https://medicaid.utah.gov/managed-care/

Utah Department of Health & Human Services

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Medicaid Managed Care Quality Strategy 2025

Division of Integrated Healthcare, Medicaid

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Executive summary

The Division of Integrated Healthcare's (DIH) vision for Utah's Medicaid program and the Children's Health Insurance Program (CHIP) is to ensure that all Utahns have fair and equitable opportunities to live safe and healthy lives. Collaboration and engagement with multiple entities—including healthcare providers, community organizations, tribal representatives, advocacy groups, and government agencies—are essential to primary and secondary prevention, tertiary care, addressing health related social needs (HRSN), disparities, and supporting the improvement of health outcomes of Medicaid and CHIP members. By fostering partnerships that prioritize culturally sensitive care, equitable resource distribution, and expanded access to preventive and chronic care delivery of services, these efforts aim to create healthier communities and sustainable healthcare outcomes for all.

TheThe 2025 DIH managed care quality strategy (MCQS) was designed with the foundation of results-based accountability (RBA) and lays out DIH's quality, population health and health equity framework and strategy to support this vision. Utah Department of Health and Human Services' (DHHS) core values of innovation, support, equity, accountability, empathy, impact, connection, and efficacy served as guiding principles in the development of the DIH quality strategy initiatives. These values also informed the development of implementation strategies and the design of quality and performance measures to ensure meaningful and measurable outcomes.

The MCQS serves as a comprehensive roadmap for managed care in both Medicaid and CHIP, guiding DHHS to drive improvements in health outcomes and quality of healthcare delivery. Note that singular references to the Medicaid program imply the CHIP program as well. **Section 1** of the DIH MCQS provides an overview of the Utah Medicaid program and quality management structure, including DHHS' vision, mission, purpose, and the MCQS that provides alignment and guidance for quality improvement. This plan supports the DHHS vision and strategic RBA goals while aligning managed care entities' (MCE) quality improvement programs and activities to enhance care outcomes for Medicaid members. DHHS' organizational structure and stakeholder committees are also described in the section.

Section 2 and **Section 3** outline DIH's Medicaid framework, quality aims, and the following key quality initiatives.

Key initiatives	
Health equity:	The strategy prioritizes identifying and addressing health equity needs through activities like NCQA HE/HE+ and TJC health equity accreditation.
Population health management (PHM):	DIH is implementing a Utah population health

	management system (UPHMS) in 2025 to improve data visibility and support targeted interventions. The PHM strategy encompasses coverage, preventive/chronic care, incarcerated care, tribal health, and disabilities care.
Quality initiatives	• MCE quality withholds which tie a percentage of capitation payments to performance on quality measures. • Quality-based auto-assignment which allocates a larger percentage of members to higher-performing plans based on performance on quality measures. • Hospital quality project which ties a percentage of hospital directed payments to performance on quality measures. • Collective PIPs which identify and implement common MCE performance improvement projects.
Interoperability:	DIH promotes interoperability through the Utah State Medicaid Health Information Technology Plan, aiming for secure and efficient exchange of electronic health information.

DIH Medicaid utilizes its quality strategy framework (see **Figure 2.3**) to oversee and evaluate the performance of its MCEs, ensuring accountability and continuous quality improvement across all programs. Guided by DIH's five quality aims, i.e., advance health equity, improve centric whole person population health, enhance member journey and experiences, improve provider and staff experiences, and exercise financial stewardship by lowering costs, the DHHS has developed a set of seven pillars to direct its quality framework (summarized below), ensuring a sustained focus on continuous improvement in its quality strategy approach. These include maternal health, adult and child physical health, adult and child behavioral health, and health equity to address HRSN, member and provider journey, experience and satisfaction and financial stewardship to control cost while optimizing quality for improved health outcomes. Additionally, key components of the quality framework are the population health model, which influences every aspect of the organization and community, and health equity, which is an integral part of the overall population health strategy and its subgroups, ensuring that the needs of the most underserved populations are effectively addressed.

Section 4 describes the process for reviewing, updating, and submitting the MCQS. When revising the MCQS, DHHS seeks input from stakeholders to ensure all partnership feedback is considered for any updates to the MCQS. The MCQS is reviewed annually and submitted, at a minimum, to CMS every three years or more frequently, as applicable. **Section 5** outlines the

timelines for assessing the effectiveness of the MCQS and for modifying or updating the MCQS. An evaluation of the MCQS is included in the annual External Quality Review (EQR) report. This report provides DHHS with a detailed analysis of each health plan's performance from the previous year. It includes an assessment of the required EQR activities, identifies strengths and weaknesses, and offers recommendations for improvement for each contracted MCE).

Section 6 and **Section 7** outline the quality assessment and performance improvement strategies, monitoring activities, and state standards such as access and availability, coordination of care, structure and operations and measurements, and improvements that DIH employs to ensure the delivery of quality healthcare across all MCEs. These strategies help DIH assess the quality and appropriateness of care provided to Medicaid members enrolled in these health plans. To support this process, Utah Medicaid contracts with a third-party External Quality Review Organization (EQRO) to perform the EQR activities mandated by regulation and outlined in each of the **managed care contracts**. Data gathered from both state and EQRO activities is used to evaluate the performance of each MCE.

Section 8 describes the improvement initiatives that support the pillars of quality framework (see **Figure 8.1**). DIH acknowledges that establishing standards is a critical first step in promoting safe and effective healthcare. To ensure these standards are consistently met, DIH conducts regular monitoring of MCEs to identify opportunities for improvement and to guarantee the delivery of high-quality, cost-effective services. Based on these monitoring activities, DIH has implemented several targeted interventions to support the seven pillars of the quality framework, aiming to optimize overall health system performance.

DIH's goal is to simultaneously improve these pillars while optimizing quality for improved health outcomes. Additional initiatives, such as the Population Health Management System, Restriction program, Medicaid promoting interoperability program, the Provider Reimbursement Information System for Medicaid (PRISM), Utah Health Information Network (UHIN) and Clinical Health Information Exchange (CHIE), the All-Payer Claims Database (APCD), and Indicator-Based Information System for Public Health (IBIS-PH) are essential data sources for monitoring performance, identifying areas for improvement, and tracking progress toward quality goals.

Section 9 outlines the managed care delivery system reform efforts which aligns with the four priorities of the MCQS: outcomes and alignment; equity and engagement; safety and resiliency; interoperability and scientific achievement. Lastly, **Section 10** outlines achievements and ongoing challenges as well as current and future initiatives. Utah Medicaid is committed to enhancing care coordination, improving preventive care for women and children, ensuring better access to and quality of services, and implementing innovative strategies to control costs while maintaining and improving the quality of care.

DIH and its contracted MCEs are actively engaged in the following:

- Working with partners and stakeholders to explore behavioral health services funding to allow greater flexibility to implement additional integrated care models

- Exploring reimbursement policies to encourage and support care integration at the clinical level
- Participating in new efforts to find more effective ways to better address the social determinants of health

Looking ahead

The MCQS is a dynamic document, continuously evolving to meet the changing needs of Utah's Medicaid and CHIP population. Key future initiatives include:

- Expanding interoperability efforts to facilitate seamless data exchange
- Strengthening rural health services and addressing health disparities
- Implementing quality-based auto-assignment to incentivize high-quality care
- Leveraging the Utah population health management system (UPHMS) to enhance population health management
- Establishing and maintaining a Utilization Management (UM) program that aligns with CMS and NCQA standards and guidelines to expand access for:
    - health information,
    - improve prior authorization, and
    - ensure coordination of care.

Conclusion

The Utah DIH MCQS demonstrates a commitment to improving the health and well-being of Medicaid and CHIP members through a comprehensive, data-driven, and stakeholder-informed approach. By prioritizing health equity, whole-person care, and innovative initiatives, the MCQS aims to create a more equitable and effective healthcare system for all Utahns.

