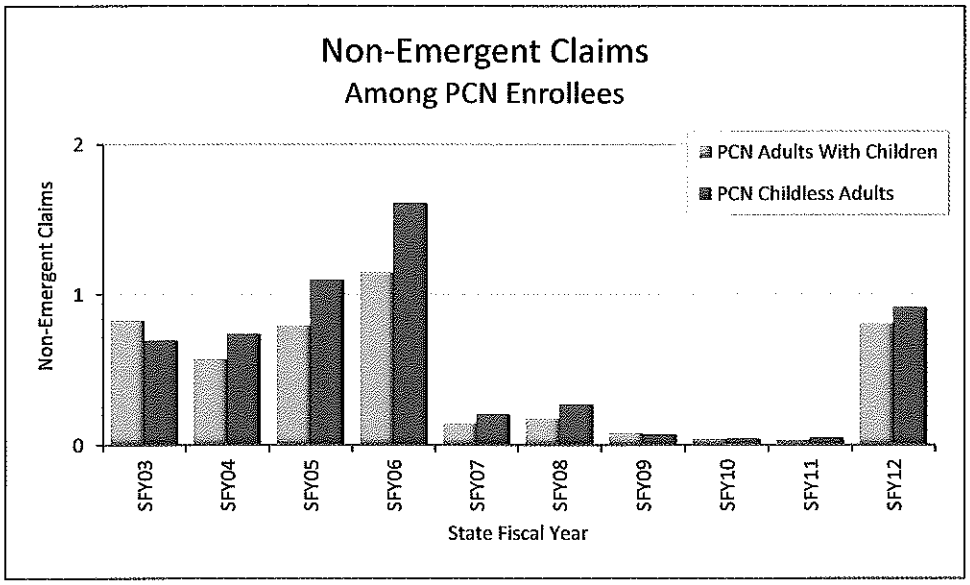
Consistent with Hypotheses 1 (PCP visits) and 2b (Rx claims), there were a higher percentage of PCN enrollees with emergency department (ED) claims in the first few years of the PCN program, primarily among childless adults, as multiple years of untreated conditions were being addressed. Indeed in state fiscal years 2004 through 2006, over one-third (33 to 36 percent) of PCN childless adults had an ED claim. In the subsequent years, the percent of PCN clients with an ED claim has maintained a downward trend, with 10 percent of PCN childless adults filing an ED claim in SFY 2012—a drop of 26 percentage points. Even among PCN adults with children, the percent with an ED claim started at 18 percent in SFY 2003 and was down to 7 percent in SFY 2012.[7]



Looking deeper at the status of ED claim—whether they were coded as emergent or non-emergent by the provider—reveals that 0.8 claims per PCN adult with children and 0.7 claims per PCN childless adult were non-emergent in SFY 2003. That rate continued to increase and reached a high in SFY 2006 with 1.1 non-emergent claims per PCN adult with children and 1.6 non-emergent claims per PCN childless adult.

In SFY 2007, efforts to educate all Medicaid enrollees about appropriate emergency department use increased and the overall number of ED claims decreased as did the incidence of non-emergent claims, dropping to 0.1 (PCN adults with children) and 0.2 (PCN childless adults) non-emergent claims per recipient.

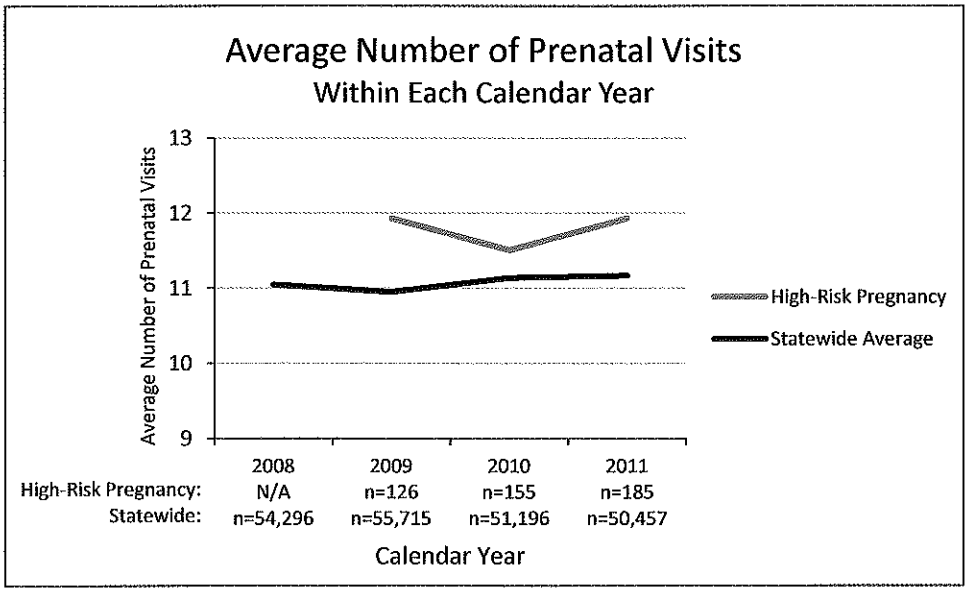
The incidence of non-emergent ED claims has increased in SFY 2012 to levels that surpass SFY 2003 (0.8 and 0.9 claims per enrollee, respectively); this calls for a renewed effort to educate public health recipients about appropriate emergency department use.



Hypothesis 4: *The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.*

According to the birth records within the Utah Office of Vital Records and Statistics, Utah women who give birth during 2008 had an average of 11.05 prenatal visits, which serves as a baseline for this comparison. This includes all women, regardless of health insurance coverage or risk level. In 2009, the statewide average number of prenatal visits decreased slightly to 10.95, but has consistently increased to an annual average of 11.17 prenatal visits in 2011.[8]

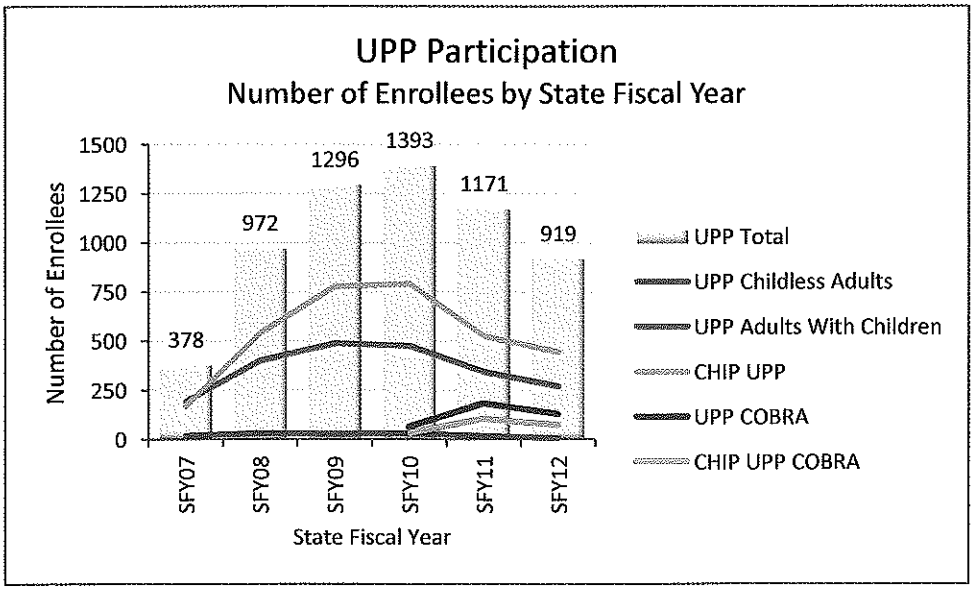
The average number of prenatal visits for the High-Risk Pregnancy group has been consistently higher than the statewide average, with an average of 11.93 prenatal visits in 2009 (compared to 10.95 statewide). The rate of prenatal visits for the High-Risk Pregnancy group dipped to 11.51 in 2010 and rebounded to 11.93 in 2011.[9] It should be noted, however that the number of births under the 1115 Waiver (3-year average: 155) is significantly smaller than the total number of births in Utah (3-year average: 52,456).



Hypothesis 5: *The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.*

In November 2006, Utah's Premium Partnership for Health Insurance (UPP) was implemented to create opportunities for qualified individuals and their family members under age 18 to purchase employer-sponsored health insurance by reimbursing health insurance premiums up to $150 per adult and $120 per child ($140 per child if dental coverage is also purchased) every month.

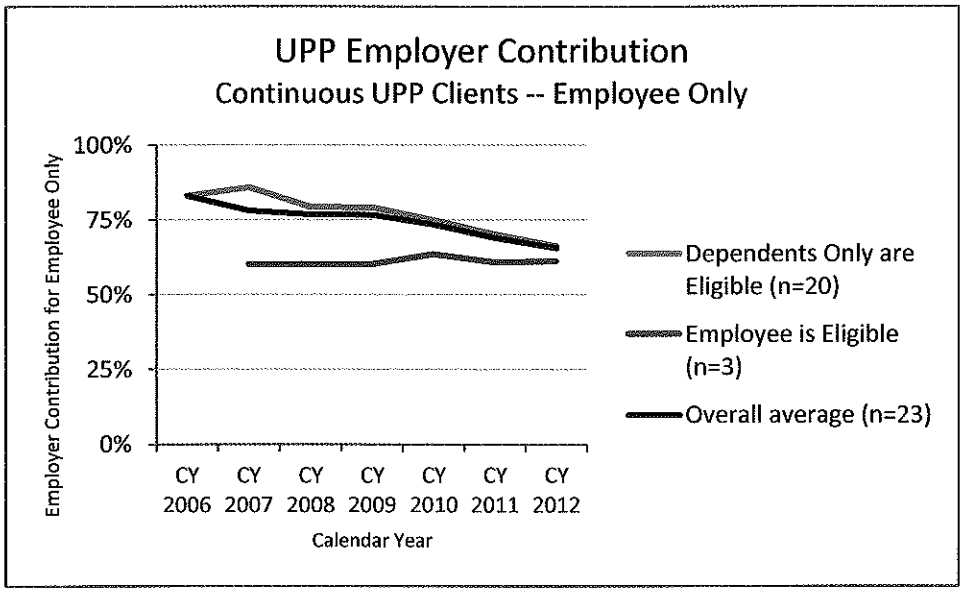
The Utah Department of Health implemented a marketing push for UPP in SFY 2008 and SFY 2009, when total enrollment in UPP reached its peak of 1,393 participants. Then in March 2010, President Obama issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to the new health insurance exchanges. It was determined that the Executive Order in conjunction with the intent of the state law created new expectations for the UPP subsidy. In April 2010, an emergency rule was filed to prohibit UPP from reimbursing participants who were enrolled in plans covering abortion services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). Subsequently, enrollment in UPP in SFY 2012—919 participants—is approximately two-thirds of what it was at its peak.



The population served by UPP is relatively small, a total of about 3,250 distinct lives over six years, counting both adults and their dependent children.[10]

Just 23 clients have been continuously enrolled in UPP for the last five years. Of these individuals, 20 were not eligible for the employer reimbursement for their personal premium, but utilized UPP to assist with health insurance premium payments for their dependents. The three individuals who have received UPP assistance with their health insurance premium have experienced no decrease in employer contributions. Indeed, their employers were paying an average of 60 percent of the premium in 2007 and an average of 61 percent in 2012.[11]

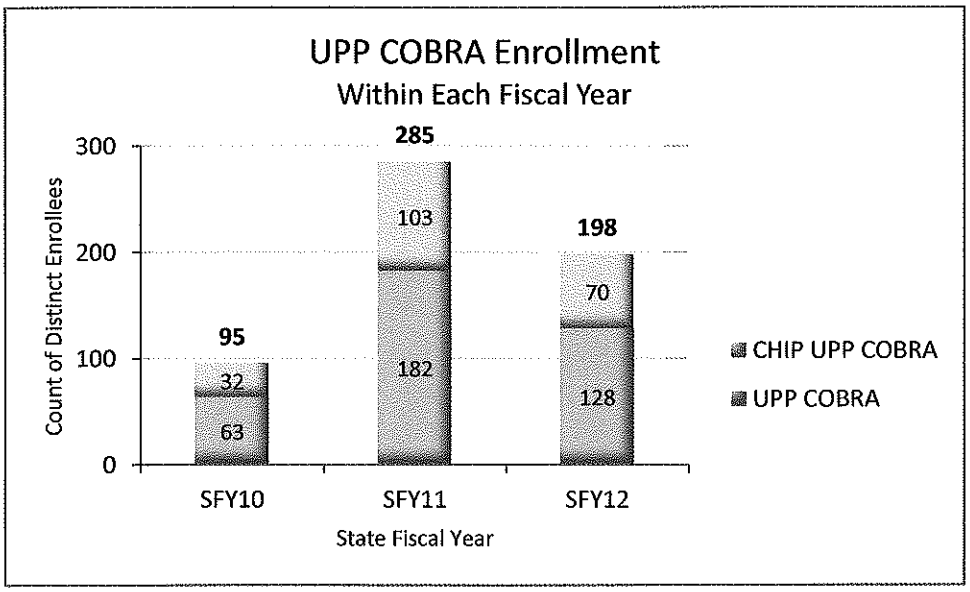
For individuals using UPP to assist with premiums for their dependents only, the employer contribution for their personal premium (not the premium of their dependents) has decreased from an average of 83 percent in 2006 to an average of 66 percent in 2012. However, UPP was not reimbursing this premium and is therefore not accountable for the decrease in the employer contribution.



Hypothesis 6: *The demonstration will assist individuals currently eligible for or enrolled in COBRA* with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.*

Utah's 1115 Waiver was amended in SFY 2010 to allow for premium assistance for COBRA coverage. Based on family size, income, and if the former employer's health insurance coverage meets basic guidelines, UPP COBRA recipients may be reimbursed for up to $150 per adult and up to $120 per child in the family (up to $140 per child, if the child is enrolled in dental coverage) every month.

In SFY 2011, the American Recovery and Reinvestment Act (ARRA) provided an additional subsidy for employers to pay for COBRA benefits resulting in higher UPP COBRA enrollment until the subsidy ended in February 2011. The end of this subsidy, combined with the 2010 executive order limiting which COBRA plans qualify for UPP assistance, resulted in 30 percent fewer UPP COBRA enrollees in SFY 2012



From its inception in SFY 2010 through the end of state fiscal year 2012, there have been 257 adults and 144 children (a total of 401 lives) who have received UPP assistance with their COBRA premiums.[12]

* Consolidated Omnibus Budget Reconciliation Act

Conclusion and Recommendations

Utah's 1115 Primary Care Network Demonstration Waiver has proved to provide a significant benefit to Utah residents who would otherwise have no health insurance coverage and would likely go without health care. Until such time, as the State of Utah determines how or if it will expand Medicaid coverage under the provisions of the federal Affordable Care Act, Utah's 1115 Primary Care Network Demonstration Waiver should continue. Without the waiver, thousands of Utahns would go without needed healthcare.

Endnotes

[1] Utah's Indicator-Based Information System for Public Health (IBIS-PH), Health Insurance Highlights Table, 2011 Behavioral Risk Factor Surveillance system Survey (BRFSS), **http://health.utah.gov/opha/publications/2011brfss/Highlights_2011.pdf.**

[2] Counts of distinct lives enrolled under Utah's 1115 Demonstration Waiver using monthly enrollment data aggregated by all-time enrollment, state fiscal year enrollment, and monthly enrollment. An individual is counted on once within any time period.

[3] Analysis of claims data for PCN and Non-Traditional Medicaid including counts of all enrollees and those with a claim containing the following CPT4 billing codes: 99201-99205, 99211-99215, 99381-99385, 99391-99395, 99241-99245, 99354, 99355, G0438, G0439, and/or S5190.

[4] Utah's Indicator-Based Information System for Public Health (IBIS-PH), Health Insurance Highlights Table, 2011 Behavioral Risk Factor Surveillance system Survey (BRFSS).

[5] PCN claims data: Count of prescription claims data for PCN adults with children and PCN childless adults compared to the number of PCN enrollee within each state fiscal year.

[6] Specialty Care Coordinator's Primary Care Network Combined Quarterly Reports from April 2005 through June 2011. Coordinators log requested specialties, outcomes, and geographic area. Outcomes were summarized for this report.

[7] Analysis of Utah Medicaid claims data for emergency department (ED) claims, including counts of enrollees, ED recipients, ED claims, and the emergency indicator.

[8] Data for All Medicaid, Not Medicaid, and Statewide Average comes from a query of Utah's Indicator-Based Information System for Public Health (IBIS-PH), Data Table of Average Number of Prenatal Visits by Mother's Medicaid Status, for years 2008 to 2011, **http://ibis.health.utah.gov/query/result/birth/BirthBirthRaceCnty/AvgPNCVisit.html.**

[9] Specific data for the High-Risk Pregnancy group comes from a query of Vital Records birth tables within the Utah Medicaid Data Warehouse; no identifier exists in the IBIS data to query at this level. This data first comes available with calendar year 2009 data.