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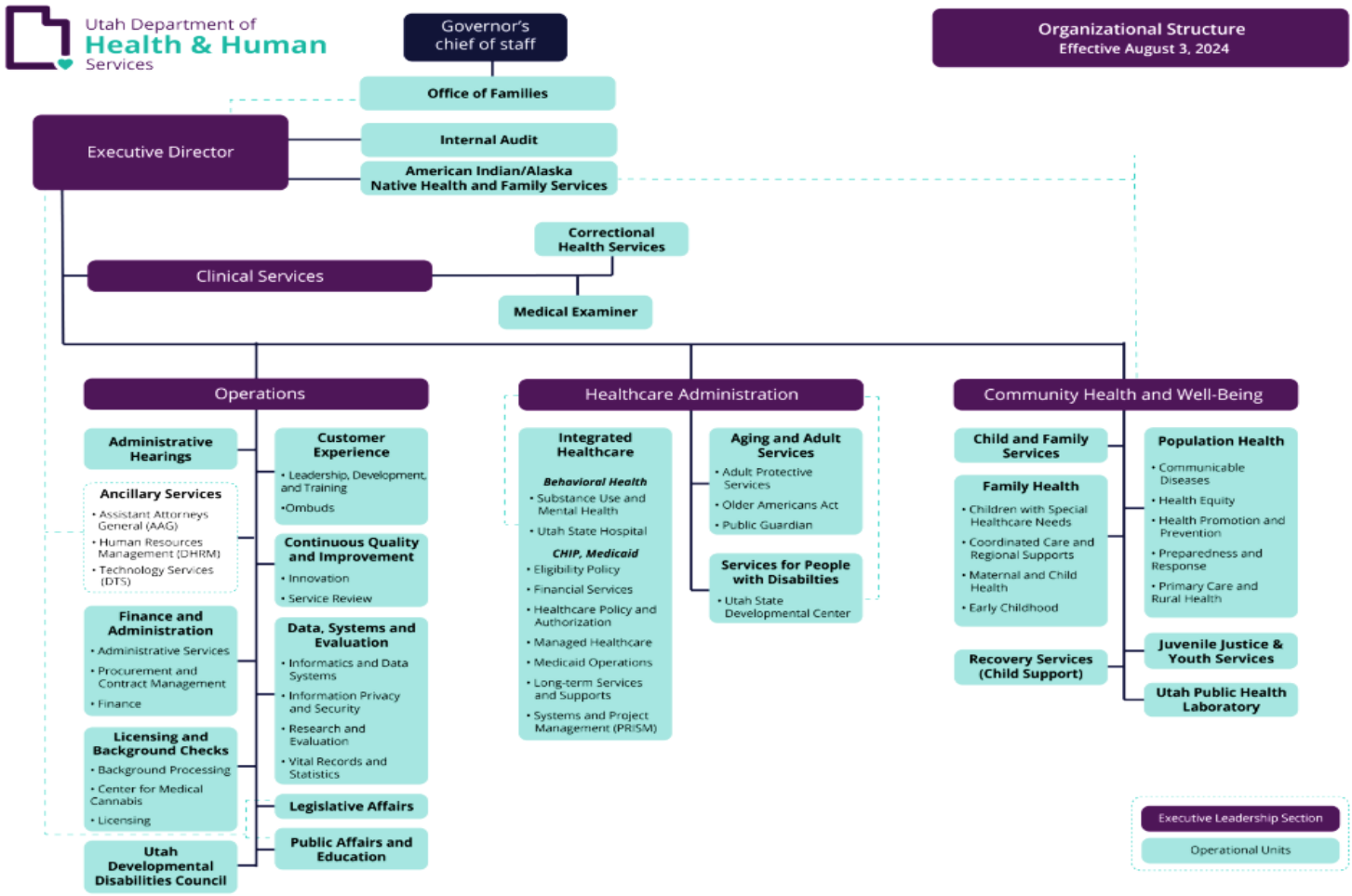
Section 1: Introduction

Background

The Utah Division of Integrated Healthcare's (DIH) Medicaid MCQS was designed with the foundation of results-based accountability (RBA) supporting the overall vision of DHHS to ensure that all Utahns have fair and equitable opportunities to live safe and healthy lives. The Utah Department of Health and Human Services' (DHHS) values of innovation, support, equity, accountability, empathy, impact, connection, and efficacy helped guide the development of the DIH MCQS initiatives, development of implementation strategies, and performance measure development.

The DHHS DIH is the state agency responsible for administering Medicaid and the Children's Health Insurance Program (CHIP). DIH reports to the DHHS Healthcare Administration Deputy Director and is led by the State Medicaid Director. The organizational structure for DHHS is outlined below.

Figure 1.1: Organizational structure



Within DIH, the Office of Managed Healthcare (OMH) is responsible for oversight of the delivery of quality healthcare services provided by contracted managed care entities (MCEs): accountable care organizations (ACOs), Utah Medicaid Integrated Care (UMIC) plans, prepaid mental health plans (PMHP), Healthy Outcomes Medical Excellence (HOME), CHIP and Medicaid and CHIP dental plans.

In FY 2012, DIH established ACO Quality Meetings as part of its quality management efforts with the intent of expanding efforts to other MCEs. The ACO Quality Meetings help inform strategic planning, prioritization, and alignment of quality measures for performance trending, improvement initiatives, contractual accountability, resource designation, and barrier mitigation to ensure a cohesive approach to realizing the mission, vision, aims, pillars, and goals of the MCQS. The ACO Quality Meetings comprise both internal and external stakeholders, including quality improvement (QI) staff from Utah's ACOs.

The ACO Quality Meetings occur monthly and are facilitated by DIH's quality and managed care

staff members.

ACO meeting activities	
1.	Share recommendations and decisions with stakeholders
2.	Obtain feedback from ACO stakeholders
3.	Review, evaluate, and provide recommendations to the MCQS at least every three years
4.	Select quality measures to monitor and analyze
5.	Review and discuss quality performance, including tracking and trending to identify and prioritize areas for QI
6.	Review ACO performance
7.	Discuss best practices and potential solutions to common opportunities for improvement
8.	Develop and review clinical initiatives

Although DIH initially started holding quality meetings with the ACOs, it is the intent of DIH to establish similar meetings for other MCE program types. To ensure member and community input, DIH also collaborates with the following stakeholder committees:

- Beneficiary Advisory Council (BAC)
- Utah Medicaid Advisory Committee (MAC)
- Utah CHIP Advisory Committee (CHIPAC)

The BAC is composed of current and former Medicaid members, as well as individuals with direct experience supporting Medicaid members. The BAC meets quarterly.

BAC responsibilities	
Advises DIH on their experiences with the Medicaid program on matters related to:	Policy development
	Effective administration of the Medicaid program

The MAC serves as an advisory committee to DHHS. Some of the BAC members also serve on the MAC.

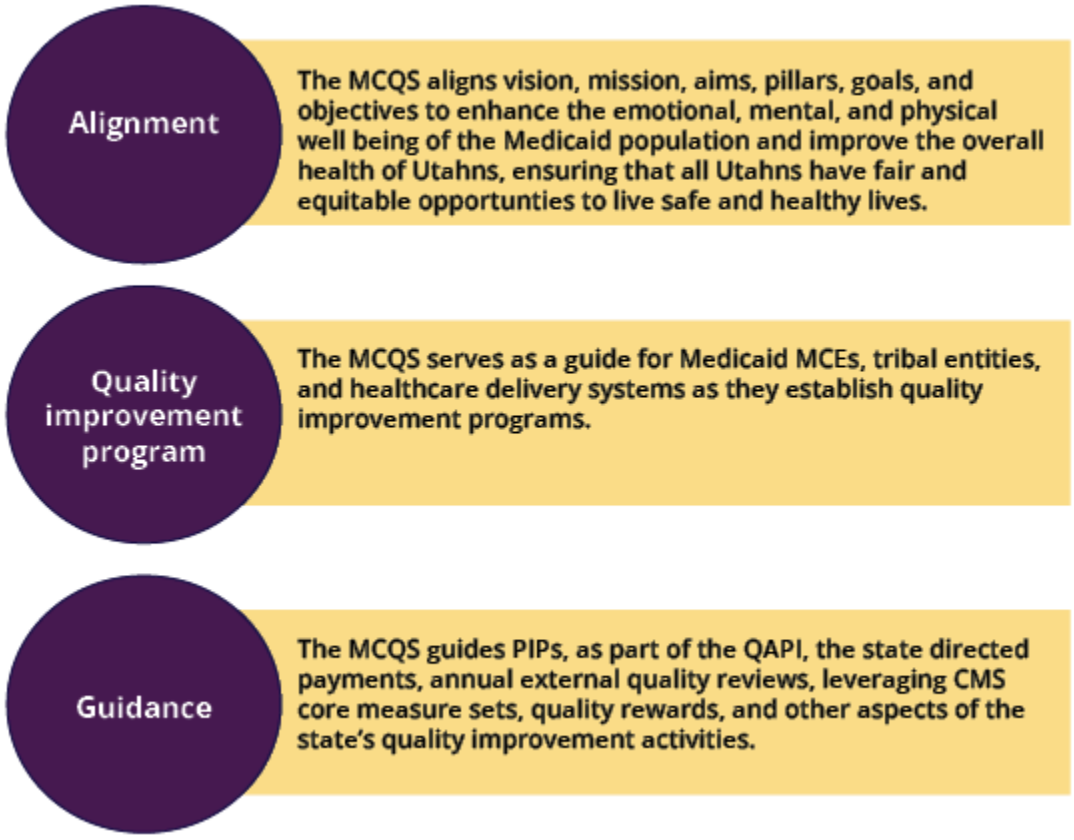
MAC responsibilities	
Advise DIH on an expanded range of issues within the Medicaid program:	Improving access to care
	Improving quality of care (QOC)
	Improving health outcomes
	Addressing health equity issues
Ensure proper and efficient administration of the Medicaid program:	Ensure proper and efficient administration of the Medicaid program, making sure services under the Medicaid program are provided in a manner consistent with the best interests of the members

The Utah CHIPAC also serves as an advisory committee to DHHS on health and medical care services within the CHIP program.