[10] Count of distinct Utah Medicaid enrollees with at least one month of eligibility, aggregated by state fiscal years 2007 to 2012.

[11] Utah Department of Health UPP Employer Contribution 2006-2012 Enrollment Report.

[12] Count of distinct Utah Medicaid UPP enrollees and their dependents with at least one month of eligibility, aggregated by state fiscal years 2010 to 2012.

ATTACHMENT 3

Special Notice

This notice was published in the December 1, 2012, issue (Vol. 2012, No. 23) of the Utah State Bulletin.

Special Notice: Special Notice for the Primary Care Network

Notice of Public Hearing on the Extension of the 1115 Primary Care Network Demonstration Waiver

Pursuant to the requirements of 42 CFR 431.408, two public hearings regarding the proposed extension of the 1115 Primary Care Network Demonstration Waiver will be held on the following dates and times:

Friday, December 7, 2012, from 4:00 PM to 6:00 PM at the Cannon Health Building, Room 125, 288 North 1460 West, Salt Lake City, Utah. Attendees may participate by telephone 801-521-5399.

Tuesday, December 11, 2012, from 3:30 PM to 5:30 PM at the Cannon Health Building, Room 101, 288 North 1460 West, Salt Lake City, Utah. This will be a special meeting of the Medical Care Advisory Committee. Attendees may participate by telephone 801-521-3615.

The Utah Department of Health, Division of Medicaid and Health Financing is submitting a request to extend the 1115 Primary Care Network Medicaid Waiver for another three years. This will allow the Department to continue operating PCN, Non-Traditional Medicaid, High Risk Pregnancy, and Utah's Premium Partnership Program through June 30, 2016. Additional information can be viewed at: http://www.health.utah.gov/medicaid/

The proposed extension is subject to Centers for Medicare and Medicaid Services (CMS) approval.

For questions regarding this notice, please contact Leigha Rodak at 801-538-6806 or lrodak@utah.gov.

Additional Information

The Portable Document Format (PDF) version of the Bulletin is the official version. The PDF version of this issue is available at http://www.rules.utah.gov/publicat/bull-pdf/2012/b20121201.pdf. The HTML edition of the Bulletin is a convenience copy. Any discrepancy between the PDF version and HTML version is resolved in favor of the PDF version.

For questions regarding *this notice*, please contact Craig Devashrayee, by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at cdevashrayee@utah.gov.

Home | Publications | Utah State Bulletin | 12/01/2012 Contents | Special Notice (sn153540)

[redacted]

ATTACHMENT 4

1115 PCN Demonstration Waiver
Application for Extension
Public Hearing
December 7, 2012
Room 125 Cannon Health Building
Attendees

NAME	Organization	Phone #	E-mail

1115 Primary Care Network (PCN) Demonstration Waiver
Application for Extension

Program Description

The Utah 1115 Primary Care Network (PCN) Demonstration Waiver was originally submitted in December 2011 and implemented on July 1, 2002. This is a statewide waiver which expands Medicaid coverage to certain able bodied adults who are not eligible for Medicaid State Plan services. The Waiver also offers these adults and children on the Children's Health Insurance Program (CHIP) an alternative to traditional direct coverage. The Waiver provides a reduced benefit package for parents and caretaker relatives who qualify for Medicaid State Plan and requires higher cost sharing for these groups. This is referred to as "Non-Traditional" Medicaid. The savings from these reductions are used to fund a Medicaid expansion for up to 25,000 uninsured adults between the ages of 19 and 65 with household incomes up to 200% of the Federal Poverty Level (FPL). This expansion population of parents, caretaker relatives and childless adults is covered for a limited package of preventative and primary care services. This is referred to as the Primary Care Network (PCN) program.

In addition, high risk pregnant women, whose resources make them ineligible under the Medicaid State Plan, are covered under this Demonstration for the full Medicaid Package

In October 2006, the Waiver was amended to also use demonstration savings to offer assistance with payment of insurance premiums for employer sponsored insurance (ESI) through the Utah's Premium Partnership for Health Insurance program (UPP). The Waiver was later amended to allow for premium assistance for COBRA continuation coverage. The UPP uses Medicaid (Title XIX) funds to provide up to $150.00 per month in premium assistance for eligible adults. UPP uses CHIP (Title XXI) funds to provide premium assistance up to $120.00 per month per child. UPP Children receive dental coverage through direct CHIP coverage or they receive an additional $20.00 per month if they receive dental coverage through ESI.

Demonstration Waiver Renewal.

CMS only approves demonstration waivers for a period of three years. If the State wishes to continue a demonstration, the State must apply for and justify an extension to CMS. The current 1115 PCN Demonstration waiver is set to expire on June 30, 2013. Therefore, the State is submitting an application to renew the waiver for an additional three year period (July 1, 2013-June 30, 2016.) Pending a final decision from the Governor and the Legislature on Medicaid expansion under the Affordable Care Act, the Department believes it is prudent to pursue an extension of the Waiver. Failure to extend the waiver will mean termination of the PCN, High Risk Pregnant women and UPP programs effective June 30, 2013.

Utah Indian Health Advisory Board (UIHAB) Meeting

ATTACHMENT 5

12/07/2012
9 AM –1 PM
Utah Department of Health
3760 So. Highland Drive
Board Room, 5th Floor
Salt Lake City, UT
84106

Meeting called by:	UIHAB DRAFT DRAFT DRAFT DRAFT DRAFT
Type of meeting:	Monthly
Facilitator:	Melissa Zito
Note taker:	Gayle Coombs (Bridge Line # 801-521-5399)
Please Review:	November Board minutes, Medicaid Rules & SPA document(s), Waiver summary(s)

Agenda topics

9:00 AM	Welcome & Introductions Approval Minutes	Amy Cesspooch
9:15 AM	Committee Updates & Discussion • Medicaid State Plan Amendments (SPA) & Rules • DWS Medicaid Eligibility • MCAC • CHIP Advisory Committee • UDOH Office of Health Disparities	Craig Devashrayee Jacoy Richens David Ward LeAnna Vankeuren Dulce Diez
10:15 AM	Asset Verification for Blind & Disabled	Jeff Nelson
10:45 AM	Extension of 1115 Wavier for PCN	Emma Chacon
11:00 AM	Clinical Health Information Exchange (cHIE)	Mary Carbaugh
11:15 AM	Gestational Diabetes; Health System Assessment	Grant Sunada
11:30 AM	Autism Waiver Amendments	Josip Ambrenac
11:45 PM	U of U Dept. of Pediatrics	Richard White
12:00 PM	UDOH Updates • Indian Health Medicaid Manual update • 2013 AI Summit; 8/14-15/2013 • OIG Audit; update	Melissa Zito Cecelia Richins
12:10 PM	I/T/U Updates	UIHAB Representatives
12:40 PM	Holiday Celebration & Gift Exchange!	
1:00 PM	Adjourn	

ATTACHMENT 6

December 17, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

We are writing in support of the application for the extension of Utah's 1115 Primary Care Network Demonstration Waiver. The current waiver is set to expire June 30, 2013. Utah's 1115 waiver created critical programs which continue to provide healthcare to thousands of Utahns between the ages of 19 and 64 who are not eligible for Medicaid. In addition, the waiver provides an opportunity for low-income families to access health insurance coverage through their employer or through COBRA continuation coverage with premium reimbursement assistance. This premium subsidy program can provide an important tool in ensuring health plans are affordable for low-income families receiving employer sponsored coverage even after the full implementation of the Affordable Care Act in 2014.

As you know, many states have yet to make a decision regarding expansion of Medicaid coverage to adults between the ages of 19 and 64 up to one hundred thirty-eight percent (138%) of the FPL. In an effort to minimize any disruption in healthcare for the individuals covered under the waiver, the Utah Medical Care Advisory Committee strongly supports an extension of the waiver as it is currently written. Depending on Utah's final decision regarding Medicaid expansion, a request for amendment or a transition plan for termination of the waiver will be submitted at a later date.

We appreciate your consideration in this matter.

Respectfully,

Lincoln Nehring, Chair
Medical Care Advisory Committee

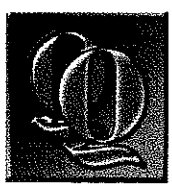
ATTACHMENT 7

Utah Department of Health
Division of Medicaid and Health Financing
Bureau of Managed Health Care

2012
Annual External Quality Review Report

Report Issued December 2012

HCE QualityQuest



Submitted by:

HCE QualityQuest

TABLE OF CONTENTS

IV. DESCRIPTION OF FINDINGS

V. CONCLUSIONS, REQUIRED CORRECTIVE ACTIONS AND UDOH RECOMMENDATIONS

LIST OF TABLES

I. EXECUTIVE SUMMARY

A. Overview of External Quality Review Requirements and Process

Medicaid is a joint federal and State program that provides medical assistance to low-income individuals including children, the elderly, individuals with disabilities, and pregnant women. Many states use managed care programs as a means of controlling expenditures while providing this medical assistance.

The State of Utah, Utah Department of Health (UDOH) contracts with eleven managed care entities (MCEs) under 1915(b) waiver authority. Two MCEs are referred to as Physical Health Plans (PHPs) in this report; one is a Managed Care Organization (MCO) and one is a Prepaid Ambulatory Health Plan (PAHP). All nine Prepaid Mental Health Plans (PMHPs) are Prepaid Inpatient Health Plans (PIHPs). For the purposes of this report, the term MCE refers to both the PHPs and PMHPs. The majority of Utah's Medicaid population is enrolled in MCEs.

The Balanced Budget Act of 1997 (BBA) added Section 1932 to the Social Security Act (the Act), pertaining to Medicaid managed care. Section 1932(c) of the Act requires states to implement a quality assessment and improvement strategy. Included in that strategy is an annual external independent review of the quality, outcomes, timeliness, and access to the services covered under each managed care contract.

The Centers for Medicare and Medicaid Services (CMS) requires states to have external quality reviews (EQR) of their MCEs. To fulfill this requirement, UDOH contracts with HCE QualityQuest (QQ), an external quality review organization (EQRO), to conduct the required EQR.

QQ's 2012 scope of work included EQR activities for all 11 MCEs. This report includes:

- The results of QQ's validation of Performance Improvement Project (PIP) activities underway during 2011 for ten MCEs (nine PMHPs and one MCO);
- Performance Measures Performance for ten MCEs (nine PMHPs and one MCO); and
- Follow-up contract compliance reviews for ten MCEs (nine PMHPs, and one PAHP)

This report also contains four appendices.

Appendix 1: *Annual Report Format Crosswalk*
This appendix contains a crosswalk that provides an overview of how the report is organized. In addition, the crosswalk describes the sections of the report containing federally mandated components under 42 CFR §438.364 and content recommended by CMS in the *Centers for Medicare and Medicaid Services' State External Quality Review Toolkit for State Medicaid Agencies, Issued October 2006* (EQR Toolkit).

Appendix 2: *Sample HEDIS Measure*
This appendix contains the information required to obtain the *Breast Cancer Screening* measure. It provides an example of the requirements for collecting one HEDIS measure.

Appendix 3: *Completion Status of Required Corrective Actions Identified in 2011*
This appendix contains a summary of the corrective actions QQ required of each MCE, based on its 2011 EQR, and the completion status of QQ's 2012 follow-up reviews.

Appendix 4: *Required Corrective Actions Identified in 2012*
This appendix contains a summary of the required corrective actions for all EQR activities performed in 2012.

This annual EQR report aggregates the data and analysis from EQR activities and presents statewide conclusions regarding quality, timeliness, and access to care. QQ produced Individual Plan Reports (IPR) for each MCE detailing the review findings and any required corrective actions the MCEs must implement.

B. Major Findings for Quality, Timeliness, and Access to Care

Performance Improvement Projects Performance

In accordance with Federal managed care regulations, the UDOH, requires the MCEs to conduct PIPs. The purpose of PIPs is to improve health outcomes and/or enrollee satisfaction.

Six of the nine PMHPs chose a topic related to improving concurrent or collaborative documentation during treatment sessions. The choice of this topic is both timely and relevant as concurrent/collaborative documentation has gained national acceptance. Three of these six PMHPs collaborated on their PIP. Of the three remaining PMHPs, one is focusing on improving assessment of possible co-occurring substance abuse disorders; one is focusing on improving therapists' use of outcomes data in treatment sessions; and the other is focusing on decreasing no-show rates for initial mental health appointments. All of the PMHPs chose meaningful and relevant study topics.

Based on QQ's review of PIP activities performed in 2011, QQ determined that overall, the PMHPs *Met* 94% of the applicable PIP criteria. PMHPs' scores ranged from 64% to 100%. Four PMHPs, Davis Behavioral Health (DBH), Northeastern Counseling Center (NCC), Southwest Behavioral Health Center (SBHC), and Wasatch Mental Health (WMH) *Met* 100% of the applicable criteria. Two PMHPs, Central Utah Counseling Center (CUCC) and Weber Human Services (WHS) *Met* 97% of the applicable criteria. Two PMHPs, Four Corners Community Behavioral Health (FCCBH), and Valley Mental Health (VMH) *Met* 92% of the applicable criteria. One PMHP, Bear River Mental Health (BRMH) *Met* 64% of the applicable criteria.

The MCO, Molina Healthcare of Utah (MHU), chose as its PIP topic the development of intervention strategies to increase the incidence of LDL screening among its enrollees

with diabetes. Improvements in blood lipid control can reduce cardiovascular complications in individuals with diabetes by as much as 50 percent; therefore, MHU's study topic is highly relevant and has the potential to significantly improve the health of its enrollees with diabetes. MHU began work on its PIP in 2010 and has completed six of the ten required activities. MHU *Met* 100% of the criteria for the PIP activities completed in 2011.

Performance Measures Performance

UDOH requires the PMHPs to collect data on three access to care standards defined in the PMHP contract and report the results annually to the State. The purpose of these performance measures is to ensure that enrollees have access to care in a timely manner based on the level of care needed. The PMHP contract requires the PMHPs to maintain an initial contact data system capable of maintaining the data elements necessary to track and report adherence to the performance standards.

QQ obtained the report specifications defined by UDOH and the data files used by the PMHPs to create their annual performance measures reports. QQ used an automated program to calculate the number of days between the initial contact and the first offered appointment time for urgent, non-urgent, and emergent contacts. QQ calculated a percentage of compliance for each performance measure and an overall compliance rate based on the total number of initial contacts for each PMHP and in aggregate. Overall, QQ validated that the PMHPs offered an appointment within the required timeframes to 96.8% of enrollees requesting an initial mental health appointment. This high level of compliance is evidence that the PMHPs provide timely access to care.

Both PHPs, MHU and Healthy U (HU), are required to collect Healthcare Effectiveness Data and Information Set (HEDIS) measures, using National Committee for Quality Assurance (NCQA) methodology, and to have its data audited by an NCQA-certified vendor. MHU and HU report the results of its HEDIS measures to the Office of Health Care Statistics (OHCS) and are required to provide a copy of the auditor's certification on an annual basis. OHCS prepares a written summary of the HEDIS findings and compares the PHP's results with the national averages. Although UDOH requires HU to report HEDIS data to OHCS, as a PAHP, the data is not comparable with an MCO and is not included in this report. Overall, OHCS identified that in the aggregate, across all measures, MHU scored at or above the national average on 81% of the HEDIS measures.

Compliance Reviews

UDOH through its contracts with the MCEs and as part of the State's quality strategies requires compliance with federal and State standards related to access to care, structure and operations, and quality measurement and improvement.

Federal regulations require a compliance review every three years. QQ evaluates each MCE once every three years to establish its level of compliance with required standards. Subsequent to the compliance reviews, MCEs are required to take corrective action on

each standard that is not in full compliance. In year two of the compliance review cycle, QQ conducts reviews to determine if MCEs successfully implemented their corrective action plans (CAPs). If all CAPs are completed, no review is conducted in year three.

In 2011, QQ conducted a full onsite compliance review of the eleven MCEs. HU, one of the PHPs, is currently contracted as a PAHP. UDOH elected to include HU in the compliance section of this report as a means of reporting HU's compliance with PAHP requirements. HU's requirements are very similar to UDOH's PIHP and MCO requirements even though the federal PAHP requirements are not as rigorous.

Overall, the PMHPs *Met* 93% of the compliance standards in 2011. Only two standards were not fully *Met* on a statewide basis. All PMHPs were required to modify their handbook to include language on the amount, duration and scope of covered benefits, and to include the potential for enrollee fraud/abuse in their compliance program. Four of the nine PMHPs (CUCC, NCC, WMH, and WHS) had no additional required corrective actions. Two PMHPs (BRMH and SBHC) had one additional required corrective action; one PMHP (FCCBH) had two additional required corrective actions; and two PMHPs (DBH and VMH) had three additional required corrective actions. In the aggregate, QQ identified the need for 28 required corrective actions. The follow-up compliance review conducted in 2012 identified that 24 of the 28 (86%) required corrective actions were completed. Three PMHPs (BRMH, CUCC, and VMH) require additional action to implement their CAPs.

Overall, the PHPs *Met* 99% of the compliance standards in 2011. MHU *Met* 100% of the standards and HU *Met* 97% of the standards. HU was required to submit corrective action plans for two standards that were not fully *Met*. The follow-up compliance review conducted in 2012 identified that additional corrective action is required for HU to complete its CAPs.

This high level of compliance with contract standards is evidence that Utah's MCEs provide timely, accessible, and high quality care to their Medicaid enrollees.

C. Summary of Strengths and Weaknesses for Quality, Timeliness, and Access to Care

Performance Improvement Projects

Six of the nine PMHPs chose to focus their PIP on improving concurrent or collaborative documentation during treatment sessions. The choice of this topic is both timely and relevant as concurrent/collaborative documentation has gained national acceptance. Three of the PMHPs (DBH, NCC and SBHC) conducted their PIPs collaboratively. This included using the same study question, indicators, data collection methodology, and analyses.

Three PMHPs (CUCC, FCCBH, and WMH) demonstrated striking improvement with their PIPs. These three PMHPs have well thought out and well executed improvement plans that addressed the causes and barriers identified for their organizations. The successful strategies should be shared with the other PMHPs. Sharing data across

PMHPs will assist in identifying best practices, is a wise use of resources, and a significant strength of the current PMHP PIPs. Collaborative projects among the PMHPs should continue to be encouraged.

PMHPs that did not demonstrate significant or sustained improvement did not develop improvement strategies that were robust enough to generate real improvement. Developing strong intervention strategies and implementation plans is the greatest opportunity for future improvements with PIP outcomes.

QQ did not identify any significant weaknesses with PIP performance on an aggregated statewide level. With the exception of one PMHP (BRMH), the PMHPs in the aggregate, meet the requirements for conducting performance improvement projects that have the potential to improve health outcomes and/or enrollee satisfaction.

Performance Measures Performance

QQ validated that in aggregate across all measures, PMHPs offered appointments within the required timeframes to 96.8% of enrollees seeking initial mental health services. This level of compliance clearly demonstrates timely and accessible care. QQ did not identify any weaknesses with performance measures performance.

MHU performed very well in three major HEDIS categories. MHU exceeded the national average in access to care and use of preventive health services; care for members with diabetes; and childhood immunizations (with the exception of the chicken pox vaccine). MHU did not perform as well in providing services to docents and older children or screening young, sexually active women for Chlamydia. Historically, adolescents and young adults are the age groups most likely to under-utilize healthcare services.

Compliance Reviews

In 2011, the PMHPs demonstrated very high levels of compliance with federal and state standards for managed care. In the aggregate the PMHPs *Met* 93% of standards. In 2012 six PMHPs (DBH, FCCBH, NCC, SBHC, WMH, and WHS) provided documented evidence that their CAPs are completed and these PMHPs are now fully compliant with the standards. BRMH and CUCC have not completed one CAP and VMH has not completed two CAPs. These three PMHPs demonstrated progress toward completing their CAPs but did not fully implement them in 2011.

In 2011, the PHPs demonstrated exceptionally high levels of compliance with federal and state requirements for managed care. MHU *Met* 100% of the standards, and HU *Met* 97% of the standards. HU was required to take correction action on two standards that were not fully met in 2011. In 2012, HU demonstrated progress toward completing its CAPs but the required actions were not completed.

II. BACKGROUND

A. History of the State's Medicaid Managed Care Programs

The Division of Medicaid and Health Financing (DMHF), Utah's Medicaid agency in the UDOH , administers the Medicaid program. The DMHF's Bureau of Managed Health Care (BMHC) has been operating two separate 1915(b) freedom-of-choice waivers. The waivers are titled, *Choice of Health Care Delivery Program (for PHPs)* and the *Prepaid Mental Health Plan (PMHP).*

The *Choice of Health Care Delivery Program* has been operating since 1982 after receiving approval of a 1915(b) freedom-of-choice waiver request on March 23, 1982. It was a voluntary program until October 1, 1995 when the State modified the program by requiring new Medicaid enrollees living in Utah's urban counties (Davis, Salt Lake, Utah, and Weber) to enroll in a PHP. Between October 1, 1995 and June 30, 1996, all of the current urban enrollees transitioned into a PHP. Since July 1, 1996, 93% to 96% of all urban Medicaid enrollees enrolled in a managed care plan.

All of the PHPs contracting with Medicaid were health maintenance organizations (HMOs) licensed by the Department of Insurance until January 1, 1998, when Utah contracted with the University Health Network that offers Healthy U as its Medicaid product. Currently, the State has contracts with three PHPs. They are Healthy U (HU), Molina Healthcare of Utah (MHU), and Select Access. HU has been under contract since January 1, 1998; MHU (known formerly as American Family Care) since January 1997; and Select Access since January 1, 1995. Major changes to these three contracts include the following:

- Effective July 1, 2002, the MHU and HU contracts changed from risk-based to non-risk. HU's contracts fall under the federal definition of PIHP. MHU's contracts fell under the PIHP definition from July 1, 2002 through August 31, 2009;
- Effective October 1, 2002, Select Access became a Preferred Provider Network and a federally defined Primary Care Case Management (PCCM) system. Since the EQR regulations under 42 CFR 438 Subpart E (External Quality Review) apply to MCOs and PIHPs only, Select Access is not included in the EQR activities;
- Effective September 1, 2009, MHU's contracts are risk-based and now fall under the federal definition of a Managed Care Organization (MCO); and
- Effective February 1, 2010, HU's contracts are non-risk and fall under the federal definition of a PAHP.

DMHF requested and CMS approved a modification to the *Choice of Health Care Delivery Program* waiver to allow the State to limit disenrollment requests by PHP enrollees covered under the waiver (since July 1, 2004, the State requires enrollees to remain enrolled in the same PHP for a minimum of 12 months).

Medicaid reimburses the PAHP the amount the PAHP reimburse its providers plus an administrative fee. The administrative fee covers the cost of all administrative functions that are necessary to operate an efficient and effective Medicaid managed care plan

including federal requirements described in 42 CFR Part 438, Managed Care. Under a non-risk contract, Medicaid's total payments to the PAHP may not exceed the total amount Medicaid would have paid for the same services on a fee-for-services basis.

Even though as a PAHP, HU is not required to comply with federal managed care quality standards, HU's contract includes State-specific quality and HEDIS reporting requirements. The PAHP quality and HEDIS requirements are the same as those required for Medicaid MCO.

The Medicaid MCO is a risk-based contract. Medicaid reimburses the MCO an all-inclusive per-member-per-month premium payment. Both PHPs submit to Medicaid encounter records for all services provided to their enrollees.

For mental health services, DMHF has been managing a waiver program called the *Prepaid Mental Health Plan* (PMHP) since July 1, 1991, after receiving approval for a 1915(b) freedom-of-choice waiver in April 1990. Medicaid recipients are automatically enrolled with the PMHP contractor serving their county of residence. The major goals of the PMHP were to provide a coordinated single point-of-entry to allow enrollees access to a coordinated managed care approach to service delivery, to manage inpatient care, and to control inpatient hospital costs.

Due to the structure of the PMHP program, contractors meet the federal definition of PIHP. In 1991, the State contracted with three mental health centers: Valley Mental Health (VMH); Four Corners Community Behavioral Health Center (FCCBH); and Southwest Behavioral Health Center (SBHC). In 1995, the State entered into contracts with five additional mental health centers: Bear River Mental Health (BRMH); Central Utah Counseling Center (CUCC); Davis Behavioral Health (DBH); Wasatch Mental Health (WMH); and Weber Human Services (WHS). In January 2001, the State also entered into a contract with Northeastern Counseling Center (NCC). Effective July 1, 2011, the State began contracting with Salt Lake County, Division of Behavioral Health Services, as the PIHP for Salt Lake County Medicaid recipients. Currently, 27 of Utah's 29 counties fall under the PMHP, and approximately 98% of Utah's Medicaid recipients are enrolled in the PMHP.

Medicaid pays monthly premiums to the PMHP contractors for each Medicaid recipient in the contractors' catchment areas. By accepting the premiums, contractors assume the risk of providing all needed inpatient and outpatient mental health services.

Table 1 describes the current contracted MCEs under the 1915(b) waivers subject to EQR in 2012.

Table 1: Utah's Medicaid MCEs Undergoing EQR Activities

Physical Health Plans	Urban	Rural	Average Number Enrolled Per Month*
Healthy U (HU)	X		37,718
Molina Healthcare of Utah (MHU)	X	X	57,545
Prepaid Mental Health Plans			
Bear River Mental Health (BRMH)		X	14,004
Central Utah Counseling Center (CUCC)		X	8,093
Davis Behavioral Health (DBH)	X		19,773
Four Corners Community Behavioral Health (FCCBH)		X	4,836
Northeastern Counseling Center (NCC)		X	4,772
Southwest Behavioral Health Center (SBHC)		X	22,615
Valley Mental Health (VMH)	X		97,578**
Wasatch Mental Health (WMH)	X		42,045
Weber Human Services (WHS)	X		24,401

Note: The urban counties are Davis, Salt Lake, Utah, and Weber. * The average number enrolled per month is based on CY 2011 data.

** In July 2011 Valley Mental Health switched to only cover Tooele and Summit Counties. Optum took over the coverage of Salt Lake Co; therefore, this number is the average of both plans. Valley had an average of 53,757 and Optum had an 97,641 average for the six months.

B. State's Quality Strategy

BMHC, is in the process of redesigning the Quality Assessment and Performance Improvement Plan (QAPIP), Utah's quality strategy for contracted PHPs, which BMHC developed in response to the Balance Budget Act of 1997 and implemented in conjunction with the effective date for the federal managed care rule (42 CFR Part 438). The focus of the QAPIP was to comply with BBA requirements pertaining to state quality strategies and delineate federal and State MCE requirements.

Another aspect of this comprehensive program refinement is to address requirements addressed in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and compliance with section 403 of CHIPRA, which applied specific Medicaid managed care requirements in section 1932 of the Social Security Act to CHIP MCEs.

The goals of this latest program development effort are four-fold:

- Reevaluate, update and improve existing QAPIP requirements and standards,
- Integrate compliance requirements for all Medicaid and CHIP MCEs under one quality strategy,
- Incorporate content and format recommendations made by CMS in CMS' *Quality Strategy Toolkit for State Medicaid Agencies* (2006, and 2012 update), and
- Address requirements in the Affordable Care Act of 2010 (ACA), pertaining to Accountable Care Organizations (ACO's), and

- Support the needs of DMHF, UDOH and interagency priorities related to Medicaid and CHIP programs.

UDOH will implement the new quality strategy in 2013 after stakeholder input, public comment and CMS approval.

C. Ongoing State Quality Initiatives

BMHC has longstanding collaborative relationships with other State agencies and interdepartmental partners to support the needs of Medicaid and CHIP programs. For example, DMHF collaborated with the Utah State Mental Health Authority, the Division of Substance Abuse and Mental Health (DSAMH), in the Department of Human Services to support various quality initiatives designed to ensure the provision of cost-effective, quality mental health care to Medicaid recipients.

In addition, BMHC works collaboratively with interdepartmental partners to support the needs of the QAPIP in strategic areas, including, but not limited to, Division of Child and Family Health Services (Bureau of Maternal Child Health, Reproductive Health Program, Bureau of Children with Special Health Care Needs, Bureau of Health Promotion, Diabetes Prevention and Control Program) and the Office of Health Care Statistics (OHCS). Below are examples of ongoing State quality initiatives:

- Preferred Practice Guidelines for the Utah Public Mental Health System

  The DSAMH, with DMHF as a sponsoring partner, developed a set of preferred practice guidelines for Utah's public mental health system (which includes DMHF's mental health managed care contractors). These preferred practices address processes of mental health care (e.g., assessment and treatment planning) as well as specific mental health conditions (e.g., Affective Disorders, Schizophrenia, Attention Deficit Hyperactive Disorder, etc.).

- Recovery-Based Services

  DMHF has collaborated with the DSAMH on its initiative to enhance the provision of quality services in the public mental health system through the support and promotion of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) ten recovery principles in service delivery.

- National Outcomes Measures

  Utah's Public Mental Health system also participated in SAMHSA's National Outcomes Measures (NOMs) project. SAMHSA has identified these measures as proxies for quality mental health care.

➢ Outcomes Project

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

➢ Pay-for-Performance Initiatives

The State has two pay-for-performance preventive health incentives for PHPs. The first incentive relates to federal EPSDT and CHEC program requirements; the other incentive relates to flu vaccines for adults 50 years of age or older. The following describes how the incentives work.

- The State gives PHPs a financial incentive for improving their CHEC screening and immunization rates for children and adolescents. The baseline for the incentive is each PHP's previous year's rates unless the PHP had a higher percentage in a prior year. The PHPs receive $500.00 for each percentage point above the baseline, up to 80%. For example, if the PHP had a screening rate the previous year of 90% or above, the State gives the PHP $10,000.00 if it maintained a rate of 90% or higher.
- PHPs receive incentives based on their HEDIS rates for immunizations for two-year olds and adolescents, and the percentage of adults age 50 and older who received a flu vaccine. The baseline for the incentive is the PHP's previous year's rates unless the PHP had a higher percentage in a prior year. The PHPs receive $300 for each percentage point above the baseline up to 50 percentage points.

➢ Tobacco Cessation Initiative

This initiative provides support and information to pregnant women on Medicaid to encourage them to stop smoking with the goal of reducing premature and low birth weight babies. When a pregnant woman applies for Medicaid, the eligibility worker asks if she uses tobacco. The Medicaid Health Program Representative (HPR) is alerted and then with the woman's permission contacts her every six weeks throughout her pregnancy helping her to reach her tobacco cessation goals. The HPR discusses with the woman the benefits of reducing or eliminating tobacco use, provides smoking information, available resources and assists with referrals to health care providers and/or local health department programs.

➢ Utah Health Plan Partnership

The Utah Health Plan Partnership (HPP) is a collaborative effort, led by UDOH Bureau of Health Promotion, in partnership with Medicaid and commercial health

plans throughout the state, and other community partners. The mission of the HPP is to improve health care performance and measures related to diabetes and cardiovascular health by sending unified, focused, and consistent information to providers and communities for the common goal of improving overall health.

The HPP works collaboratively to identify issues and develop interventions to improve care; increase patient and provider awareness of quality indicators; improve patient self-care and medication adherence; and increase system-based support related to health care delivery, tracking, and reporting of health indicators. Between 2004 and 2009, performance for all diabetes measures improved as a result of the HPP's efforts, including measures for average blood glucose control, lipid control, eye examination rates, and screening to assess kidney function. By creating shared success, the HPP has improved HEDIS performance measures which translates into improved care for individuals with diabetes.

Utah's HPP is one of only three diabetes-focused health plan partnerships nationally. The CDC has promoted the HPP on an ongoing basis as a model program for other states to follow. Most recently, Dr. Ann Albright, Director of the Division of Diabetes Translation at the CDC, presented Utah's HPP before the United States Congress as an example of a successful public and private collaborative health partnership. The CDC listed Utah's HPP in its Best Practice Initiatives in 2001-2003. In 2002, the HPP received the Award of Excellence at the Sixteenth Annual Chronic Disease Conference, in Atlanta Georgia. HPP initiatives have been repeatedly presented at the CDC's Diabetes conferences.

- Maximizing Enrollment for Kids—Transforming State Health Coverage/Working Smart for Utah Kids

In 2009, Utah was one of eight states awarded a $1 million grant, Maximizing Enrollment for Kids: Transforming State Health Coverage, from the Robert Wood Johnson Foundation. UDOH operates this grant. The goal of Utah's program, also known as Working Smart for Utah's Kids, is to ease the administration of health insurance coverage to eligible children in Medicaid and the CHIP. The grant is designed to help Utah improve its policies and procedures and to measure the impact of these changes, ultimately aiming to reduce barriers for families applying for public health insurance.

As Utah begins to wrap up the fourth and final year of the grant, the team continues to work hard to complete several outstanding projects. Nonetheless, the Working Smart for Utah's Kids team is pleased to report that many of the goals outlined in the work plan have been met. Significant changes have been made which streamline the application process, simplify the renewal process, improve client education and improve the management and analysis of data in order to identify barriers. We expect these accomplishments will make the state eligible for the CHIPRA Performance Bonus, a bonus which helps support the additional costs for states who are successful

in enrolling eligible children in Medicaid and CHIP above target levels. The bonus application has been submitted and a decision is expected to be received by mid December, 2012.

Utah has many reasons to adopt these strategies beyond qualifying for the performance bonus. Better enrollment and retention promotes children's access to preventative care and improves health outcomes and quality of care. In addition, streamlining enrollment and retention processes may reduce state administrative burdens and costs.

The work completed thus far, in conjunction with current projects will also help prepare our state for the January 1, 2014 implementation of the Affordable Care Act.