CHIPAC responsibilities	
Advise DIH and makes recommendations on a variety of CHIP related issues.	Gathers input to advise DIH on important areas such as eligibility criteria, outreach efforts, and health needs of CHIP beneficiaries.

In accordance with 42 Code of Federal Regulations (CFR) 438.340(a) and 42 CFR 457.1240(e), each state is responsible for the development, implementation, and maintenance of the MCQS. The MCQS supports DHHS' vision and strategic RBA goals while also providing alignment and guidance to MCE QI programs and activities to achieve improved outcomes of care for Medicaid members.

Figure 1.2: Managed care quality strategy (MCQS) providing alignment and guidance for quality improvement

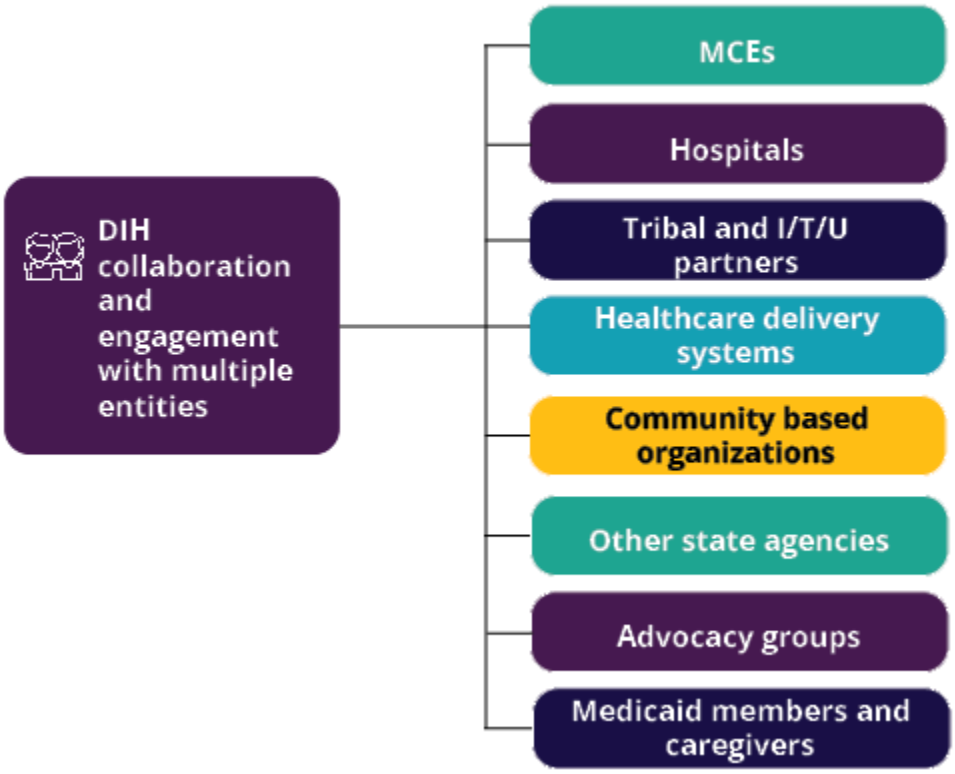


DIH requests feedback from stakeholders, including the public stakeholders, to successfully take action on improvement opportunities related to social needs and disparities.

DIH uses stakeholder engagement, like providers and MCEs, to develop their own suggestions for contract language arrangements. DIH may work with stakeholders on different quality proposals developed by providers or MCEs to ensure consistency with the broader quality goals outlined by DIH. If a provider-led or MCE-led quality proposal furthers quality goals, DIH will work with stakeholders to create pathways to implementation.

The MCQS establishes top priorities to address quality and performance metrics and evaluate its effectiveness. The MCQS is updated at least every three years or more frequently as needed and it is made publicly available on the DIH Medicaid Managed Care webpage. During the three-year cycle, consideration is given to the needs of the population, as well as the segmentation of the population through a multi-faceted approach which includes engaging the following entities in the figure below.

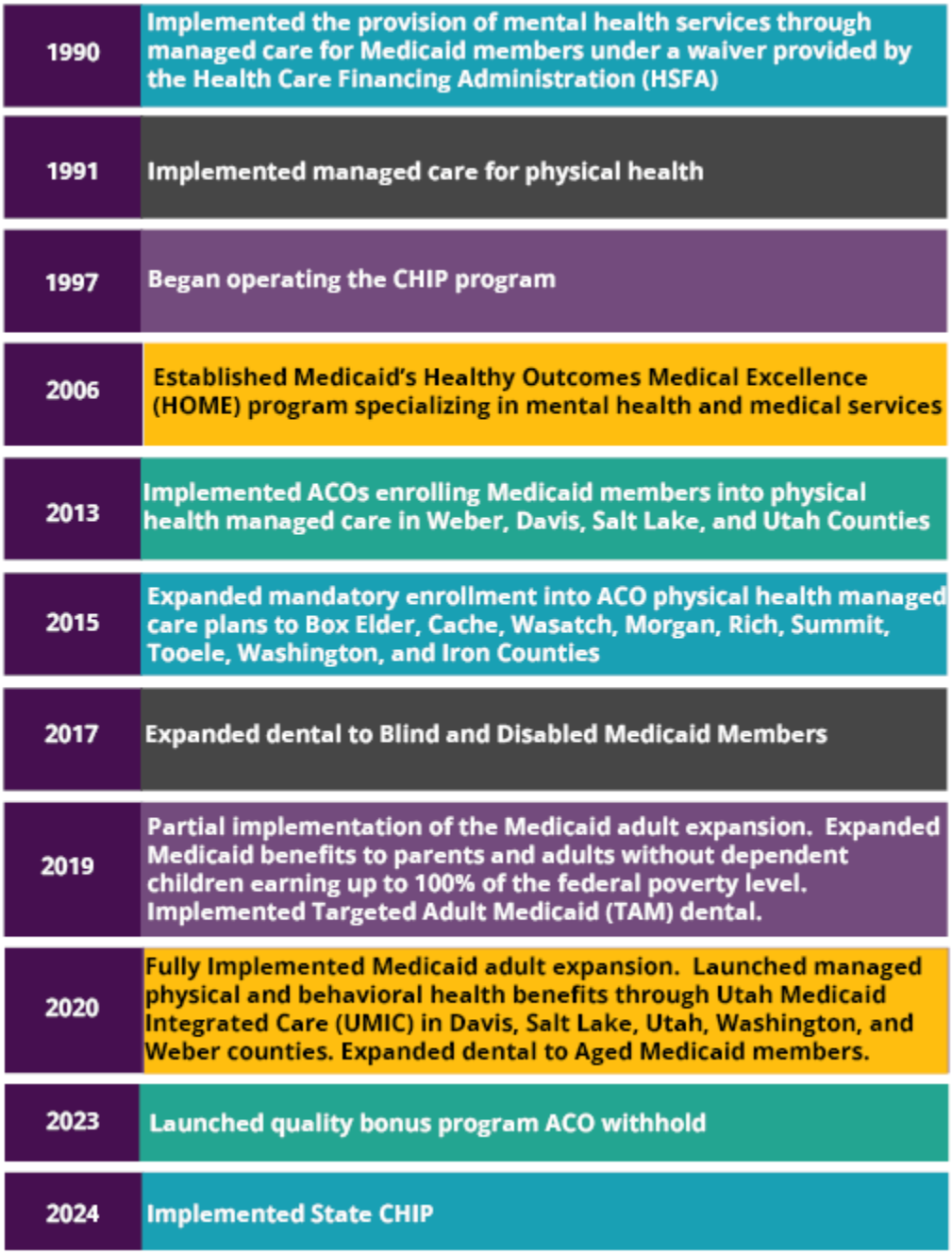
Figure 1.3: DIH Medicaid collaboration with multiple entities



Program current state

A historical timeline of the DIH Medicaid program with some qualitative elements in Utah is located below. From a quality perspective, historic updates have included revised quality metrics over the life of the ACO and UMIC contracts for continuous alignment with the changes in regulatory and accreditation requirements issued by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS). For many years, MCEs reported on identified metrics which were publicly reported by ACO plans. More recently, a quality incentive and performance withholds were put in effect starting in the fiscal year (SFY) 2024 ACO contracts.