➢ The Children's Healthcare Improvement Collaborative (CHIC)

In 2010 the State, in partnership with Idaho, received a 5 year grant in the amount of $10,277,360. Utah and Idaho have been developing a regional quality system guided by the medical home model to enable and assure ongoing improvement in the healthcare of children enrolled in Medicaid and CHIP programs.

The project focuses on improving health outcomes for children and youth with special health care needs through the a robust plan involving integration of HIT tools, electronic health records (EHRs), health information exchanges (HIEs), and other health information technology (HIT) tools into primary and specialty care offices.

A key component of CHIC involves embedding Medical Home Coordinators in primary and specialty care practices to support ongoing coordination and improvement in care and services for children with chronic and complex conditions. The program staff hired in Utah and Idaho, are at various stages of implementing CHIC activities. The States hopes to successfully implement a regional quality system, and develop QI tools/resources to share with other States and regions.

Key year to date accomplishments include:

- The project is now fully staffed and operational in Idaho and Utah;
- 12 Utah Medical Home Demonstration sites are fully operational in Utah and Idaho selected 3 sites to participate in March 2012;
- Family Partners have been identified for all 15 clinics and are supported by Utah Family Voices and Idaho Parents Unlimited
- Successfully developed an on line QI TeamSpace communication tool to support the current and future needs of project teams;
- Completed 5 additional learning collaboratives in partnership with Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) surrounding mental health integration, asthma care management, immunization registry management, specialty referral and care coordination plans;

- Completed the development of www.medicalhomeportal.org to include a full listing of appropriate resources from both Utah and Idaho;
- Selected a new independent evaluation team and began the data collection process to compare practices to the Medical Home Index.

➢ Chronic Disease Self-Management Program (CDSMP)

The American Recovery and Reinvestment Act of 2009 (ARRA), Communities Putting Prevention to Work program, announced a funding opportunity through the Department of Health and Human Services, Administration on Aging (AoA) in December of 2009.

The UDOH's Arthritis Program, in partnership with the Utah Division of Aging and Adult Services and the Utah Medicaid program received funding for the implementation of CDSMP from the Centers for Disease Control and Prevention (CDC) Arthritis Program's Utah State Public Health Approaches to Improving Arthritis Outcomes Grant in June 2012, and from the Administration on Aging (AoA) Utah Approach to Empowering Older Adults and Adults with Disabilities through Statewide Chronic Disease Self Management Education Delivery Grant, September 2012.

The CDSMP is an evidence-based program developed by Stanford University to empower individuals with a chronic health condition to develop and improve self-management skills and subsequently achieve better outcomes and well-being. The program involves a six-week lay-led training covering health education topics related to healthy eating, exercise, managing fatigue, depression, communicating with health care professionals, etc. Stanford specifically designed the CDSMP to be delivered by trained, non-health professionals in community settings. Research has shown the program to be helpful in improving participants' overall health and creating cost savings.

UDOH has been developing and strengthening a statewide infrastructure for the systematic delivery of the CDSMP throughout Utah to underserved older populations since 2008 and continues to plan strategic activities to help raise awareness of the program.

➢ Health Information Technology

Utah Medicaid is participating in the Medicaid Health Information Technology (HIT) Incentive Payment Program supported through CMS' Office of the National Coordinator for Health Information Technology (ONC), as part of the ARRA. The goal of the program is part of a national effort to improve quality of patient care, patient safety and patient involvement in treatment options by using certified Electronic Health Record (EHR) technology.

Eligible providers (EP) can receive their first year's incentive payment for adopting certified EHR technology but must demonstrate meaningful use of the technology in ways that improve quality, safety, and effectiveness of patient-centered care in order to qualify for subsequent year payments. Physicians and other eligible health care professionals can receive up to $63,750 dollars; hospitals in Utah can expect between $350,000 and $4 million as incentive to adopt or upgrade their EHR systems.

The State received approval from CMS to make EHR incentive payments to eligible Medicaid providers as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Meaningful use includes electronically capturing health information in a coded format, using that information to track clinical conditions, as well as communicating that information for care coordination.

An Eligible Provider (EP) includes: MD's, DO's, DDS's, CNM's, NP's, and PA's practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA. Hospital-based EPs may not participate. An EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.

Medicaid EPs must meet patient volume criteria, providing services to those who are Medicaid eligible or, in some cases, needy individuals. Eligible professionals and groups must demonstrate 30% Medicaid patient volumes; (20% for pediatrics) for a representative 90-day period in the previous calendar year. Eligible hospitals (EH) must see at least 10% Medicaid patient volume and have an average length of stay less than 25 days in order to qualify.

As of September 30, 2012 Utah Medicaid paid over 300 eligible providers and 13 hospitals a total of $13,400,395.

➢ Restriction Unit Quality Improvement Initiative

In 2011 the Medicaid Restriction Unit (MRU) began an initiative to implement a Quality Management Plan (QMP). The initiative focuses on integrating the Restriction Unit's core activities under one QMP, which includes development of standardized and innovative processes to ensure consistency, as well as strengthen and enhance Restriction Unit operations. QMP activities include the following:

- Implementation of a standardized referral process for the MCEs submitting client referrals for the Restriction and Care Management Program (Lock-in). This process/form enables an accurate and consistent means of assessing enrollment appropriateness and the efficient processing of lock-in within three working days.
- Implementation of standardized criteria for enrolling minors in the care of a legal guardian, into the Lock-in Program. Currently there is an increase in the number of Medicaid recipients who are minors (under the age of majority), that meet Lock-in criteria. Enrolling minors into the Lock-in (i.e., into care with one PCP and pharmacy), helps to minimize enrollees using the Emergency Department

(ED), in place of care by a PCP. This also limits the ability of recipients under the age of majority seeking commonly drugs and reduces overall costs to Medicaid. This process also supports quality of care for Medicaid recipients under the age of majority.

- Implementation of standardized tools for evaluation of claims with "non-emergent" diagnosis and assessing clients for appropriateness in the Lock-in program. Previously, only the first diagnosis listed in an emergency department claim triggered evaluation for enrollment in Lock-in.
- Innovative strategies to improve utilization surveillance efforts, including use of funding from "Safe to Wait," an Emergency Room Diversion Grant (ERDG) funded by CMS in 2008, to enhance two new Lock-in assessment and surveillance tools.

The standardized tools developed by the MRU, take into consideration all "non-emergent" diagnoses for a client's emergency department claims and is a more accurate and thorough means of assessing potential over-utilization. In addition, the additional information improves quality in case management.

The innovative strategies the MRU used to enhance to improve the new Lock-in assessment and surveillance tools, enhance the ability to make an appropriate lock-in enrollment. Moreover, this enhanced electronic vigilance also allows a greater number of complex Medicaid recipients to be enrolled into the Lock-in program for case management, without addition of Lock-in staff.

The first of the two new surveillance tools, built using a Cognos Database, provides a comprehensive view of all Medicaid recipients meeting any one of four distinctly described restriction criteria designed to capture anomalies in utilization patterns. It also provides a total of costs to Medicaid for the individual recipient's benefit utilization that serves as a baseline from which to monitor cost savings in the future.

The second, newly executed surveillance tool is a *Point of Sale Pharmacy Utilization Reporting System*. This tool provides a report of all pharmacy claims submitted for payment for scheduled drugs, as well as the numbers of pharmacies each client has visited in a 30-day period of time. By combining data from the previously implemented *ED Diversion Surveillance Tool* with both the *Cognos Database* and the *Point of Sale Pharmacy Surveillance Tool*, the Restriction Unit now has the means by which Medicaid recipients can be locked-in and case-managed systematically and with greater timeliness.

Overall, in 2011-2012, as the MRU has implemented process standardization and innovative improvements, Medicaid is poised to realize greater efficiencies to monitoring and managing utilization of its most complex and challenging benefit utilization recipients.

- Chronic Disease Management Quality Improvement Initiative

In 2011 the MRU embarked on the planning and implementation phases of a systematic approach to chronic disease management for recipients enrolled in fee-for-service Medicaid. Thus far, the MRU has been able to create the electronic system criteria for identification and surveillance of Medicaid recipients with a diagnosis of Diabetes, Type I or II, who frequently seek care in the ED for treatment of certain critical, disease-related symptoms, which may demonstrate underutilized or ineffective primary care.

The claims system generates a diabetes surveillance alert that is sent to the MRU staff. MRU staff utilize a standardized algorithm to perform an assessment for each member for whom an alert is generated. Staff contact members, identify if diabetes self-management resources are needed and assist members with obtaining services. Additional follow-up contacts and outreach interventions are conducted when necessary. Staff are planning an outcomes analysis and program evaluation. If the program demonstrates success, additional chronic diseases will be added to the program.

III. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

A. Overview of External Quality Review Requirements

The BBA added Section 1932 to the Act, which pertains to Medicaid managed care. Section 1932(c) of the Act requires states to implement a quality assessment and improvement strategy. Included in that strategy is an annual external independent review of the quality, outcomes, timeliness, and access to the services covered under each managed care contract. CMS requires states to have EQRs of their MCEs. UDOH contracts with QQ to perform the EQR activities for its Medicaid MCEs.

Federal regulations require the EQRO to use information from the following mandatory activities, which it or another appropriate entity conducted.

- Validation of one or more performance improvement projects (PIPs) required by the State to comply with requirements set forth in 42 CFR §438.240(b)(1) and that were underway during the preceding 12 months;
- Validation of one or more performance measures reported to the State or performance measures calculated by the State during the preceding 12 months to comply with requirements set forth in 42 CFR §438.240(b)(2); and
- Reviews at least every three years to determine the MCEs' compliance with standards required by the State to comply with 42 CFR §438.204(g) that are related to access to care, structure and operations, and quality measurement and improvement.

The federal regulations require that the EQRO produce a detailed technical annual report that describes at the minimum the following information.

- A description of the activities conducted related to §438.358;
- The objectives and methodology for data collection, aggregation, and analysis;
- A description of the way in which the EQRO drew its conclusions related to quality, timeliness, and access to care;
- The conclusions drawn;
- An assessment of each MCE's strengths and weaknesses with respect to quality, timeliness, and access to care;
- As the State determines methodologically appropriate, comparative information about all MCEs;
- Recommendations for improving the quality of health care services provided by each MCE; and
- An assessment of the degree to which each MCE has effectively addressed the quality improvement recommendations made by an EQRO during the previous year.

This report is prepared in accordance with these regulations.

B. Performance Improvement Projects Performance

1. Description of Activity

Through its contracts with the MCEs, and as part of the State's Quality Assessment and Performance Improvement Strategies, UDOH requires the MCEs to conduct PIPs. The purpose of these projects is to comply with requirements set forth in 42 CFR §438.240(b)(1) and 42 CFR §438.240(d). PIPs should achieve, through ongoing measurement and intervention, significant improvement sustained over time in clinical or non-clinical areas, and have a favorable impact on health outcomes, enrollee satisfaction, or a valid proxy of these outcomes. UDOH requires the MCEs to conduct PIPs consistent with the CMS PIP protocol. UDOH contracted with QQ to validate one PIP for each PMHP and the Medicaid MCO. HU, as a PAHP, is not required to conduct PIPs.

2. Objectives

The objectives for the PIP validation are to determine to what extent the MCEs are in compliance with requirements set forth in 42 CFR §438.240(d). The MCEs are to conduct clinical or non-clinical PIPs that include:

- Measuring performance using objective study indicators;
- Implementing system interventions intended to achieve measurable performance improvement;
- Evaluating the effectiveness of the interventions; and
- Planning and initiating activities to increase or sustain improvement.

3. Methods

QQ uses the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities,* as a guide for conducting its review. The protocol requires an assessment of ten activities. Each activity includes multiple criteria. The following are the ten activities and a description of the criteria used for evaluating each activity.

Activity 1—Appropriate Study Topic

- The study topic is clearly stated and specifies if it was assigned by the State;
- Details are provided on how the study topic was selected (e.g., through data collection and analysis of comprehensive aspects of enrollee needs, care, and services);
- The study topic reflects a significant portion of the MCE's enrollee population;
- The study topic reflects high-volume or high-risk conditions (i.e., for clinical topics); and
- The study topic has the potential to affect enrollee health, functional status, or satisfaction.

Activity 2—Clearly Defined and Answerable Study Question

- The study question is stated in clear, simple terms; and
- The study question is answerable or provable.

Activity 3—Clearly Defined Study Indicator(s)

- The study indicator(s) are well defined, objective, and measurable;
- The study indicator(s) are based on current evidence-based practice guidelines, pertinent peer-reviewed literature, or other consensus expert panels, or rationale is provided as to why the indicator(s) were selected;
- The study indicator(s) allow for the study question or hypothesis to be answered or proven;
- The study indicator(s) measure changes (outcomes) in health or functional status, enrollee satisfaction, or valid proxies of these outcomes;
- The study indicator(s) measure important aspects of care or services;
- Data are available and can be collected on each study indicator; and
- Rationale is provided as to why the indicators were selected.

Activity 4—Unambiguously Defined Study Population

- The study population is appropriate, complete, and well defined;
- The description of the study population includes requirements, if any, for the length of an enrollee's enrollment in the MCE; and
- The study population captures all enrollees to whom the study question applies.

Activity 5—Valid Sampling Techniques (If Sampling is Used)

- Methods for selecting the sample are appropriate, complete, and well defined;
- Methods for identifying the sample include inclusion and exclusion criteria for the study population;
- The confidence level and acceptable margin for error are specified and appropriate;
- The sample is representative of the eligible population; and
- The sampling methods are statistically sound.

Activity 6—Accurate and Complete Data Collection

- The data to be collected are clearly identified;
- Information is included on the data sources to be used, and how and when the baseline and remeasurement data will be collected;
- Individuals collecting the data are identified and have appropriate qualifications to perform this function;
- The instruments used for data collection are identified;
- Information is provided as to whether qualitative or quantitative data or both will be collected;

- Information is provided as to whether the data will be collected on the entire population or a sample;
- Information is provided as to whether the measurements obtained from the data collection will be compared to results of previous or similar studies;
- Information is provided as to whether the PIP will be compared to the performance of another MCE, or a number of MCEs; and
- Information is provided on the data analysis plan and all pertinent methodological features.

Activity 7—Appropriate Performance Improvement Strategies

- Intervention/improvement strategies undertaken are related to causes or barriers identified through data analysis and quality improvement (QI) processes;
- Intervention/improvement strategies address whether they are likely to induce permanent change;
- Intervention strategies address whether they will be revised if original interventions are unsuccessful; and
- Intervention strategies address whether they will be standardized and monitored if interventions are successful.

Activity 8—Analysis and Interpretation of Data

- Data analysis and interpretation was conducted according to the data analysis plan;
- Data analysis and interpretation allow for the generalization of results to the study population (if sampling was used);
- Data analysis and interpretation identify factors that threaten internal or external validity of findings;
- Data analysis and interpretation are presented in a way that provides accurate, clear, and easily understood information;
- Data analysis and interpretation identify initial measurement and remeasurement of study indicators;
- Data analysis and interpretation identify factors that affect the ability to compare initial measurement with remeasurement; and
- Data analysis and interpretation include the extent to which the study was successful.

Activity 9—Real Performance Improvement Achieved

- Remeasurement methodology is consistent with baseline measurement methodology;
- There is documented improvement in processes or outcomes of care;
- The improvement appears to be the result of planned intervention(s)/improvement strategies; and
- There is statistical evidence that an observed improvement is real improvement.

Activity 10—Real Performance Improvement Sustained

- Repeated measurements over comparable time periods demonstrate sustained improvement, or a decline in improvement is shown not to be statistically significant.

4. Data Obtained

QQ, in collaboration with UDOH, developed a *PIP Reporting and Evaluation Form* that incorporates evaluation elements from the CMS protocol for validating PIPs and provides for a systematic assessment of each of the ten activities.

Each MCE was required to complete the form to document its progress on the ten PIP activities undertaken during 2011. Each MCE submitted the completed reporting form and supporting documentation directly to QQ.

C. Performance Measures Performance

1. Description of Activity

In accordance with 42 CFR §438.358(b)(2), validation of performance measures is a mandatory EQR activity. UDOH requires the PMHPs to report three access to care performance measures annually using the State defined methodology and report template.

These performance standards govern the timeframes from the initial contact until offering the first face-to-face service to enrollees who are seeking mental health services for the first time. The purpose of the performance measures is to ensure that enrollees have access to care in a timely manner based on the level of care needed.

The three PMHP access to care standards are as follows:

Table 2: Enrollee Initial Contact Classifications

Performance Measures Standards	
Emergent	Providing First Service for Emergent Care (a telephone clinical screening within 30 minutes of the call and offering a face-to-face evaluation, if indicated, within one hour).
Urgent	Offering First Service for Urgent Care (within 5 business days).
Non-Urgent	Offering First Service for Non-Urgent Care (within 15 business days).