Figure 1.4: Timeline of Medicaid and CHIP programs

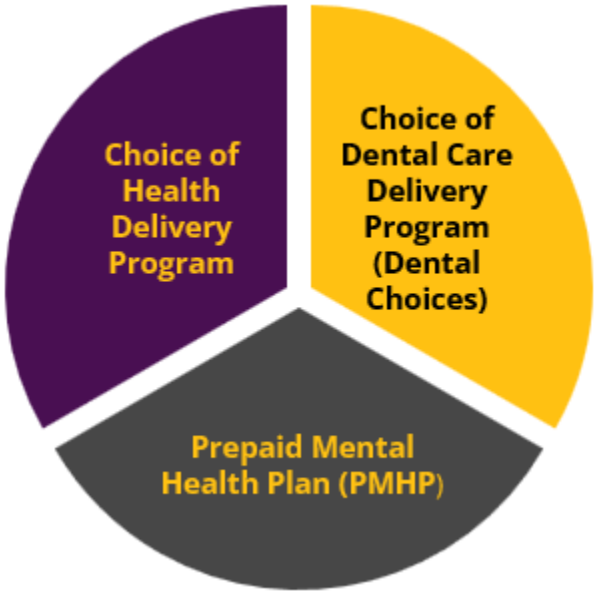


OMH is currently working towards implementation of several new initiatives over the next three years.

Current and future Office of Managed Healthcare quality initiatives	
SFY 25: July 1, 2024 - June 30,2025	ACO Capitation Withhold Program (ongoing) UMIC Capitation Withhold Program (planning phase for SFY 2026 contracts)
Beginning 2025	PMHP and Dental Quality Initiatives-identify and establish quality performance metrics for PMHP and dental SFY 2027 contracts
Beginning July 2024 (SFY 25)	Hospital Quality Project-Up to 3% of a hospital's directed payments at risk
Beginning January 2026	ACO Quality-Based Auto-Assignment
Beginning July 2027	NCQA certification required of all ACO plans

DIH operates three separate 1915(b) Freedom of Choice waivers.

Figure 1.5: Freedom of Choice Waivers



Managed care provisions are also included in Utah's 1115 demonstration waiver for the adult

expansion group.

Waiver requirements	
Choice of Health Delivery Waiver	Requires Medicaid recipients living in 13 of Utah's 29 counties to enroll in an MCE covering physical healthcare
Dental Choices Waiver	Medicaid recipients who have Medicaid dental coverage are required to enroll in a managed care dental plan*

*The dental 1915(b) Dental Choices waiver requires EPSDT eligible children ages 0-18, EPSDT children who are disabled 0-20, and pregnant members who have dental coverage to enroll in a managed care dental plan. Enrollees who receive full dental care who are not included in the 1915(b) waiver are: EPSDT children 19-20, blind and disabled adults 21-64, and aged adults 65-99.

There are currently 7 managed care program types operated by 17 MCEs in the state of Utah. Below is a summary of all MCEs by type. For additional information please visit the Utah Managed Care website.

Summary of Managed Care Entities (MCEs) by type and operating authority	
MCE type	**Operating authority**
Eleven Medicaid Prepaid Mental Health Plans (PIHP) • Bear River Mental Health • Southwest Behavioral Health Center • Four Corners Community Behavioral Health • Northeastern Counseling Center • Davis Behavioral Health • Central Utah Counseling Center • Salt Lake County Division of Behavioral Health • Healthy U Behavioral • Optum Tooele County • Wasatch Behavioral Health • Weber Human Services	1915(b) Prepaid Mental Health Plans (PMHPs) waiver

Summary of Managed Care Entities (MCEs) by type and operating authority	
MCE type	**Operating authority**
Four Medicaid ACOs (MCO) • Health Choice Utah • Healthy U • Molina Healthcare • Select Health Community Care	1915(b) Choice of Health Care Delivery (CHCD) waiver
Four Utah Medicaid Integrated Care (UMIC) plans (MCO) • Integrated Health Choice • Integrated Healthy U • Integrated Molina • Integrated Select Health	1115 waiver
Three CHIP Plans (MCO) • Healthy U CHIP • Molina Healthcare CHIP • SelectHealth Community Care CHIP	CHIPRA authority
Two Medicaid Dental Plans (PAHP) • MCNA • Premier Access Medicaid	1915(b) Choice of Dental Care Delivery Program waiver
One CHIP Dental Plan (PAHP) • Premier Access CHIP	CHIPRA authority
Healthy Outcomes Medical Excellence (HOME)	1915(a) UNI HOME Program

Medicaid members living in Davis, Box Elder, Cache, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties are required to enroll in one of four ACOs, except for Adult Expansion members living in Davis, Salt Lake, Utah, Washington and Weber counties who are required to enroll in one of four UMIC plans. Members living outside of these 13 mandatory enrollment counties have the voluntary option to enroll with an ACO, if available in their county of residence, regardless of their specific Medicaid eligibility.

Under the PMHP waiver, Medicaid members are automatically enrolled for behavioral health services in the PMHP that serves the recipient's county of residence. PMHPs are in all but one county (Wasatch).

Medicaid currently has two managed care dental plans operating statewide: Premier Access and MCNA. Premier Access provides dental coverage to both CHIP and Medicaid members and MCNA provides dental coverage to Medicaid members only. Managed care dental coverage is available to:

- Those who qualify for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits;
- Those who are pregnant

The following Medicaid members receive dental services through the University of Utah School of Dentistry and their network of providers, which is paid for through Medicaid fee for service (FFS):

- Targeted Adult Medicaid (TAM) members (age 21 and over) who are receiving treatment in a Substance Use Disorder Treatment Program
- Adults, 21 and older, who are on Medicaid due to a disability or blindness
- Adults, age 65 and older

In April 2025, Medicaid is expanding dental coverage to previously uncovered adults, and this coverage will be made available through the University of Utah School of Dentistry, paid through Medicaid FFS. This final expansion of dental coverage makes dental benefits available to all Medicaid and CHIP members.

Federally Recognized Tribes

Utah is home to eight federally recognized tribes. Utah has no state-recognized tribes within the state's boundaries. Figure 1.6 shows the federally recognized tribes in Utah.

Figure 1.6: Federally recognized tribes

For additional online resources related to federally recognized tribes, please refer to the Resources section within this document.

American Indian and Alaska Native (AI/AN) Medicaid members enrolled in a plan can still get physical and behavioral health services directly from an Indian Health Service (IHS), Indian Tribal or Urban Indian Organization (I/T/U). No authorization is required from the plan for AI/AN Medicaid members to receive services from an I/T/U. These services are paid by the Medicaid agency and for CHIP members, paid by the MCE. They have the following Medicaid and CHIP protections:

- Are not required to pay Medicaid premiums or enrollment fees, if they are eligible to receive or have received care from an I/T/U or through a Purchased/Referred Care (PRC) referral to a non-Indian provider.
- Are not required to pay any cost sharing, such as copayments, deductibles, or co-insurance for any Medicaid service from any Medicaid provider if they are currently receiving or have ever received care from an I/T/U or through a PRC program.
- Certain types of tribal income and resources for AI/AN applicants are not counted when determining Medicaid or CHIP eligibility.

Vision, mission, and purpose

The DIH vision, mission, and purpose listed below is shared with stakeholders.

Vision: All Utahns have equitable access to timely, evidence-based, and cost-effective healthcare services and supports that meet individual needs, are integrated, and outcome driven.

Mission: To provide individual and community centered services supporting timely access to quality and cost-effective "whole patient care" to achieve optimal health and well-being for all eligible Utahns through effective policy and operations.

Purpose: To promote the health of Utahn's served under the Medicaid program through a commitment to quality in alignment with CMS's four priorities.	
Outcomes and alignment	1. Leverage quality measures to improve health outcomes results 2. Set benchmarks to track progress towards meeting its goals 3. Develop aligned approaches across quality programs cross-functionally 4. Align quality measures through the Universal Foundation measures, as part of the CMS adult and child core set
Equity and engagement	1. Advance health equity in whole person care by embedding it in all quality programs and policies 2. Use effective incentives to advance health equity and improve data collection, standardization, and analysis 3. Engage with Medicaid members and their caregivers to provide input into strategy and policy to increase reported outcomes and experience measures 4. Give health information and data that is meaningful to the members and provide a platform for public reporting so that members and caregivers can make informed decisions about their healthcare choices
Safety and resiliency	1. Expand transparency to increase accountability for safety and reduce harm to zero 2. Drive improvements in safety through meaningful quality incentives and initiatives, as well as quality and compliance oversight

Purpose: To promote the health of Utahn's served under the Medicaid program through a commitment to quality in alignment with CMS's four priorities.	
	3. Promote safety initiatives that protect the healthcare workforce for transparency and reporting 4. Improve ongoing safe and secure use of electronic health records (EHRs) and personal data 5. Build resiliency within healthcare delivery systems by addressing staffing and infrastructure needs to improve quality 6. Support emergency response activities to enable providers to continue providing high-quality care through times of unexpected crisis 7. Address population and healthcare system needs during climate events
Interoperability and scientific achievement	1. Champion the standards and technology needed for interoperability and integrate across partners and stakeholders 2. Transition to digital quality measurement to advance interoperability and optimize data 3. Promote organizational shifts and collaboration for interoperability readiness for successful execution

2

Section 2: Framework

Utah DIH Medicaid quality strategy framework

DIH Medicaid applies its quality strategy framework to oversee the quality performance of its ACO, UMIC, PMHP, HOME, dental and CHIP managed care plans. The supports contained within the framework were designed to support partnering entities with the purpose of establishing and describing the following scope.

- QI structure that serves as oversight to QI programs and activities
- Quality performance measures aimed at achieving better care, better health, and better value including measures related to:

        - Appointment access
        - Network adequacy
        - Utilization
        - QOC
        - Safety of care
        - Quality of service
        - Member experience
            - Population health framework
            - Behavioral health framework
- Performance improvement projects (PIPs)
- Mechanisms to assess the quality and appropriateness of care to all Medicaid members:
    - Within the behavioral framework
    - With special healthcare needs
    - With chronic conditions
    - Needing long term services and supports (LTSS)
- Advance whole-person care and assess:
    - Health care disparities
    - Gaps in care
    - Inequities
- Mechanisms to monitor compliance:
    - Regulatory requirements
    - Contractual requirements
- Value-based purchasing (VBP) performance metrics that align with the state's key focus areas for improved care and member outcomes
- Adoption of innovative QI strategies:
    - Ensure MCEs are in tune with the latest advances in science through participation
        - QI trainings and other technical assistance sessions sponsored by CMS and/or external quality review organizations (EQRO)

The DIH quality strategy framework adapts various elements from other established quality frameworks, integrating approaches and methodologies from these sources as it aims towards moving Utah's healthcare quality forward. This includes DIH adaptation of the Institute of Healthcare Improvement's (IHI) Quintuple AIM to align with DHHS' own aims and goals. IHI's quintuple aims include (a) advance health equity; (b) lower the cost of care; (c) improve population health; (d) improve staff experience; and (e) enhance patient experience. Utah Medicaid utilized these IHI's aims and expanded its definition to meet DHHS' needs. The visualization below displays Utah's quality aims:

Figure 2.1: DIH Medicaid quality aims

With DIH Medicaid's five quality aims to serve as guide, DIH Medicaid developed a set of seven pillars to direct its quality framework towards continuous improvements in its quality strategy approach.

DIH Medicaid's seven pillars
1. Maternal health
2. Adult and child physical health
3. Adult and child behavioral health
4. Health equity to address health related social needs
5. Community support via community based organizations
6. Member and provider journey, experience, and satisfaction
7. Financial stewardship to control cost while optimizing quality for improved health outcomes

For each aim, DIH Medicaid developed specific objectives to drive the quality and the value of the care provided to members. DIH Medicaid further identified a set of goals that will serve as the roadmap to move the quality strategy forward. These objectives and goals for continuous QI consider all populations and services within Utah's MCEs. Figure 2.2 represents the MCQS's aims, objectives, and pillars, and provides an example of improvement goals, which include, but are not limited to, the following:

Figure 2.2: Aims, goals, objectives, and pillars

Aims		Goals	Objectives	Pillars
	**Aim 1: Advance health equity**	**Goal 1.1: Address the number of undetermined screenings for SDOH via NCQA HE/HE+ accreditation activities for health plan and The Joint Commission (TJC) health equity accreditation activities for hospital and ambulatory delivery systems**	**Identify and address health equity needs via NCQA HE/HE+ and TJC health equity accreditation activities**	**Health equity to address health related social needs**
	**Aim 2: Improve member centric, whole person population health**	**Goal 2.1 Improve the health of members with diabetes**	**Improve health and services via the universal measure of the CMS Child and Adult Core Set**	**Adult and child physical health**
		Goal 2.2: Improve pre-and post-natal and newborn care		**Maternal health**
		Goal 2.3: Improve screening for depression and follow-up		**Adult and child behavioral health**

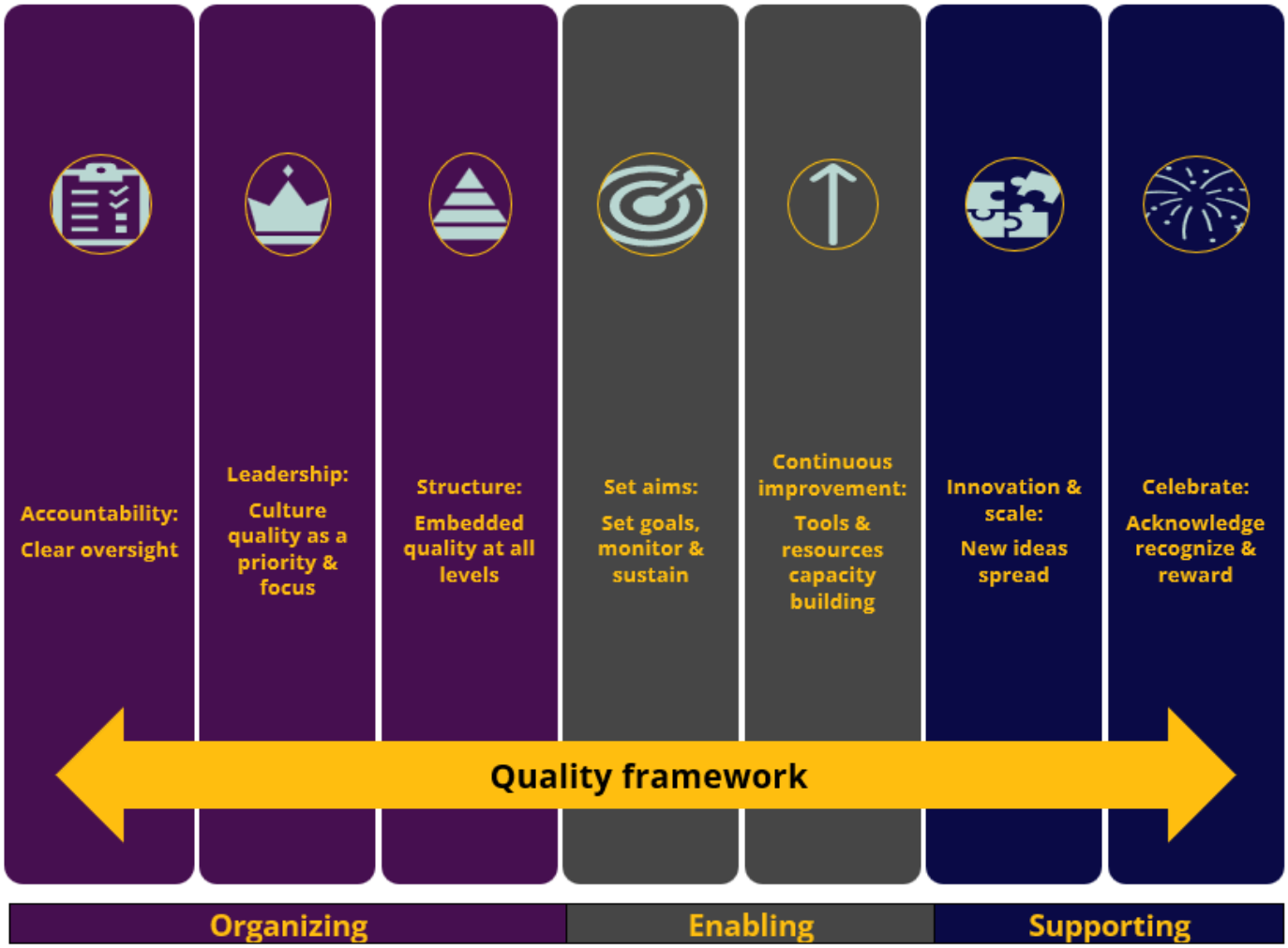
Aims		Goals	Objectives	Pillars
		Goal 2.4: Improve immunization rates		Adult and child physical health
		Goal 2.5: Engage with community resources to support population health program		Community support via community based organizations
		Goal 2.6: Improve the quality of healthcare delivery through incentives		Adult and child physical health
	Aim 3: Enhance member's journey and experience	Goal 3.1: Improve well-child and adolescent visits	Improve member experience and access via the universal measure of the CMS Child and Adult Core Set and via CAHPS overall rating measures	Adult and child physical health
		Goal 3.2: Increase dental visits and dental services		Adult and child physical health
		Goal 3.3: Enhance member experience		Member and provider journey, experience, and satisfaction
	Aim 4: Improve provider and staff experience by reducing burden to optimize QOC	Goal 4.1: Proactive identification of hospital-acquired conditions	Reduce number of quality-of- care grievances and adverse events	Member and provider journey, experience, and satisfaction
		Goal 4.2: Timely review and investigation of quality-of-care concerns		Member and provider journey, experience, and satisfaction
	Aim 5: Financial stewardship	Goal 2.1: Reduce all-cause re-admission and emergency room utilization	Smarter spending via the VBP Alternative Payment Model (APM)/Learning and Action Network (LAN) model	Financial stewardship to control cost while optimizing quality for improved health outcomes
		Goal 2.2: Provide effective care/case management and coordination of care		Financial stewardship to control cost while optimizing quality