The UDOH contract requires the PMHPs to maintain an initial contact data system that allows for tracking, monitoring, calculating, and reporting adherence to

performance standards for first face-to-face services when initial contacts are made during regular business hours. The PMHPs are required to document the following:

- The date and time of all initial contacts and whether initial contacts that require emergency services are by telephone or on a walk-in basis;
- The date and time of telephonic clinical screenings for emergencies and if completed within 30 minutes;
- Whether the PMHP is able to offer a first face-to-face service within the required timeframe and if not, the reason for the delay;
- The date and time of any scheduled face-to-face appointments for outpatient emergent, urgent, or non-urgent care; and
- The status of scheduled first face-to-face appointments (if kept, cancelled, and/or rescheduled by the enrollee or the PMHP).

PHPs are required to collect HEDIS measures using NCQA established methodology and to have their data audited by a vendor certified by NCQA. HEDIS is developed and maintained by NCQA and is considered the national standard for measuring and reporting health plan performance. The requirements for reporting HEDIS are set forth in the State's administrative rules. The PHPs provide HEDIS data to the OHCS and are required to provide a copy of the auditor's certification on an annual basis. HEDIS measures included in this report are the following:

- Access
  - Percentages by age groups of members with an MCO primary care physician visit
  - Percentages by age group of members with an ambulatory or preventive care visit

- Childhood Immunizations
  - Percentages of children receiving timely vaccinations

- Women's Health and Maternity Care
  - Percentages of women receiving cancer screenings
  - Percentages of women tested for Chlamydia
  - Percentages of women with postpartum visits receiving prenatal care

- Child and Adolescent Well-Care
  - Percentages of children and adolescents with well-care visits
  - Percentages of children and adolescents with pharyngitis receiving strep test and antibiotic
  - Percentage with an upper respiratory infection and no antibiotic prescription three dates after episode date

- Use of Medication
  - Percentage of members by two age groups with persistent asthma appropriately prescribed medication

- Care for People With Diabetes
  - Percentage of members who had a retinal exam
  - Percentage of members with above- or below-specified HbA1c and LDL levels and screenings
  - Percentage of members who had a kidney disease screening

- Health Care for Adults
  - Percentage of members with acute low back pain but no imaging study

Some measures may use administrative data (from claims systems) and others may require a hybrid approach (administrative data and medical record reviews). The hybrid method takes longer and costs more, but the reported values for HEDIS measures are usually more accurate than when the PHPs use the administrative method. Therefore, differences in PHPs may be because the PHPs differ in quality, or because the PHPs collected data using different methods. The auditor ensures the validity and reliability of the data and determines if missing data should be included, or if it can remain absent from the report.

2. Objectives

The objectives of the EQR are to evaluate the accuracy of the performance measures reported by the PMHPs and to determine if the methodologies used in the calculations are consistent with the specifications required by UDOH. For the PHPs, QQ's objective is to report the results of the audited HEDIS measures data.

3. Methods

QQ uses the CMS protocol, *Validating Performance Measures, A Protocol for Use in Conducting External Quality Review Activities,* as a guide for conducting its review.

QQ obtained the report specifications defined by UDOH and the data files used by the PMHPs to produce the annual performance measures reports. QQ used an automated program to calculate the number of days between the initial contact and the first offered appointment time for urgent, non-urgent, and emergent contacts. QQ calculated a percentage of compliance for each performance measure and an overall compliance rate based on the total number of contacts. This report presents the overall findings of the performance measures validation by PMHP and in aggregate.

In accordance with PHP contracts and OHCS' administrative rule, MCEs required to submit HEDIS, annually submit audited HEDIS data. OHCS analyzes the results for all MCEs reporting data and produces a performance report. Since the MCEs submitted audited HEDIS data, QQ did not validate these findings. OHCS provided its analysis of MHU's HEDIS performance, and collaborated with UDOH regarding the information presented in this report.

MCEs collect the measures using an administrative (electronic records) or hybrid (medical record review and electronic records) methodology. The methodology used

may vary based on the measure. Appendix 2, *Sample HEDIS Measure*, contains the information required to obtain the *Breast Cancer Screening* measure. It provides an example of the requirements for collecting one HEDIS measure.

4. Data Obtained

Data obtained for the PMHP performance measure validation included the initial contact data files provided by the PMHPs and the annual performance measures reports for the period ending December 2011. OHCS provided the 2011 HEDIS measures data for MHU.

D. Compliance Reviews

1. Description of Activity

In accordance with 42 CFR §438.358(b)(3), MCEs must comply with standards established by the State to meet the requirements in 42 CFR §438.204(g) related to access to care, structure and operations, and quality measurement and improvement. UDOH's quality strategies require MCEs to comply with the following federal regulations:

Access Standards
42 CFR §438.206 through §438.210
- Availability of services
- Assurances of adequate capacity and services
- Coordination and continuity of care
- Coverage and authorization services

Structure and Operation Standards
42 CFR §438.214 through §438.230
- Provider selection, enrollee information, grievance systems
- Subcontractual relationships and delegation

42 CFR §438.400 through §438.424 – Subpart F—Grievance System
- Statutory basis and definitions and general requirements
- Notice of action and handling of grievances and appeals

Measurement and Improvement Standards
42 CFR §438.236 through §438.242
- Practice guidelines
- Quality assessment and performance improvement program
- Health information systems

Federal regulations require a compliance review every three years. QQ conducted a full compliance review of the MCEs in 2011. The MCEs were required to take corrective action on each standard that was not in full compliance. In 2012 QQ conducted a follow-up compliance review to determine if the MCEs completed their CAPs.

2. Objectives

The objective of the follow-up review is to determine to what extent the MCEs have executed their required CAPs.

3. Methods

In 2012, follow-up compliance reviews were limited to the standards that were not fully *Met* in 2011. QQ required the MCEs to complete a *Follow-up Compliance Review Reporting and Evaluation Form*, and submit documentation on implementation and completion of their required corrective actions. UDOH reviewed the responses and documentation and determined if the required corrective actions were completed or if further corrective action is needed.

E. Strategies for Using External Quality Review Findings

The EQR report identifies where the MCEs need to make improvements to be fully compliant with federal and State requirements. UDOH uses the report as a method of evaluating the overall performance of the MCEs and identifying where contract language could be improved, clarified, modified, or added. Each MCE uses its individual EQR report as the basis for developing its CAPs.

IV. DESCRIPTION OF FINDINGS

A. Prepaid Mental Health Plans

1. Performance Improvement Projects Performance

Introduction

In 2012 QQ validated the PIP activities completed by each PMHP during calendar year 2011. QQ validated the following PIPs:

- BBRMH: Substance Abuse Assessment Study;
- CUCC: Rates of Real Time Treatment Documentation of Individual Therapy Sessions;
- DBH: Increasing the Practice of Collaborative Documentation by Reporting and Rewarding Compliance;
- FCCBH: Project to Increase Concurrent Documentation;
- NCC: Increasing the Practice of Collaborative Documentation by Reporting and Rewarding Compliance;
- SBHC: Increasing the Practice of Collaborative Documentation by Reporting and Rewarding Compliance;
- VMH: Improving Timeliness of Clinical Documentation;
- WMH: Improving Youth and Adult Outcome Questionnaire (Y/OQ) Data Collection and Enhanced Use of the Outcome Data by Clinicians at WMH; and
- WHS: No-Show Rates of Initial Mental Health Evaluation Appointments.

Findings

Overall, the PMHPs *Met* 94% of the applicable PIP criteria in 2011. Four PMHPs (DBH, NCC, SBHC and WMH) *Met* 100% of the criteria; two PMHPs (CUCC and WHS) *Met* 97% of the criteria; two PMHPs (FCCBH and VMH) met 92% of the criteria; and BRMH *Met* 64% of the criteria.

Table 3 presents an overview of the validation scores by PMHP, by activity, and in aggregate. A narrative summary of the findings by activity follows.

Table 3: PIP Validation Scores by Activity, by PMHP, and in Aggregate

Review Activity Description	BRMH	CUCC	DBH	FCCBH	NCC	SBHC	VMH	WMH	WHS	Aggregate PMHP-Wide Score
Study Topic	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
Study Question	50%	100%	100%	100%	100%	100%	100%	100%	100%	**94%**
Study Indicator(s)	71%	100%	100%	100%	100%	100%	100%	100%	100%	**97%**
Study Population	66%	100%	100%	100%	100%	100%	100%	100%	100%	**96%**
Sampling Techniques	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**
Data Collection	66%	100%	100%	100%	100%	100%	100%	100%	100%	**96%**
Improvement Strategies	100%	100%	100%	100%	100%	100%	0%	100%	66%	**87%**
Analysis	0%	83%	100%	66%	100%	100%	100	100%	100%	**83%**
Improvement Achieved	100%	100%	100%	75%	100%	100%	100%	100%	100	**96%**
Improvement Sustained	N/A	N/A	100%	N/A	100%	100%	N/A	N/A	N/A	**100%**
OVERALL PMHP SCORE	**64%**	**97%**	**100%**	**92%**	**100%**	**100%**	**92%**	**100%**	**97%**	**94%**

Activity 1—Appropriate Study Topic

All of the PMHPs *Met* the criteria for this activity. The PIP topics were selected by the PMHPs and were not assigned by the UDOH. All of the PMHPs selected an appropriate study topic based on data analysis, relevance to the population, and the potential to affect enrollee health, functional status, or satisfaction. All PMHPs provided rationale to support their choice of the study topic.

Activity 2—Clearly Defined and Answerable Study Question

The study question for each PMHP is as follows:

- BRMH: Does the implementation of a specific assessment instrument for identifying the need for substance abuse services (X) result in a greater rate of BRMH Medicaid recipients being indicated as needing substance abuse assessment and/or treatment (Y)?
- CUCC: Does showing CUCC therapists the current average individual times it is taking to record individual therapy sessions decrease the average length of time taken for documentation of individual therapy sessions with all Medicaid enrollees receiving mental health treatment with CUCC?
- DBH: Will specific interventions involving recognition and non-monetary rewards directly and positively influence mental health clinicians to increase the practice of collaborative documentation?

- FCCBH: Will increasing concurrent documentation training for clinicians directly increase the rate of concurrent documentation compliance?
- NCC: Will specific interventions involving recognition and non-monetary rewards directly and positively influence mental health clinicians to increase the practice of collaborative documentation?
- SBHC: Will specific interventions involving recognition and non-monetary rewards directly and positively influence mental health clinicians to increase the practice of collaborative documentation?
- VMH: Does increasing concurrent documentation correlate with improved client function as measured with the outcome questionnaire?
- WMH: Does training support staff and clinicians on the importance of outcome data collection increase the number of outcome data protocols collected on average per client in outpatient clinics during a 12-month study period; and does training clinicians on the use and interpretation of the Y/OQ outcome data increase the number of reference data made in the client's clinical progress notes on average per client over a period of one year?
- WHS: Do interventions implemented by the WHS no-show committee result in a statistically significant decrease in client no-show rates to their mental health evaluation appointment?

Eight of the nine PMHPs *Met* the criteria for a clear and answerable study question. BRMH's study question, while revised, remains ambiguous. It is not clear if BRMH is studying the use of an assessment tool, or if clinicians appropriately document the need for a referral, or both. BRMH's study question is not stated in clear and simple terms. Therefore BRMH did not fully meet one criteria.

Activity 3—Clearly Defined Study Indicator(s)

Eight of the nine PMHPs *Met all seven of the* criteria for selecting the study indicator(s). BRMH *Met* five of the criteria. All PMHPs presented objective and measurable indicators based on current evidence-based practice guidelines, or pertinent peer-reviewed literature. All study indicators measure change in important aspects of care or service and all PMHPs report the data are readily available for outcomes analysis. BRMH's study question has two components. The study indicator measures only one component of the question. Therefore the study indicator will not fully answer the study question. As a result, BRMH did not fully meet two criteria.

Activity 4—Unambiguously Defined Study Population

Eight of the nine PMHPs *Met* the criteria for clearly identifying their study population. The study populations are complete and capture all enrollees to whom the study question applies. BRMH's study question has two components. The study population identified by BRMH is consistent with its study indicator but will only address one component of its study question. Therefore BRMH did not fully meet one criterion.

Activity 5—Valid Sampling Techniques

This activity was *Not Applicable* for all of the PMHPs. No PMHP used sampling to select the study population for its PIP.

Activity 6—Accurate and Complete Data Collection

Eight of the nine PMHPs *Met* all of the criteria for this activity. BRMH *Met* six of the nine criteria. All of the PMHPs clearly identified the data to be collected, the source of the data, whether the data are qualitative or quantitative, and reported that data will be collected on the entire population. Each described a data analysis plan that included the methodology to be used in its data analysis.

BRMH did not provide information on the individuals collecting the data or identify if they have appropriate qualifications to perform this function. BRMH's data analysis plan does not accurately describe the data to be captured as described by its study indicator. The study question, study indicators, and the data analysis plan are not consistent with each other. Therefore BRMH did not fully meet three criteria.

Activity 7—Appropriate Performance Improvement Strategies

The PMHPs are at various stages of implementing their intervention strategies. All nine PMHPs used the quality improvement process to develop their intervention strategies and addressed whether the strategies are likely to induce permanent change. Seven of the nine PMHPs *Met* all of the applicable criteria for this activity. WHS's intervention strategies do not adequately address the causes and barriers related to its PIP. This resulted in a score of *Substantially Met* for one applicable criterion for this activity. VMH did not provide complete information on how its improvement strategies were implemented. This resulted in a score of *Partially Met* for the three applicable criteria for this activity.

Activity 8—Analysis and Interpretation of Data

All of the PMHPs have collected some remeasurement data and analyzed and interpreted their results. Six of the PMHPs *Met* all of the criteria and presented their findings in a clear and easily understood format.

CUCC did not label the columns in its data table making it difficult to track the findings with the narrative. Some of the numbers in the table did not match the numbers in the narrative and not all of the data used in the calculations was presented. QQ was not able to independently calculate and verify all of CUCC's reported findings. As a result, one criterion was rated as Substantially Met.

FCCBH conducted its data analysis and interpretation according to its data analysis plan. However, no plan for evaluating the significance of its improvement or the extent to which the study was successful was presented. This resulted in a score of Substantially *Met* for two criteria.

BRMH was rated as *Not Met* for all of the criteria in this activity because it did not present its findings as required. Baseline and remeasurement data were analyzed, interpreted, and reported in 2010, but the findings and the changes required as a result of the unsuccessful interventions were not presented on the PIP Reporting and Evaluation Form as required.

Activity 9—Real Performance Improvement Achieved

All nine PMHPs have completed at least one remeasurement. All applied the same methodology used to obtain their baseline measurement. Seven of the nine PMHPs reported an improvement in performance at measurement one compared to baseline. The improvements appear to be the result of the improvement strategies implemented by the PMHPs.

Three PMHPs (WMH, CUCC, and FCCBH) demonstrated highly significant improvement and clearly documented the changes made to their organizational processes that contributed to the improvements. Three PMHPs (DBH, NCC, and SBHC) demonstrated improvement but the improvement fluctuated from one measurement period to another and has little clinical relevance. BRMH demonstrated improvement at measurement one but not at measurement two. BRMH's data fluctuated significantly from one measurement period to another. BRMH's data do not appear to be valid.

Two PMHPs (WHS and VMH) did not demonstrate improvement. WHS modified its intervention strategy based on its findings. VMH is in the process of reviewing its strategy.

Activity 10—Real Performance Improvement Sustained

Three PMHPs (DBH, NCC, and SBHC) have completed this activity. The three PMHPs worked collaboratively on the same project to increase the rate of collaborative documentation as a means to improve the accuracy of clinical documentation, efficiency, and enhance client participation in their recovery. The three PMHPs have completed four remeasurements. All demonstrated some improvement at the first measurement but improvement fluctuated at subsequent measurements. While no significant improvement was demonstrated beyond the first remeasurement, the levels of collaborative documentation at remeasurement four remained above the baseline. Two of the three PMHPs (DBH and SBHC) were in the process of transitioning to a new electronic health record and believe this impacted their ability to demonstrate continuous and sustained improvement.

Follow-Up on Required Corrective Actions

In 2011, five PMHPs (BRMH, CUCC, NCC, SBHC, and WMH) were required to take corrective action on PIP related activities. ***Appendix 3*** provides a description of the corrective actions required and their completion status for each PMHP.

All of the PMHPs, with the exception of BRMH, completed their required corrective actions. In 2011, BRMH was required to revise its study question to clearly identify what is being studied; and to submit a revised PIP Reporting and Evaluation Form. In addition, BRMH was told to follow the PIP protocol and complete the PIP Reporting and Evaluation Form for all Activity 8 criteria. The PIP Reporting and Evaluation Form that BRMH submitted for review in 2012, included only two of the required corrective actions. BRMH did not successfully complete the required corrective actions identified in 2011.

Strengths, Weaknesses, and Opportunities for Improvement

Six of the nine PMHPs chose to focus their PIP on improving concurrent or collaborative documentation during treatment sessions. The choice of this topic is both timely and relevant as concurrent/collaborative documentation has gained national acceptance. Three of the PMHPs (DBH, NCC and SBHC) conducted their PIPs collaboratively. This included using the same study question, indicators, data collection methodology, and analyses.