Aims		Goals	Objectives	Pillars
				for improved health outcomes

Health equity is integrated within the overall population health-based quality program. The best practice approach is to have a quality program that focuses on:

- Creating accountability and cross-functionality to
    - Organize
    - Enable
    - Support
- Developing new ideas to
    - Innovate to scale
    - Reach sustainability
- Identifies the problems to
    - Solve through Plan-Do-Study-Act (PDSA)
    - Generate new and improved process
    - Create time-sensitive action plans

Figure 2.3: Quality framework



Population Health Alliance, "PHA Framework," accessed January 10, 2024, from https://populationhealthalliance.org/research/understanding- population-health/

In addition, a key component of the quality framework is the population health model that touches every aspect of the organization and community by addressing whole-person-centered care for both primary and secondary prevention and tertiary care. Health equity is embedded within population health and its subgroups to address the most underserved customers.

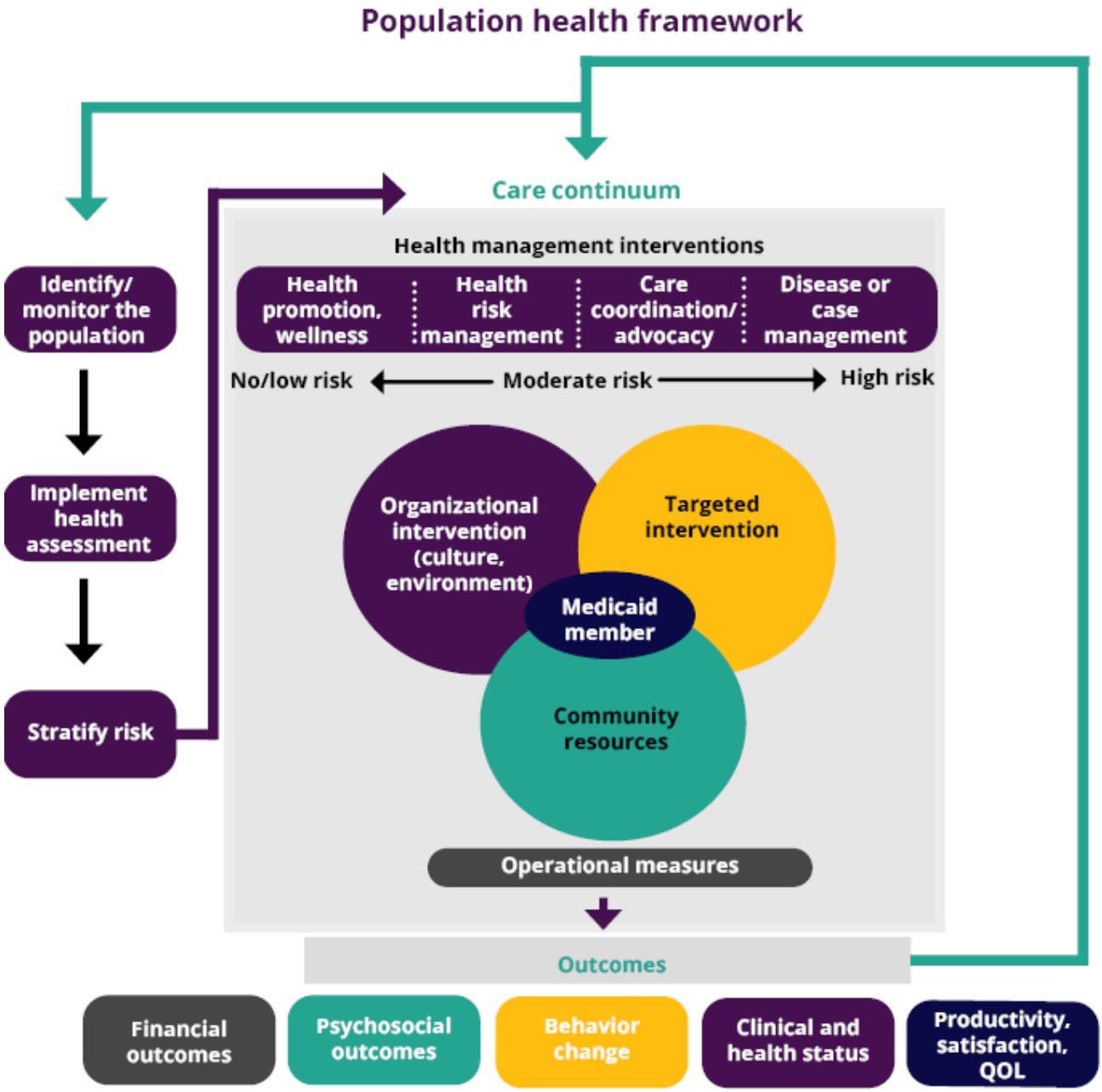
The 3-year MCQS aims to maintain compliance and apply continued innovation strategies. The DIH Medicaid population health framework and approach requires continuous updates to align with the rapid changes in:

- CMS
- State
- Accreditation
- National quality organizations

- Regulatory requirements

The framework is displayed below.

Figure 2.4: Population health framework



Accrediting bodies align with this strategy through their quality standard requirements. The population health framework embraces health equity in every aspect of programs and services. The MCQS contains a strong framework while developing new ideas for innovation to scale and

reach sustainability.

Quality aims, SMARTER (specific, measurable, achievable, relevant, timebound, evaluate and review) goals, and pillars were developed to meet CMS and DIH priorities, goals, and objectives while aligning with IHI's quintuple-aim to solve the state's greatest problems.

DIH's goals of the managed care delivery model are to align with these pillars and goals to address cost, health outcomes, and QOC.

Figure 2.5: MCE alignment to pillars and goals

This may include the development and implementation of MCE value-based care and reimbursement arrangements that improve these three pillars.

DIH collaborates with MCEs, hospitals, and other key stakeholders by establishing best practice improvement methodologies to identify aims and problems to solve for continuous QI.

Methods such as Plan, Do, Study, Act (PDSA) can be used to:

- Monitor performance measures
- Identify opportunities for improvement
- Implement intervention strategies to test change for improvement outcomes and performance
- Evaluate interventions to determine if the changes resulted in successfulness improvements
- Reassess performance through measurement to identify new opportunities for improvement

PDSA method breakdown	
Plan	1. Identify opportunities for improvement 2. Define baseline 3. Describe root cause(s) 4. Develop an action plan
Do	1. Communicate change/plan 2. Implement change plan
Study	1. Review and evaluate result of change 2. Communicate progress
Act	1. Reflect and act on learning
Name the aim:	What are we trying to accomplish? What problem are we trying to solve?
How will we measure:	How will we know that a change is an improvement?
Select a change:	What changes can we make that will result in improvement or solve the problem?

Figure 2.6: Example of the use of PDSA approach

Setting aims, establishing success metrics via the Child and Adult Core Set tied to Universal Measures, and integrating health equity success metrics into an APM delivery system of care by aligning measures via a PDSA approach on a rapid improvement cycle to test if change has transpired to achieve the desired results can lead to improved health outcomes on the basis of a strong quality framework, strategy, and program. MCEs may include capitated arrangements via their value-based care or purchasing arrangements in their contracts assuming share or full risk arrangement to manage health care costs for their members.

Standardize processes and celebrate success

The MCQS establishes mechanisms to assess DIH's Medicaid Quality Program structure and processes of MCEs and hospitals. Utah's Quality Program integrates physical health, behavioral, oral, and population health and assigns responsibility to appropriate entities to operationalize DIH's MCQS.

DIH's MCQS includes the development and maintenance of the following Medicaid Quality Program documents:

- **Managed care quality strategy (MCQS), which describes the Quality Program's governance, scope, goals, measurable objectives, structure and responsibilities for the current year. At a minimum, the document must include the following components:**
    - Functional areas and their responsibilities
    - Reporting relationships of Quality Department staff, quality committee and subcommittees
    - Resources and analytical support
    - Delegated activities, if applicable
    - Collaborative activities, if any
    - How the QI and population health management (PHM) programs are related in terms of operations and oversight
    - Behavioral healthcare and health equity aspects of the program
    - Dental and oral health services
    - Involvement of a designated physician and behavioral health practitioners in the DIH Medicaid Quality Program
    - Committee structure and oversight
- **Annual quality assessment and performance improvement plan (QAPIP) documents/templates are submitted by each health MCE annually. QAPIP documents include the following:**
    - Each contracted MCE must develop a written QAPIP that addresses the MCE's proposed methodology to meet or exceed the standards and requirements of

the contract. MCEs with more than one line of business may consolidate them to submit a single QAPIP. The QAPIP must describe how program activities will improve the QOC and service delivery for enrolled members. The QAPIP, and any subsequent modifications, must be submitted to OMH for review and approval prior to implementation and contain key components:

- QAPIP Program Description: The program description is a formal document that provides detailed information regarding the oversight and function of the health plan, and its quality improvement program. The Program Description must be submitted at the beginning of each contract cycle, and should be updated and submitted to DOH as needed.
- QAPIP Work Plan: The program description is implemented through the Work Plan. Presented in a table view, the Work Plan topics and activities are broken down to outline and assess the plan's performance improvement projects (PIPs), and other quality initiatives. MCE's are also required to report their annual rate percentages for each targeted HEDIS and CAHPS quality measure. The Work Plan must be updated annually.
- QAPIP Work Plan Evaluation: Shown side by side with the Work Plan activities, the previous year's progress will be assessed using the Work Plan Evaluation. It is here that the results, completion dates, constraints and barriers, recommendations, and next steps are addressed for each work plan activity. To include a thorough evaluation of each project/initiative, quality measure percentage rates are reported annually to ensure MCEs are at or above the national average.

- MCEs are also required to evaluate their PHM framework annually. The annual evaluation must include, at a minimum, the following:
  - Assessment of the population to determine the need to revise programs and resources
  - Selection and analysis of cost/utilization measures to assess PHM programs
  - Selection and analysis of member experience with population health programs and services
  - Identification of opportunities for improvement and appropriate interventions
  - Measurement of the effectiveness of interventions

- **Annual External Quality Review (EQR) Technical Report to assess how well the organization met its annual performance goals and objectives annual evaluation for improving the quality and safety of clinical care and services as specified in the program description and work plan. The annual evaluation must be posted on DHHS' website and include, at a minimum, the following:**

  - Summary of completed and ongoing activities
  - Trending of QI measure results

- Evaluation of the effectiveness of the DIH Medicaid Quality Program to include adequacy of resources, adequacy of quality committee and subcommittee structure, adequacy of practitioner participation and leadership involvement in the DIH Medicaid Quality Program
- Assessment of need to restructure and/or change the DIH Medicaid Quality Program for the subsequent year

The DIH Medicaid Quality Program delineates the mechanisms (EQRO activities) to assess quality and performance improvement.

DIH Medicaid quality program minimum inclusions:	
Mechanisms	• Mechanisms to detect under and over utilization • Mechanisms to assess the quality and appropriateness of care provided to members with special health care needs and members using LTSS • Mechanisms to support seamless continuity and coordination of care between MCEs (ACO, UMIC, PMHP, HOME, dental plans and CHIP), between practitioners, and between settings • Mechanisms to assess member experience with services
Measures	• Measures to assess the quality and safety of the care provided to members to include measures to prevent, detect, and remediate critical incidents, never events, and hospital-acquired conditions (HAC) • Measures to assess the quality, safety and accessibility of office sites where care is delivered • Measures to assess appropriate handling and timeliness of grievances and appeals • Measures to assess the timeliness and appropriateness for making decisions and authorizing payment for services
Initiatives	• Maternal and Child Health • Oral Health • Behavioral Health
Development	• Development and maintenance of PIPs to measure the plans' performance in achieving quality goals and objectives and to identify opportunities for improvement and appropriate interventions to

	correct areas of deficiencies

Metrics and targets	• Measure selection guided by established performance benchmarks and a standardized agreed-upon scoring methodology
	• Strategic alignment of measures with the CMS Child and Adult Core Sets and informed by state and partnership priorities
	• Quality measures drawn from a diverse set of standard metrics including Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and serving as a comprehensive tool to assess clinical effectiveness, service quality, and member experience
	  ○ HEDIS evaluates clinical performance and adherence to evidence-based guidelines in treating and preventing various conditions, such as vaccination rates, cancer screening, and diabetes care
	  ○ CAHPS captures insights on consumer and member experiences with healthcare delivery, including communication with doctors, access to care, and overall satisfaction with health plans and care providers

External independent review	• Arrangement of annual external independent reviews of quality outcomes, timeliness, and access to services

Population health management framework

The population health management (PHM) framework includes coverage, preventive/chronic, incarcerated, tribal, and disabilities care, drug coverage and prescriptions. The DIH's PHM strategy is aimed at the provision of coverage and the coordination of effective delivery for behavioral, physical and oral health services and pharmacy needs for members to promote optimal health and wellness.

In 2025, DIH Medicaid will be implementing a Utah population health management system (UPHMS) that will make available state, health plan, and public level dashboards that provide visibility to reporting elements within the PHM framework strategy.

The scope of the PHM strategy focuses on four areas:

Figure 2.7: Population health management scope

DIH will emphasize that PHM programs and services offered to members align with these focus areas and include:

- Multiple sources to identify members benefiting from PHM programs and services
- Multiple avenues to refer members to PHM programs and services
- Measures to assess performance that include target population and goals. Assessment of performance includes conducting quantitative and qualitative analysis to identify opportunities and appropriate interventions to close gaps
- Coordination of services and care across settings, providers and levels of care to minimize confusion for members who are contacted by multiple sources
- Actions to promote equity in the management of member care
- Measures to assess member experience with population health programs and services
- Assessment of performance includes conducting quantitative and qualitative analysis to identify opportunities and appropriate interventions to close gaps in services

PMH programs will provide insights into the populations served by MCEs by conducting an annual assessment. The assessment will include an evaluation of the characteristics and needs, including social determinant of health, of the following:

- Entire member population
- Child and adolescent members
- Members with disabilities
- Members with serious mental illness or serious emotional disturbance

- Members of racial or ethnic groups
- Members with limited English proficiency
- Relevant member subpopulations
- Members who have incarcerated care needs, especially transitioning back in the community
    - For more information: RETURNING TO THE COMMUNITY: HEALTH CARE AFTER INCARCERATION - A Guide for Health Care Reentry (English)

DIH will encourage and support the MCEs use of the results of the population assessment to review and update PHM activities and resources to address member health related social needs, including health disparities.

Quality and safety of care framework

DIH ensures the consistency and compliance with accepted standards of practice in care delivery and services rendered by monitoring the quality and safety of care provided to members. DIH requires MCEs to collect, respond and investigate potential quality of care (PQOC) issues in a timely manner. PQOCs include:

- Adverse events
- Preventable conditions
- Critical incidents
    - Abuse/neglect/exploitation
    - Never events
- Healthcare acquired conditions, that may be referred through various avenues
    - Including, but not limited to:
        - Complaints
        - Grievances and appeals
        - Utilization management (UM)
        - Case management
        - Pharmacy
        - Members
        - Practitioners
        - Providers
        - Facilities

The Quality and Safety Framework includes a process for reporting to DIH issues determined to have not followed the accepted standards of care.

Health-care acquired conditions (HCAC)	Section 2702 Patient Protection and Affordable Care Act of 2010 prohibits federal payments to states under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for HCACs

CMS requires the identification of HCAC that:

- are high cost, high volume, or both
- result in higher claim payments because of the presence of the HCACs as a secondary diagnosis
- could reasonably have been prevented through the application of evidence-based guidelines

At minimum, DIH requires MCEs to report on the following:

Category 1 – Health care-acquired conditions (any inpatient hospital settings)

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma, including fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Surgical site Infection Following:
    - Coronary artery bypass graft (CABG) - Mediastinitis
    - Bariatric surgery including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
    - Orthopedic procedures including spine, neck, shoulder, elbow
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions

Category 2 - Other provider preventable conditions (OPPC) (any health care setting)

- Wrong Surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

Critical incidents	DHHS' Rule R380-600
MCEs are required to report the following:	
• Allegation or confirmation of abuse, neglect, or exploitation • A loss or impairment of the function of a bodily member, organ, or mental faculty or significant disfigurement • A death related to an adverse event • A death of a minor • A medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, or hospitalization • An allegation or confirmation of waste, fraud or abuse of Medicaid funds • Any medical emergency requiring treatment beyond basic first aid • A missing client • Any significant criminal activity • Any property damage or infestation that jeopardizes services • Any prohibited practice as described in Section 26B-2-123 including misuse or unauthorized use of restrictive interventions, seclusion, or body cavity search.	