All six of the PMHPs trained their staff on the importance of collaborative documentation and noted varying degrees of improvement. FCCBH documented striking improvement. FCCBH improved its rate of concurrent documentation from 14% to 58% at remeasurement two. FCCBH's intervention strategies were the most robust and included a well developed protocol and incorporated staff performance of collaborative documentation into the annual staff performance evaluation. WMH and CUCC also demonstrated striking improvement with their PIPs. These three PMHPs (FCCBH, WMH, and CUCC) have well thought out and well executed improvement plans that addressed the causes and barriers identified for their organizations.

The successful strategies should be shared with the other PMHPs. Sharing data across PMHPs will assist in identifying best practices, is a wise use of resources, and a significant strength of the current PMHP PIPs. Collaborative projects among the PMHPs should continue to be encouraged.

PMHPs that did not demonstrate significant or sustained improvement did not develop improvement strategies that were robust enough to generate real improvement. Developing strong intervention strategies and implementation plans is the greatest opportunity for future improvements with PIP outcomes.

QQ did not identify any significant weaknesses with PIP performance on an aggregated statewide level. With the exception of BRMH, the PMHPs in the aggregate, meet the requirements for conducting performance improvement projects that have the potential to improve health outcomes and/or enrollee satisfaction.

2. Performance Measures Performance

Introduction

In 2012, QQ validated three performance measures that each PMHP reported for calendar year 2011. QQ obtained the report specifications defined by UDOH and the data files the PMHPs used to produce their individual annual performance measures reports.

QQ used an automated program to calculate the number of days between the initial contact and the first offered appointment time for urgent, non-urgent, and emergent contacts. QQ calculated a percentage of compliance for each performance measure and an overall compliance rate based on the total number of contacts for each PMHP and in aggregate. This section of the report summarizes QQ's findings.

Findings

Table 4 presents the findings reported by the PMHPs to UDOH for 2011 and the findings validated by QQ. The reported and validated findings represent the percentage of compliance for each performance measure.

Table 4: PMHP Compliance with Access to Care Performance Measures

PMHPs	Initial Contacts							
	Emergency		Urgent		Non-Urgent		Overall	
	Reported	Validated	Reported	Validated	Reported	Validated	Reported	Validated
BRMH	100.0%	100.0%	95.8%	95.8%	97.6%	97.0%	97.6%	97.1%
CUCC	100.0%	100.0%	100.0%	100.0%	98.0%	99.6%	99.8%	99.4%
DBH	None reported	None Validated	89.6%	89.6%	97.5%	100.0%	97.3%	97.3%
FCCBH	100.0%	66.7%	100.0%	94.1%	100.0%	100.0%	100.0%	99.2%
NCC	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
SBHC	100.0%	100.0%	98.6%	98.6%	97.6%	97.6%	97.6%	97.6%
VMH	100.0%	75.0%	92.7%	92.5%	97.8%	97.0%	97.7%	96.9%
WMH	93.7%	93.8%	100.0%	100.0%	98.9%	94.8%	98.8%	94.7%
WHS	100.0%	100.0%	100.0%	100.0%	99.7%	96.5%	99.7%	96.5%
Statewide	**98.9%**	**96.8%**	**95.7%**	**95.3%**	**98.5%**	**96.9%**	**98.5%**	**96.8%**

Statewide, the PMHPs reported 98.9% compliance with the emergency appointment standard, 95.7% compliance with the urgent appointment standard, and 98.5% compliance with the non-urgent appointment standard. Overall, the PMHPs, reported a compliance rate of 98.5% for offering an initial mental health appointment within the required timeframes.

QQ validated 96.8% compliance with the emergency appointment standard, 95.3% compliance with the urgent appointment standard, and 96.9% compliance with the non-urgent appointment standard. Overall, QQ validated a statewide compliance rate of 96.8% for offering an initial mental health appointment within the required timeframes. The following summarizes QQ's findings by type of contact.

Emergency

Statewide, ninety-five (95) enrollees were identified as requiring an initial emergent mental health appointment in 2011. Of these, 96.8% were provided an initial emergent service within the required time. Five of the nine PMHPs (BRMH, CUCC, NCC, SBHC and WHS) *Met* the emergent care standard 100% of the time. WMH *Met* the standard 93.8% of the time; VMH Met 75.0% of the time; and FCCBH Met the standard 66.7% of the time. DBH did not report any enrollee requests for initial emergent mental health services.

The number of enrollees requiring an initial emergency service from each PMHP ranged from none to twenty-eight. For five of the PMHPs (DBH, FCCBH, NCC, SBHC, and VMH) the number of enrollees in need of an initial emergent appointment was fewer than ten. Initial Emergency service requests accounted for less than one percent of the initial service requests in 2011, and therefore do not have a major impact on overall statewide compliance with initial appointment requirements.

Urgent

Statewide, 232 enrollees were identified as requiring initial urgent mental health services. In the aggregate 95.3% were offered an appointment within five working days. Four of the nine PMHPs (CUCC, NCC, WMH, and WHS) *Met* the standard 100% of the time; BRMH *Met* the standard 95.8% of the time; DBH *Met* the standard 89.6% of the time; FCCBH *Met* the standard 94.1%; SBHC *Met* the standard 98.6% of the time and VMH *Met* the standard 92.5% of the time.

The number of enrollees requiring an initial urgent visit appointment from each PMHP ranged from 1 to 69. The compliance determination for WMH is based on only one enrollee and NCC is based on four enrollees. Requests for initial urgent mental health services accounted for 2.8% of the initial mental health service requests in 2011.

Non-Urgent

Statewide, 10,651 initial non-urgent requests for mental health services were identified in 2011. In the aggregate, the PMHPs complied with the required non-urgent appointment standard 96.9% of the time. Three PMHPs (DBH, FCCBH and NCC) *Met* the appointment standard 100% of the time. All nine PMHPs *Met* the Non-Urgent care appointment standard greater than 94% of the time. Enrollees who were given an appointment that exceeded the 15 day standard were primarily given

the appointment because the enrollee requested a later date. All PMHPs documented a reason for scheduling an appointment that did not comply with the standards.

Follow-Up on Required Corrective Actions

In 2011, two PMHPs (BRMH and WMH) were required to take corrective action on Performance Measures related activities. BRMH successfully implemented and completed its CAPs. WMH continues to have discrepancies in the files it submits to UDOH and QQ for validation of its performance measures data. WMH has not fully implemented and completed its CAP. ***Appendix 3*** includes a description of the required corrective actions and completion status for each CAP required in 2011.

Strengths, Weaknesses and Opportunities for Improvement

Overall, the PMHPs report a high level (98.5%) of compliance with access to care standards. QQ validated that in aggregate, across all measures, the PMHPs offered an appointment within the required time frames to 96.8% of enrollees seeking initial mental health services. This level of compliance clearly demonstrates timely and accessible care.

QQ did not identify any weaknesses with performance measures performance. The PMHPs have consistently demonstrated impressive compliance with access to care standards required by the State. UDOH, in collaboration with the PMHPs, should consider developing new performance measures that focus on program areas where meaningful improvement can be achieved.

3. Follow-up Compliance Reviews

Introduction

In 2011, QQ conducted a full compliance review to determine the PMHPs compliance with standards as required by §438.204(g) and other state specific standards relative to credentialing, re-credentialing, and program integrity requirements.

UDOH required PMHPs to meet or exceed its requirements related to access standards, structure and operations standards, and measurement and improvement standards. Overall the PMHPs *Met* 93% of the compliance standards in 2011.

QQ required each PMHP to submit a CAP for each standard that was not fully met. In 2012, PMHPs were required to submit documented evidence that the CAPs were implemented and completed. This section of the report summarizes the findings of the follow-up review of the standards that were not fully *Met* in 2011.

Findings

All nine PMHPs were required to revise their member handbook to include language on the amount, duration, and scope of covered benefits. All PMHPs modified their

handbooks to include appropriate language and obtained approval from UDOH on their revisions. All nine PMHPs are now in compliance with the information requirements standard.

All nine PMPHs were required to revise their corporate compliance plans to include the potential for enrollee fraud in their fraud and abuse program, and to develop a procedure to identify potential enrollee fraud. Seven of the nine PMHPs completed the required corrective actions. CUCC and VMH updated their corporate compliance plans to include the potential for enrollee fraud however, a procedure for detecting and reporting enrollee fraud have not been completed.

Appendix 3 identifies the corrective actions required by each PMHP in 2011 and their completion status, based on the follow-up review conducted in 2012. Six of the nine PMHPs completed all of their required corrective actions. BRMH and CUCC have one remaining corrective action and VMH has two remaining corrective actions. ***Appendix 4*** identifies the corrective actions that were not completed in 2011 and continue to be required in 2012.

B. Physical Health Plan

1. Performance Improvement Projects Performance

Introduction

In 2012 QQ validated the PIP activities completed by MHU during calendar year 2011. QQ validated the following PIP:

- Increasing LDL Screening Incidence for Diabetic Molina Healthcare of Utah Members.

Findings

MHU is in year two of this PIP and has completed six of the ten required PIP activities. MHU *Met* 100% of the criteria for the activities completed in 2011. **Table 5** presents an overview of the validation scores by activity. A narrative summarizing the findings for each activity follows.

Table 5: MHU PIP Validation Scores by Activity

Review Activity Number and Description	MHU
1. Study Topic	100%
2. Study Question	100%
3. Study Indicator(s)	100%
4. Study Population	100%
5. Sampling Techniques	100%
6. Data Collection	100%
7. Improvement Strategies	N/A
8. Analysis	N/A
9. Improvement Achieved	N/A
10. Improvement Sustained	N/A
Overall PHP Score	100%

Activity 1 – Appropriate Study Topic

MHU selected LDL screening among its diabetic Medicaid enrollees as the topic for this PIP based on an analysis of its 2011 HEDIS findings. MHU's rate of LDL screening for diabetic Medicaid enrollees is below the 50th percentile nationally. Current case management/disease management activities have not significantly impacted LDL screening rates; therefore, MHU is interested in exploring additional strategies to help it reach the 75th percentile for LDL screening rates for its diabetic enrollees.

The study topic reflects a significant portion of MHU's Medicaid population and reflects both a high volume and high risk condition. Diabetes is consistently ranked in the top 10 diagnoses for MHU Medicaid enrollees. Current medical and health care literature identifies diabetes as a significant and growing healthcare problem that currently affects approximately ten percent of the population. The health risks and complications associated with diabetes are well documented.

Improvements in blood lipid control can reduce cardiovascular complications in diabetics by as much as 50 percent. Improvements in health status are correlated with improvements in both functional status and enrollee satisfaction. MHU demonstrated that it selected its study topic based on data analysis, relevance to its population, and the potential to affect enrollee health.

Activity 2—Clearly Defined and Answerable Study Question

MHU's study question is: Will outreach efforts result in an increase of LDL screening incidence for diabetic members? MHU will compare its rate of LDL screening before and after it implements outreach activities. The study question is answerable.

Activity 3—Clearly Defined Study Indicator(s)

The study indicator is the percentage of members 18-75 years of age with diabetes who had LDL screening in 2009. The study indicator is a HEDIS measure for Comprehensive Diabetes Care and is objective and measurable. HEDIS measures are developed from evidence-based practice guidelines and are nationally recognized as the standard for measuring health care quality. HEDIS findings will be tracked over time to determine if interventions are effective. MHU's study indicator answers the study question. MHU is required to collect HEDIS data annually; therefore, the data are readily available for use as a study indicator.

Activity 4—Unambiguously Defined Study Population

MHU is using its HEDIS data to identify the study population. HEDIS criteria for selecting the study population are appropriate, complete, well-defined, and audited by an approved NCQA vendor.

Activity 5—Valid Sampling Techniques

MHU is using the HEDIS methodology to select its study population. HEDIS methodology is statistically sound, ensures the sample is representative of the eligible population, and includes an acceptable margin of error for inclusion in the sample.

Activity 6—Accurate and Complete Data Collection

MHU is using the NCQA methodology to collect and analyze its data. The HEDIS methodology clearly identifies and defines the data to be collected for this measure. MHU identified the team members responsible for collecting the data for its PIP. All are nurses experienced in Medicaid data extraction for HEDIS hybrid measures. MHU compares its Medicaid HEDIS performance to its commercial business and national Medicaid HEDIS benchmarks. HEDIS findings are audited by a vendor certified by NCQA on an annual basis.

Follow-Up on 2011 Recommendations

There are no required corrective actions from the previous review.

Strengths, Weaknesses, and Opportunities for Improvement

MHU's choice of the study topic to increase LDL screening of its adult diabetic population is timely and relevant. The decision to utilize HEDIS methodology and its HEDIS data to monitor and track its progress is a wise use of resources. QQ did not identify any weaknesses in the activities completed to date.

In the coming year, MHU should focus on intervention strategies that go beyond the usual outreach activities of reminder notices, letters and phone calls and current case management and disease management activities.

2. Performance Measures Performance

Introduction

In 2012, OHCS, in collaboration with UDOH, prepared a summary of the results of the HEDIS measures reported by MHU based on 2011 data. This section of the report includes OHCS' findings based on the 2011 data.

Findings

Table 6 provides an overview of the findings by domain, compared to the national averages.

Table 6: MHU HEDIS Scores Compared to National Average

HEDIS Measure	MHU	National Average
Access		
The percentage of members 12 to 24 months who had a visit with an MCO primary care practitioner.	97.97	96.07
The percentage of members 7 to 11 years who had a visit with an MCO primary care practitioner.	90.74	89.54
The percentage of members 12 to 19 years who had a visit with an MCO primary care practitioner.	89.87	87.89
The percentage of members 20 to 44 who had an ambulatory or preventive care visit.	85.30	80.04
The percentage of members 45 to 64 who had an ambulatory or preventive care visit.	90.15	86.05
The percentage of members 65 years and older who had an ambulatory or preventive care visit.	90.40	83.47
Childhood Immunizations		
The percentage of children who received four DTaP/DT vaccinations; three IPV vaccinations; one MMR vaccination; three HiB vaccinations; three hepatitis B vaccinations; and one VZV vaccination on or before the child's second birthday.	79.17	74.48
The percentage of children who received an initial DTaP vaccination followed by at least three DTaP, DT or individual diphtheria and tetanus shots, with different dates of service on or before the child's second birthday.	77.55	70.64
The percentage of children that received three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.	92.82	88.78
The percentage of children that received three H influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday.	93.52	90.98
The percentage of children that received at least three polio vaccinations (IPV) with different dates of service on or before the child's second birthday.	93.52	90.54
The percentage of children that received at least one measles, mumps, and rubella (MMR) vaccination, with a date of service falling on or before the child's second birthday.	91.67	90.87
The percentage of children that received at least one chicken pox vaccination (VZV), with a date of service falling on or before the child's second birthday.	90.05	90.47

HEDIS Measure	MHU	National Average
Women's Health and Maternity Care		
The percentage of women who had a mammogram to screen for breast cancer.	51.50	50.43
The percentage of women 21 to 64 years of age who received one or more Pap tests to screen for cervical cancer.	70.07	66.72
The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	40.40	59.17
The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	69.44	64.12
The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO.	88.19	82.75
Child and Adolescent Well-Care		
The percentage of members who were 12 to 19 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	41.67	49.71
The percentage of members who were three, four, five or six years of age who received one or more well-child visits with a primary care practitioner during the measurement year.	63.19	72.03
The percentage of members who turned 15 months old during the measurement year and who had 5 well-child visits with a primary care practitioner during their first 15 months of life.	17.59	16.19
The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a primary care practitioner during their first 15 months of life.	60.88	61.75
Child and Adolescent Health Care		
The percentage of members 2 to 18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).	73.12	66.66
The percentage of members age 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the Episode Date.	90.15	85.32
Use of Medication		
The percentage of members 5 to 11 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	95.19	90.51
The percentage of members 12 to 50 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	82.97	80.67
Care for People with Diabetes		
Percentage of members who had a retinal exam by an eye care professional.	62.02	53.35
The percentage of members who had an HbA1c level above 9.0% during their last visit. Lower numbers are better.	30.77	43.04
The percentage of members who had one or more HbA1c tests.	89.66	82.53

HEDIS Measure	MHU	National Average
Care for People with Diabetes (continued)		
The percentage of members who had an LDL level less than 100 mg/dl at their most recent test in the past two years.	39.42	35.23
The percentage of members who had a kidney disease (nephropathy) screening test.	83.17	77.84
Health Care for Adults		
The percentage of members with acute low back pain for whom imaging studies did not occur.	76.45	75.78

Strengths, Weaknesses, and Opportunities for Improvement

MHU performed very well in three major HEDIS categories. MHU exceeded the national average in access to care and use of preventive health services; care for members with diabetes; and childhood immunizations (with the exception of the chicken pox vaccine). MHU did not perform as well in providing services to adolescents and older children or screening young, sexually active women for Chlamydia. The performance measures that represent the greatest opportunities for improvement are:

- The percentage of women that have had Chlamydia screenings;
- Adolescent well-care visits; and
- The percentage of members who were three, four, five or six years of age who received one or more well-child visits with a primary care practitioner during the measurement year.

3. Follow-up Compliance Reviews

Introduction

In 2011, QQ conducted a full compliance review of MHU and HU to determine their compliance with federal managed care requirements in 42 CFR Part 438 and other additional contract requirements. Although HU is a PAHP, UDOH elected to include HU in the compliance section of this report because their requirements are similar to those required of other MCEs. In 2011, MHU *Met* all of the required compliance standards. HU *Met* 97% of the standards and was required to submit corrective action plans for two standards that were not fully Met. This report is limited to the follow-up on the two standards that were not fully *Met* in 2011.

Findings

Table 7 details HU's required corrective actions and the completion status based on the 2012 review.

Table 7: Completion Status of 2012 Compliance Review Healthy U Required Corrective Actions

Standard	Regulatory Citation	Requirements	CAP Completed
1.4 General Provisions	§438.10(f)(6) Information Requirements	HU must simplify the language in the *What is Emergency Care* section of its member handbook.	No
3.5 Quality Assessment and Performance Improvement—Access Standards	§438.206(c)(2) Availability of Services	HU must incorporate in policy its efforts to provide culturally competent care to enrollees from diverse ethnic backgrounds beyond the provision of interpreter services.	No

HU revised the language in the "What is Emergency Care" section of its Member Handbook. UDOH determined the language could be further simplified and provided suggested language for HU to use in its Member Handbook. HU revised its Provider Manual to include provider responsibilities related to culturally competent care, but did not revise its Cultural and Linguistically Appropriate Care Services Policy to include cultural and ethnic needs or considerations beyond the need for interpreter services. HU did not provide documentation describing how staff members are trained to provide culturally competent care and how HU monitors if care is provided in a culturally competent manner. HU did not fully implement and complete its CAPs. Additional corrective action is required to complete the CAPs.

V. CONCLUSIONS, REQUIRED MCE CORRECTIVE ACTIONS AND UDOH RECOMMENDATIONS

A. Prepaid Mental Health Plans

1. Performance Improvement Projects Performance

Conclusions

In aggregate, the PMHPs *Met* 94% of the PIP criteria for the activities completed in 2011. Individual PMHP scores ranged from 64% to 100%. Four of the nine PMHPs *Met* 100% of the PIP criteria and an additional four PMHPs *Met* more than 92%. One plan, BRMH, continues to struggle with following the PIP protocol and may benefit from UDOH intervention and guidance. With the exception of BRMH, the PMHPs in the aggregate, meet the requirements for conducting performance improvement projects that have the potential to improve health outcomes and/or enrollee satisfaction. The PMHPs continue to work toward mastering the activities and associated criteria for conducting a meaningful PIP.

Required Corrective Actions

QQ did not identify any statewide required corrective actions. The required corrective actions for the individual PMHPs with outstanding CAPs are identified in ***Appendix 4***.

2. Performance Measures Performance

Conclusions

Overall, the PMHPs reported a high level (96.8%) of compliance with access to care standards. QQ validated that, across all measures, the PMHPs offered an appointment within the required timeframes to 96.8% of enrollees seeking initial mental health services. Based on QQ's findings, the PMHPs meet the standards for providing timely and accessible care. The PMHPs have consistently (over several years) demonstrated impressive compliance with the access to care standards.

Required Corrective Actions

QQ did not identify any statewide required corrective actions. The required corrective action for one PMHP is identified in ***Appendix 4.***

3. Compliance Reviews

Conclusions

Overall, the PMHPs demonstrated very high levels of compliance with Federal and State standards for managed care. In the aggregate, the PMHPs *Met* 93% of the

compliance standards in 2011. In 2012 six PMHPs (DBH, FCCBH, NCC, SBHC, WMH and WHS) provided documented evidence that their CAPs are completed and these PMHPs are now fully compliant with all of the standards. Two PMHPs (BRMH and CUCC) have not completed one CAP, and one PMHP (VMH) has not completed two CAPs. The three PMHPs demonstrated progress toward completing their CAPs but did not fully implement them in 2011.

Required Corrective Actions

QQ did not identify any statewide required corrective actions. The required corrective actions for the three PMHPs with outstanding CAPs are identified in ***Appendix 4***.

B. Physical Health Plans

1. Performance Improvement Projects Performance

Conclusions

MHU is in year two of its PIP on increasing LDL screening rates for its diabetic enrollees. MHU *Met* 100% of the criteria for the activities completed in 2011. In the coming year, MHU plans to focus on developing intervention strategies that go beyond its current disease management program to improve LDL screening rates. MHU followed the CMS PIP protocol and demonstrated appropriate progress in 2011.

Required Corrective Actions

QQ did not identify any required corrective actions.

2. Performance Measures Performance

Conclusions

Overall, MHU performed at or above the national average on 81% of the HEDIS performance measures and has demonstrated improvement over time. Based on the findings, MHU meets the standards for reporting of performance measures required under 42 CFR §438.240(c). However, MHU is below the national average for Chlamydia screening, adolescent well-care visits, and well-care visits for children three to six years of age.

Required Corrective Actions

- MHU must develop and implement strategies to improve Chlamydia screening for women;
- MHU must develop and implement strategies to improve adolescent well-care visits

- MHU must develop and implement strategies to increase the rate of well-child visits for members three through six years of age.

3. Compliance Reviews

Conclusions

In 2011, the PHPs demonstrated exceptionally high levels of compliance with Federal and State requirements for managed care. MHU *Met* 100% of the standards and HU *Met* 97% of the standards. HU was required to take corrective action on two standards that were not fully met in 2011. In 2012, HU demonstrated progress toward completing its CAPs but the required actions are not complete. Therefore, HU continues to have two required CAPs for 2012.

Required Corrective Actions

QQ did not identify any statewide required corrective actions.

HU is must complete the two following corrective actions.

- Simplify the language used to describe "What is an Emergency Service" in its member handbook; and
- Expand its cultural competency program to include important cultural and ethnic considerations of its population.

C. UDOH Recommendations for all MCEs

1. Performance Improvement Projects Recommendations

- UDOH should continue to encourage collaboration on PIPs to maximize the benefit of testing multiple strategies to impact shared problems.
- UDOH should provide a forum for the MCEs to share intervention strategies that demonstrate significant improvement and best practices.

2. Performance Measures Recommendations

- UDOH, in collaboration with the PMHPs, should consider developing new performance measures that focus on program areas where meaningful improvement can be achieved.

3. Compliance Reviews Recommendations

QQ did not identify UDOH-level recommendations for improvement related to compliance review activities.

Appendix 1

Annual Report Format Crosswalk

Appendix 1 – Annual Report Format Crosswalk

In collaboration with UDOH, QQ made a number of format improvements to the annual EQR report in 2009. In order to address both federally mandated components under 42 CFR Part §438.364, and content recommended in the *Centers for Medicare and Medicaid Services' State External Quality Review Toolkit for State Medicaid Agencies, Issued October 2006* (EQR Toolkit), QQ made additional improvements in 2011. The grid below explains the format of the 2012 Annual Report.

Annual Report Format			
Section	**Content**	**Requirements**	**Comments**
I. Executive Summary	A summary of the key points of the report, including an overview of findings; summary of strengths and weaknesses; recommendations and; strategies for using the EQR report.	Not specifically mandated by §438.364 but it is a recommended component of annual EQR reports in CMS' EQR Toolkit and is related to §438.364(a)(1)	This section includes major findings and opportunities for improvement. The details are in Section III.
II. Background	A History of State Medicaid Managed Care Programs. A description of how UDOH uses EQR reports to assess its program.	Not mandated by §438.364 but it is a recommended component of annual EQR reports in CMS' EQR Toolkit.	This section includes all of the content recommended in CMS' EQR Toolkit.
III. Description of EQR Activities	A Describes each EQR activity included in the report, the data obtained for each activity, and the objectives and methods for conducting each activity.	Is a federally mandated component of EQR reporting per §438.364(a)(1)(i-iii) and is addressed in CMS' EQR Toolkit.	This section includes all but one recommended component in CMS' EQR Toolkit. CMS' suggestion to summarize how UDOH uses the EQR process/information to evaluate its program is included in Section II. All three EQR activities are summarized in this section.
IV. Description of Findings	Results for each activity, including an introduction, findings, follow-up from prior EQR activities and corrective action plans (CAPs); and a summary of strengths, weaknesses and opportunities for improvement.	Is a federally mandated component of EQR reporting per §438.364(a)(1)(iv); §438.364(a)(2); (a)(3); and (a)(4).	This section includes the description of findings for each EQR activity .In addition, discussion of best/emerging practices is in this section, if applicable. Plan level findings are summarized and aggregated in the body of this report, rather than in a separate appendix. In addition, QQ produces an individual report for each MCE beyond §438.364 reporting requirements. The detailed reports are available on request.
V. Conclusions Related to Completion of CAPs	A full summary of all findings and CAPs, including the progress each plan made in addressing prior year recommendations and the degree to which each plan successfully implemented their CAPs.	Is a federally mandated component of EQR reporting per §438.364(a)(1)(iv); §438.364(a)(2), (a)(3), and (a)(5). Details expanded to reflect UDOH recommendations.	This section includes recommendations for the State and MCEs, if applicable, Please see ***Appendix 3*** for a Summary of Required Corrective Actions for each MCE for all EQR Activities Reviewed in 2012.

Appendix 2
Sample HEDIS Measures

Appendix 2 - Sample HEDIS Measures

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS 2011

- Deleted CPT codes 76090–76092 from Table BCS-A.

Note: *NCQA intends to review this measure in 2011 to assess recently revised guidelines. No changes will be made for HEDIS 2011; any changes will be reflected in HEDIS 2012.*

Description

The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	Women 42–69 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.

Appendix 2 - Sample HEDIS Measures

Numerator One or more mammograms during the measurement year or the year prior to the measurement year. A woman had a mammogram if a submitted claim/encounter contains any code in Table BCS-A.

Table BCS-A: Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	V76.11, V76.12	87.36, 87.37	0401, 0403

Exclusion *(optional)*

- Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the member's history through December 31 of the measurement year. Exclude members for whom there is evidence of two unilateral mastectomies. Refer to Table BCS-B for codes to identify exclusions.

Table BCS-B: Codes to Identify Exclusions

Description	CPT	ICD-9-CM Procedure
Bilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307 ***WITH*** Modifier .50 or modifier code 09950*	85.42, 85.44, 85.46, 85.48
Unilateral mastectomy (members must have 2 separate occurrences on 2 different dates of service)	19180, 19200, 19220, 19240, 19303-19307	85.41, 85.43, 85.45, 85.47

*.50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session.

Note: *The purpose of this measure is to evaluate primary screening. Do not count biopsies, breast ultrasounds or MRIs for this measure because they are not appropriate methods for primary breast cancer screening.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Appendix 2 - Sample HEDIS Measures

Table BCS-1/2/3: Data Elements for Breast Cancer Screening

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Appendix 3
Completion Status of Required Corrective Actions Identified in 2011

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Bear River Mental Health (BRMH)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 2 Criterion 1	The study question is stated in clear, simple terms.	BRMH must submit clarification of the study question within 30 days of receipt of this required corrective action. The revised study question will be evaluated by QQ and UDOH prior to BRMH conducting further activity on its PIP. Once the revised study question is approved by QQ and UDOH, BRMH must submit a revised PIP Reporting and Evaluation Form to QQ for validation. The revised PIP Reporting and Evaluation form must be submitted to QQ and UDOH within 90 calendar days of approval of the revised study question.	No
Activity 3 Criterion 1	The study indicator(s) are well defined, objective, and measurable.	BRMH must define its study indicator so that it clearly and accurately describes what is to be measured.	No
Activity 6 Criterion 3	Individuals collecting the data are identified and have appropriate qualifications to perform this function.	BRMH must provide more information on any BRMH staff responsible for collecting the data.	No
Activity 6 Criterion 4	The instrument(s) used for data collection are identified.	Since only one indicator is described in Activity 3, it appears the study is on increasing the number of people identified who need a referral, whether an actual referral is made or not. BRMH must provide clarification on whether and, if so how, actual referrals are part of this PIP.	No
Activity 6 Criterion 9	Describe the data analysis plan and all pertinent methodological features.	BRMH must recalculate percentage data and present it in accordance with the study indicator definition.	No
Activity 8 Criterion 1	Data analysis and interpretation were conducted according to the data analysis plan.	BRMH did not provide answers to Activity 8 Criteria 1 even though data analysis and interpretation occurred in 2010. BRMH must provide answers for the relevant criteria relating to Baseline 1 and 2 and Remeasurement 1. BRMH must provide these answers in the sections entitled, "MCE's Proposed Corrective Action Plan (CAP)" in this report in Section D. "Performance Improvement Project (PIP) Reporting and Evaluation Tool." BRMH must also document its plan for ensuring its documentation is complete in its 2012 PIP Reporting and Evaluation Form that it submits to QQ	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Bear River Mental Health (BRMH) (continued)			
Performance Improvement Project Required Corrective Actions (continued)			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 8 Criterion 3	Data analysis and interpretation identify factors that threaten internal or external validity of findings.	BRMH did not provide answers to Activity 8 Criteria 3 even though data analysis and interpretation occurred in 2010. BRMH must provide answers for the relevant criteria relating to Baseline 1 and 2 and Remeasurement 1. BRMH must provide these answers in the sections entitled, "MCE's Proposed Corrective Action Plan (CAP)" in this report in Section D. "Performance Improvement Project (PIP) Reporting and Evaluation Tool." BRMH must also document its plan for ensuring its documentation is complete in its 2012 PIP Reporting and Evaluation Form that it submits to QQ	No
Activity 8 Criterion 4	Data analysis and interpretation are presented in a way that provides accurate, clear, and easily understood information.	BRMH did not provide answers to Activity 8 Criteria 4 even though data analysis and interpretation occurred in 2010. BRMH must provide answers for the relevant criteria relating to Baseline 1 and 2 and Remeasurement 1. BRMH must provide these answers in the sections entitled, "MCE's Proposed Corrective Action Plan (CAP)" in this report in Section D. "Performance Improvement Project (PIP) Reporting and Evaluation Tool." BRMH must also document its plan for ensuring its documentation is complete in its 2012 PIP Reporting and Evaluation Form that it submits to QQ	No
Activity 8 Criterion 5	Data analysis and interpretation identify initial measurement and remeasurement of study indicators.	BRMH did not provide answers to Activity 8 Criteria 5 even though data analysis and interpretation occurred in 2010. BRMH must provide answers for the relevant criteria relating to Baseline 1 and 2 and Remeasurement 1. BRMH must provide these answers in the sections entitled, "MCE's Proposed Corrective Action Plan (CAP)" in this report in Section D. "Performance Improvement Project (PIP) Reporting and Evaluation Tool." BRMH must also document its plan for ensuring its documentation is complete in its 2012 PIP Reporting and Evaluation Form that it submits to QQ	No
Activity 8 Criterion 6	Data analysis and interpretation identify factors that affect the ability to compare initial measurement with remeasurement.	BRMH did not provide answers to Activity 8 Criteria 6 even though data analysis and interpretation occurred in 2010. BRMH must provide answers for the relevant criteria relating to Baseline 1 and 2 and Remeasurement 1. BRMH must provide these answers in the sections entitled, "MCE's Proposed Corrective Action Plan (CAP)" in this report in Section D. "Performance Improvement Project (PIP) Reporting and Evaluation Tool." BRMH must also document its plan for ensuring its documentation is complete in its 2012 PIP Reporting and Evaluation Form that it submits to QQ	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Bear River Mental Health (BRMH) (continued)			
Performance Improvement Project Required Corrective Actions (continued)			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 8 Criterion 7	Data analysis and interpretation include the extent to which the study was successful.	BRMH did not provide answers to Activity 8 Criteria 7 even though data analysis and interpretation occurred in 2010. BRMH must provide answers for the relevant criteria relating to Baseline 1 and 2 and Remeasurement 1. BRMH must provide these answers in the sections entitled, "MCE's Proposed Corrective Action Plan (CAP)" in this report in Section D. "Performance Improvement Project (PIP) Reporting and Evaluation Tool." BRMH must also document its plan for ensuring its documentation is complete in its 2012 PIP Reporting and Evaluation Form that it submits to QQ	No
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Item 4	Please explain the process you use to assure the data you are submitting to UDOH is complete and accurate (quality assurance processes).	BRMH must provide QQ with the same data file that it uses to report its performance measures data to UDOH. It is important that QQ has the same data file to ensure it is validating the same contacts as reported on the health plan's performance measures annual report.	Yes
Item 5	Please provide any other information that you would like to include and consider valuable in reporting your performance measures data.	BRMH must fully implement its revised procedures to improve its ability to offer first appointments within state-established standards. This will be evaluated by BRMH's overall compliance rate in its 2011 performance measures report.	Yes
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	BRMH must revise its PMHP member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Bear River Mental Health (BRMH) (continued)			
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
4.3 Quality Assessment and Performance Improvement—Measurement and Improvement Standards	§438.240(b), (d) Quality Assessment and Performance Improvement Program	BRMH must submit clarification of the study question within 30 calendar days of receipt of this required corrective action. The study question will be evaluated by QQ and UDOH prior to BRMH conducting further activity on its PIP. Once the study question is approved by QQ and UDOH, BRMH must submit to QQ for validation a new PIP Reporting and Evaluation Form addressing the study question. The new PIP Reporting and Evaluation form must be submitted to QQ and UDOH within 90 calendar days of approval of the revised study question.	No
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	BRMH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program and develop a process to address this potential.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Central Utah Counseling Center (CUCC)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 6 Criterion 3	Individuals collecting the data are identified and have appropriate qualifications to perform this function.	CUCC must provide the name and job title for all individual staff responsible for collecting data and demonstrate they have appropriate qualifications to perform this function.	Yes
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	CUCC must revise its PMHP member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	CUCC must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Davis Behavioral Health (DBH)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	DBH must revise its PMHP member handbook to include language on the amount, duration, and scope of benefits and obtain approval from the state on the revisions.	Yes
2.1 Enrollee Rights and Protections	§438.100(b)(2) and §438.10(b) Enrollee Rights	DBH must simplify the language and reformat its Member Handbook so that it is easily understood.	Yes
3.0 Quality Assessment and Performance Improvement—Access Standards	§438.206(b)(1) Availability of Services	DBH must include in policy how network adequacy is evaluated and who is responsible for monitoring and oversight.	Yes
5.10 Grievance System	§438.408(d), (e) Resolution and Notification: Grievances and Appeals	DBH must revise its Notice of Appeal Resolution letter to include a statement that indicates it is their last and final decision.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Davis Behavioral Health (DBH) (continued)			
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	DBH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Four Corners Community Behavioral Health (FCCBH)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	FCCBH must revise its member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
3.9 Quality Assessment and Performance Improvement—Structure and Operation Standards	§438.214(c) Provider Selection and §438.12(a)(1) Provider Discrimination Prohibited	FCCBH must revise its policies on provider selection and retention to include the provision that the MCE's provider selection and retention criteria do not discriminate against health care professionals who serve high-risk populations or who specialize in treatment of costly conditions.	Yes
5.10 Grievance System	§438.408(d), (e) Resolution and Notification: Grievances and Appeals	FCCBH must revise its Notice of Appeal Resolution and Notice of Action Failure to Resolve Appeal Timely letter templates to include a statement that indicates it is the MCE's last and final decision.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	FCCBH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Northeastern Counseling Center (NCC)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 1 Criterion 3	The study topic reflects a significant portion of the MCE's enrolled population.	NCC must validate the numbers presented for the study population prior to submitting its PIP Reporting and Evaluation Form in CY 2012 to ensure the study population is accurately identified and reflects a significant portion of the enrolled population.	Yes
Activity 1 Criterion 3	The study topic reflects a significant portion of the MCE's enrolled population.	NCC must validate the numbers presented for the study population prior to submitting its PIP Reporting and Evaluation Form in CY 2012 to ensure the study population is accurately identified and reflects a significant portion of the enrolled population. NCC must correct the definitions of SVD and/or MH prior to submitting its PIP Reporting Evaluation Form in CY2012 so that they accurately reflect the numbers listed in those columns.	Yes
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	NCC must revise its PMHP member handbook to include language on the amount, duration, and scope of benefits and obtain approval from the state on the revisions.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	NCC must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Southwest Behavioral Health Center (SBHC)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 1 Criterion 3	The study topic reflects a significant portion of the MCE's enrolled population.	SBHC must validate the numbers presented for the study population prior to submitting its PIP Reporting and Evaluation Form in CY 2012 to ensure the study population is accurately identified and reflects a significant portion of the enrolled population. SBHC must correct the definitions of SVD and/or MH prior to submitting its PIP Reporting Evaluation Form in CY2012 so that they accurately reflect the numbers listed in those columns.	Yes
Activity 7 Criterion 3	Intervention strategies address whether they are revised if original interventions are unsuccessful.	SBHC must explain why there were nearly three times as many Planning and Review checkpoints during Remeasurement one as during a comparable length of time during Baseline. SBHC must justify why the interpretation that the interventions were successful was based on index data, when data from each of the three indicators do not support SBHC's assertion of success. Given that the data show that the original interventions were unsuccessful, SBHC must describe efforts to develop and implement revised interventions, including a timeframe for developing new intervention(s), timeframe for implementing new intervention(s), and a new timeline for subsequent remeasurements. Since SBHC has completed the interventions that it is measuring in the remeasurement cycle of July through December 2011; SBHC should proceed with the data analysis as planned but also use the time to develop new or additional interventions starting in January 2012.	Yes
Activity 8 Criterion 7	Data analysis and interpretation include the extent to which the study was successful.	SBHC must explain why there were nearly three times as many Planning and Review checkpoints during Remeasurement one as during a comparable length of time during Baseline. SBHC must justify why the interpretation that the interventions were successful was based on index data, when data from each of the three indicators do not support SBHC's assertion of success. Given that the data show that the original interventions were unsuccessful, SBHC must describe efforts to develop and implement revised interventions, including a timeframe for developing new intervention(s), timeframe for implementing new intervention(s), and a new timeline for subsequent remeasurements. Since SBHC has completed the interventions that it is measuring in the remeasurement cycle of July through December 2011; SBHC should proceed with the data analysis as planned but also use the time to develop new or additional interventions starting in January 2012.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Southwest Behavioral Health Center (SBHC) (continued)			
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	The State-approved member handbook must be revised to include language on the amount, duration, and scope of covered benefits.	Yes
2.1 Enrollee Rights and Protections	§438.100(b)(2) and §438.10(b) Enrollee Rights	SBHC must use a more effective means of evaluating the readability of its member handbook or apply the Power Sumner Pearl Formula to more than a single 100 word sample and must update its written policy and procedure to reflect this revised methodology.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	SBHC must update its compliance plan to include enrollees and the potential for member fraud in the fraud and abuse program.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Valley Mental Health (VMH)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	VMH must revise its PMHP member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes
3.8 Quality Assessment and Performance Improvement—Structure and Operation Standards	§438.214(b) Provider Selection	VMH must implement processes to ensure compliance with its policy for credentialing and recredentialing subcontracted providers, and to ensure 100% of files are complete and current at all times. The following deficiencies were identified in the review sample: ➢ 83% contained expired professional licenses. ➢ NPI verification was not included in any files. VMH policy, "Subcontractor Outpatient Services: Application to Become a Provider" states NPI verification will be documented in credentials files. ➢ Two provider applications were denied. The denial letters sent to the requesting providers did not include the reason VMH denied the application. VMH policy "Subcontractor Outpatient Services: Application to Become a Provider" states denial letters will include the reason for the denial.	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Valley Mental Health (VMH) (continued)			
Compliance Review Required Corrective Actions (continued)			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
5.5 Grievance System	§438.404(a), (b) Notice of Action	VMH must revise its Notice of Action template to include all information required in its contract with the UDOH (*Contract, Article X, Section C*). The following information was missing from VMH's Notice of Action template and sample notices reviewed during the on-site compliance review: ➢ the enrollee's or the provider's right to file an appeal with the MCE ➢ procedures for requesting an appeal ➢ procedures for exercising rights specified in §438.404 ➢ procedures under which expedited resolution is available and how to request it ➢ the enrollee's right to have benefits continue pending resolution of the appeal, how to request benefits be continued, and the circumstances under which the enrollee may be required to pay the cost of those	Yes
5.10 Grievance System	§438.408(d), (e) Resolution and notification: Grievances and Appeals	VMH must implement procedures to ensure its Notice of Appeal Decision letters include all information required in its contract with the UDOH *(Contract, Article XI, Section C, 5; Article X, Section B)* and as included in its Appeal Decision template notices, for all appeal decisions.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	VMH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Wasatch Mental Health (WMH)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Activity 8 Criterion 4	Data analysis and interpretation are presented in a way that provides accurate, clear, and easily understood information.	In its 2011 PIP Reporting and Evaluation Form, WMH must present complete data analysis and interpretation on each of the two indicators for Baseline and each re-measurement in response to Activity 8 Criterion 4, Activity 8 Criterion 5, and Activity 8 Criterion 7 WMH must submit only one CAP to address how it will ensure it will provide complete data analysis and interpretation in its 2011 PIP for each of the two indicators in response to Activity 8 Criterion 4, Activity 8 Criterion 5, and Activity 8 Criterion 7.	Yes
Activity 8 Criterion 5	Data analysis and interpretation identify initial measurement and re-measurement of study indicators.	WMH must submit only one CAP to address how it will ensure it will provide complete data analysis and interpretation in its 2011 PIP for each of the two indicators in response to Activity 8 Criterion 4, Activity 8 Criterion 5, and Activity 8 Criterion 7.	Yes
Activity 8 Criterion 7	Data analysis and interpretation include the extent to which the study was successful.	WMH must submit only one CAP to address how it will ensure it will provide complete data analysis and interpretation in its 2011 PIP for each of the two indicators in response to Activity 8 Criterion 4, Activity 8 Criterion 5, and Activity 8 Criterion 7.	Yes
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
Item 4	Please explain the process you use to assure the data you are submitting to UDOH is complete and accurate (quality assurance processes).	The results of QQ's analysis of the data file submitted by WMH do not match the results WMH reported to UDOH. WMH must fully implement its quality assurance processes for tracking and monitoring to ensure it is accurately reporting data from its performance measures database to both UDOH and QQ. WMH must document how it will ensure the data submitted to QQ for validation match the data reported to UDOH in annual reports.	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Wasatch Mental Health (WMH) (continued)			
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	WMH must revise its PMHP member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	WMH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Weber Human Services (WHS)			
Performance Improvement Project Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Performance Measures Required Corrective Action			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.3 General Provisions	§438.10(f)(6) Information Requirements	WHS must revise its PMHP member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	WHS must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.	Yes

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Healthy U (HU)			
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
1.4 General Provisions	§438.10(f)(6) Information Requirements	HU must simplify the language in the *What is Emergency Care* section of its member handbook.	No
3.5 Quality Assessment and Performance Improvement—Access Standards	§438.206(c)(2) Availability of Services	HU must incorporate in policy its efforts to provide culturally competent care to enrollees from diverse ethnic backgrounds beyond the provision of interpreter services.	No

Appendix 3 - Completion Status of Required Corrective Actions Identified in 2011

Molina Healthcare of Utah (MHU)			
Compliance Review Required Corrective Actions			
Activity	**Requirement**	**Required Corrective Action**	**Completed? Yes or No**
NA	NA	None	NA

Appendix 4
Summary of Required Corrective Actions Identified in 2012

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Bear River Mental Health (BRMH)		
Performance Improvement Project Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
Activity 2 Criterion 1	The study question is stated in clear, simple terms.	BRMH must restate its study question in clear and simple terms.
Activity 3 Criterion 1	The study indicator(s) are well defined, objective, and measurable.	BRMH must define its study indicator so that it clearly and accurately describes what is to be measured
Activity 6 Criterion 4	The instrument(s) used for data collection are identified.	BRMH must carefully define the use of the term "study population." Some columns are subsets of others. The number of study population indicated for referral is not accurately labeled.
Activity 6 Criterion 9	Describe the data analysis plan and all pertinent methodological features.	BRMH must recalculate percentage data and present it in accordance with the study indicator definition or redefine and clarify the study indicator.
Activity 8 Criterion 1, 3, 4, 5, 6 and 7	Data analysis and interpretation	BRMH did not provide answers to Activity 8 Criteria 1, 3, 4, 5, 6, and 7 even though data analysis and interpretation occurred in 2011. BRMH must provide answers to these criteria.
Compliance Review Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
4.3 Quality Assessment and Performance Improvement—Measurement and Improvement Standards	§438.240(b), (d) Quality Assessment and Performance Improvement Program	BRMH must submit clarification of the study question within 30 calendar days of receipt of this required corrective action. The study question will be evaluated by QQ and UDOH prior to BRMH conducting further activity on its PIP. Once the study question is approved by QQ and UDOH, BRMH must submit to QQ for validation a new PIP Reporting and Evaluation Form addressing the study question. The new PIP Reporting and Evaluation form must be submitted to QQ and UDOH within 90 calendar days of approval of the revised study question.

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Central Utah Counseling Center (CUCC)		
Performance Improvement Project Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
Activity 8 Criterion 4	Data analysis and interpretation are presented in a way that provides accurate, clear, and easily understood information.	In its 2013 submission of the PIP reporting tool, CUCC must label all columns and ensure that the data presented in its tables matches the data reported in the narrative.
Compliance Review Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	CUCC must develop policies and procedures for detecting and reporting potential enrollee fraud or abuse. These policies and procedures may be contained in CUCC's Corporate Compliance Plan or in a separate document that is cross-referenced in the Corporate Compliance Plan.

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Four Corners Community Behavioral Health (FCCBH)		
Performance Improvement Project Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
Activity 8 Criterion 1	Data analysis and interpretation were conducted according to the data analysis plan.	FCCBH must describe in its submission of the PIP reporting tool in 2013 the statistical techniques it used, or plans to use, in its data analysis.
Activity 8 Criterion 7	Data analysis and interpretation identify initial measurement and remeasurement of study indicators.	FCCBH must describe in its submission of the PIP reporting tool in 2013how it evaluated, or plans to evaluate the extent of the projects success. For example, what goal or benchmark, is or was, used as a measure of success
Activity	**Requirement**	**Required Corrective Action**
Activity 9 Criterion 4	There is statistical evidence that an observed improvement is real improvement.	FCCBH must describe in its submission of the PIP reporting tool in 2013 what statistical evidence it used, or plans to use, to identify real improvement.

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Valley Mental Health (VMH)		
Performance Improvement Project Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
Activity 7 Criterion 1	Intervention/improvement strategies undertaken are related to causes or barriers identified through data analysis and QI processes.	In its 2013 PIP submission VMH must provide information on how it implemented the strategies within its organization.
Activity 7 Criterion 2	Intervention/improvement strategies address whether they are likely to induce permanent change.	In its 2013 PIP submission VMH must provide information on what actions are taken by managers once the reports are received and address how the actions are likely to induce permanent change.
Activity 7 Criterion 3	Intervention strategies address whether they are revised if original interventions are unsuccessful.	In its 2013 PIP submission VMH must provide an analysis of why its intervention strategies are not successful and modify its strategies accordingly.
Compliance Review of Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
3.8 Quality Assessment and Performance Improvement—Structure and Operation Standards	§438.214(b) Provider Selection	VMH must implement processes to ensure compliance with its policy for credentialing and recredentialing subcontracted providers, and to ensure 100% of files are complete and current at all times. The following deficiencies were identified in the review sample: ➢ 83% contained expired professional licenses. ➢ NPI verification was not included in any files. VMH policy, "Subcontractor Outpatient Services: Application to Become a Provider" states NPI verification will be documented in credentials files. ➢ Two provider applications were denied. The denial letters sent to the requesting providers did not include the reason VMH denied the application. VMH policy "Subcontractor Outpatient Services: Application to Become a Provider" states denial letters will include the reason for the denial.
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	VMH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Wasatch Mental Health (WMH)		
Compliance Review Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
Item 4	Please explain the process you use to assure the data you are submitting to UDOH is complete and accurate (quality assurance processes).	The results of QQ's analysis of the data file submitted by WMH do not match the results WMH reported to UDOH. WMH must fully implement its quality assurance processes for tracking and monitoring to ensure it is accurately reporting data from its performance measures database to both UDOH and QQ. WMH must document how it will ensure the data submitted to QQ for validation match the data reported to UDOH in annual reports.

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Weber Human Services (WHS)		
Performance Improvement Project Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
Activity 7 Criterion 2	Intervention/improvement strategies address whether they are likely to induce permanent change	If the addition of the Friday walk-in clinic does not demonstrate a significant reduction in its no-show rate, WHS must reevaluate the causes and barriers affecting its no-show rates and propose interventions that are likely to produce meaningful and permanent change. This analysis and proposed interventions, including a timeline for implementation, must be included in the 2013 PIP Reporting and Evaluation Tool.

Appendix 4 - Summary of Required Corrective Actions Identified in 2012

Healthy U (HU)		
Compliance Review Required Corrective Actions for 2012		
Activity	**Requirement**	**Required Corrective Action**
1.4 General Provisions	§438.10(f)(6) Information Requirements	HU must simplify the language in the *What is Emergency Care* section of its member handbook.
3.5 Quality Assessment and Performance Improvement—Access Standards	§438.206(c)(2) Availability of Services	HU must incorporate in policy its efforts to provide culturally competent care to enrollees from diverse ethnic backgrounds beyond the provision of interpreter services.

ATTACHMENT 8

The most recent Utah 2011 Customer Satisfaction Survey (CAHPS) Report can found at:

https://health.utah.gov/myhealthcare/reports/cahps/2011/index.php?page=home