Quality of care (QOC) complaints	
MCEs are required to:	

• Within 30 calendar days:
  ○ Receive
  ○ Investigate
  ○ Resolve
• Have a process for referring QOC complaints for further review
  ○ When a deviation of standard care has been identified	

MCEs are responsible for compliance with all of these standards as specified in their managed care contracts, and DIH oversees MCEs through the required report which can be found in Appendix E.

Health equity/health-related social needs (HRSN) framework

DIH's health equity strategy is aligned with the CMS Health Equity Framework and NCQA's health equity standards and guidelines. MCEs will have access to member level information from which they can construct a population assessment.

Health equity/HRSN minimum inclusions:	
Development	• Development and maintenance of health equity program documents describing the overall objectives for serving a culturally and linguistically diverse population, work plan listing all health equity activities with measurable goals and objectives, and an annual evaluation assessing annual performance • Community engagement in the review of health equity goals and interventions to promote culturally and linguistically appropriate services
Data collection	• Demographic data
Assessment	• Assessment of network adequacy to meet the diverse needs of the members • Assessment of the social needs and social risks of the communities to gain understanding of the resources needed to improve the health of its population • Assessment of disparities and gaps in care using clinical and member experience measures stratified by RELD and SOGI data to identify opportunities and appropriate interventions • Assessment of the workforce (staff and leadership), committees and governance body membership composition to build capacity and reduce health care disparities and bias
Evaluation	• Evaluation of safety net providers and partners to support underserved communities and ensure every person and family can access the care needed
Provisions	• Provision of language services and resources to members and providers • Provision of tools to assist members gain understanding of their health coverage and make informed decisions about their care

Medicaid uses the benefits application process to identify race, ethnicity, and primary language, which are optional fields on the application. The Utah Department of Workforce Services (DWS) processes Medicaid applications in Utah. The information from the application is entered into the DWS database which is then shared with DIH. DIH sends the MCEs an eligibility file with the available information regarding the primary language, race, and ethnicity of each Medicaid and CHIP member.

DIH will continue to utilize the data gathered through the enrollment process to identify, evaluate, and reduce, to the extent possible, health disparities. The ACO Quality Workgroup is exploring their plans' ability to stratify HEDIS and CAHPS measures to identify health disparities based on zip code, age, race, ethnicity, sex, primary language, and disability status. Individuals meet the definition of blindness or disability when they have:

- Been approved for or receive SSI because of blindness or disability
- Been approved for or receive Social Security Disability insurance (SSDI)
- Been approved for or receive survivor's benefits such as Childhood Disability Benefits (for adults) (330- 1), or Disabled Widow/Widower Benefits (330-4)
- Been determined blind or disabled by the State Medicaid Disability Office
- Died (people are disabled for this reason only in the month of death)

DIH will engage with the Office of Health Equity (OEH) and other public health entities within DHHS to explore data collection and coordination of efforts to address health disparities. In the future, DIH will require MCEs to complete the following activities:

Develop and maintain a health equity program description to describe the overall objectives for serving a culturally and linguistically diverse population which must:
1. Include the following components in the program description: ○ How the program is organized to meet program objectives ○ The functional areas and their responsibilities ○ The reporting relationships of staff who provide culturally and linguistically appropriate services (CLAS) ○ How the organization involves members of the culturally diverse community to provide input into the program ○ Measurable goals for the improvement of CLAS and reduction of health care inequities ○ A plan to monitor performance against established goals
2. Develop an annual work plan that contains health equity and CLAS activities related to network cultural responsiveness, language services, performance measures to identify health care disparities and data collection.
3. Evaluate the health equity program at least annually to assess performance against established goals and objectives.
4. Have policies and procedures describing the methodology used to collect RELD, SOGI, and disability data and the systems used for receiving, storing and retrieving the data.

5. **Use the data to assess language profile and language needs of the population and provide language services and resources, such as reports to providers with language needs and publishing language services availability.**
6. **Assess its network composition by collecting RELD data to determine if the needs of the members are being met and adjust the network accordingly**
7. **Select and stratify clinical and member experience measures as well as language services experience measures to conduct an assessment to identify opportunities for improving disparities and gaps in care and develop and implement appropriate interventions.**

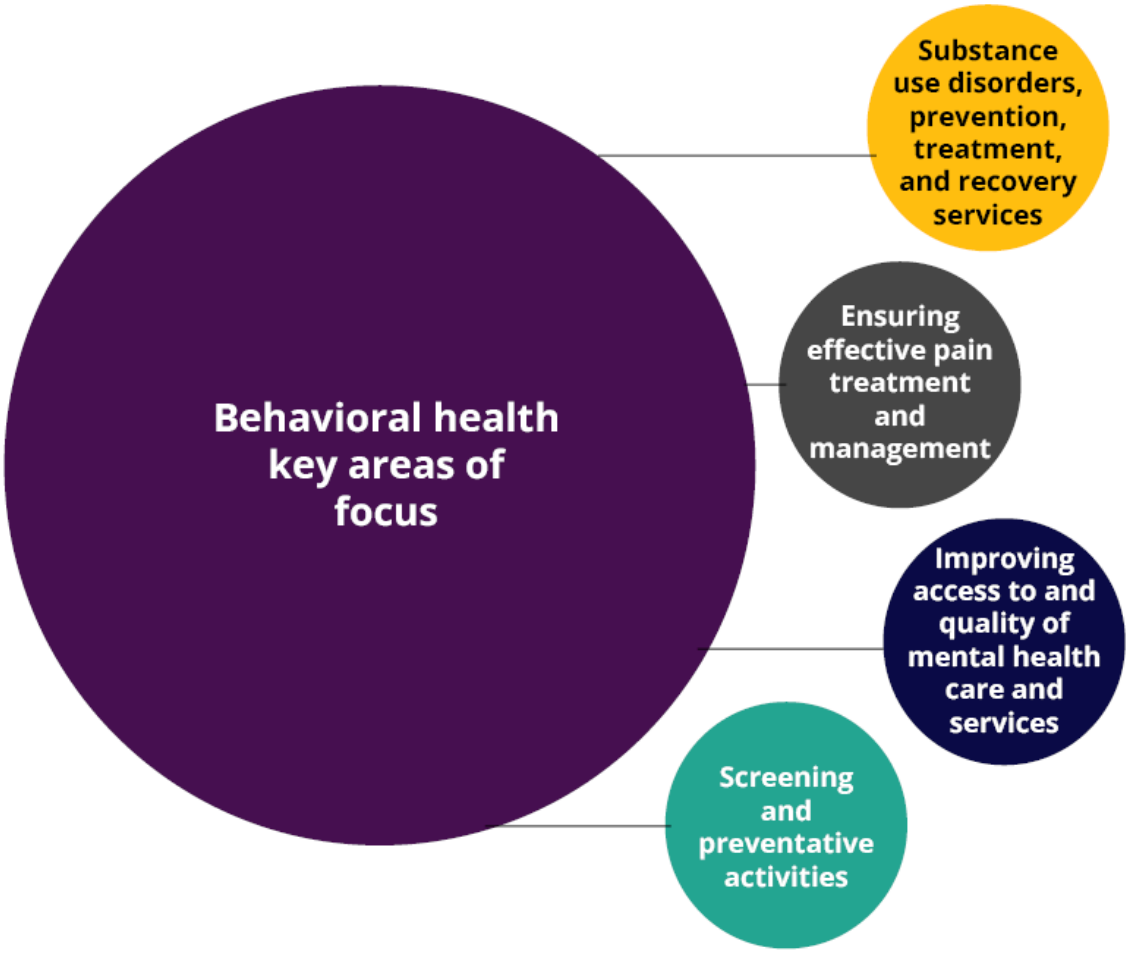
Per CMS' Framework for Health Equity "Members of the health care team have a unique role in understanding and addressing many of the social risk factors and unmet social needs that can lead to health and health care disparities.[1]" To deliver on this, MCEs must gain understanding of the composition of its workforce, including leaders, and adjust its hiring and recruitment practices to promote cultural humility.

Behavioral health framework

DIH's behavioral health framework is integrated throughout the DIH Medicaid MCQS for whole person-centered care within the population health framework to receive timely and affordable care to enable optimal health and wellness. Three key areas of focus are:

[1] Centers for Medicare & Medicaid Services, The CMS Framework for Health Equity 2022).

Figure 2.8: Key areas of focus for behavioral health framework



These areas are aligned with CMS's overall focus on four health outcomes-based domains and with Utah's Behavioral Health Master Plan.

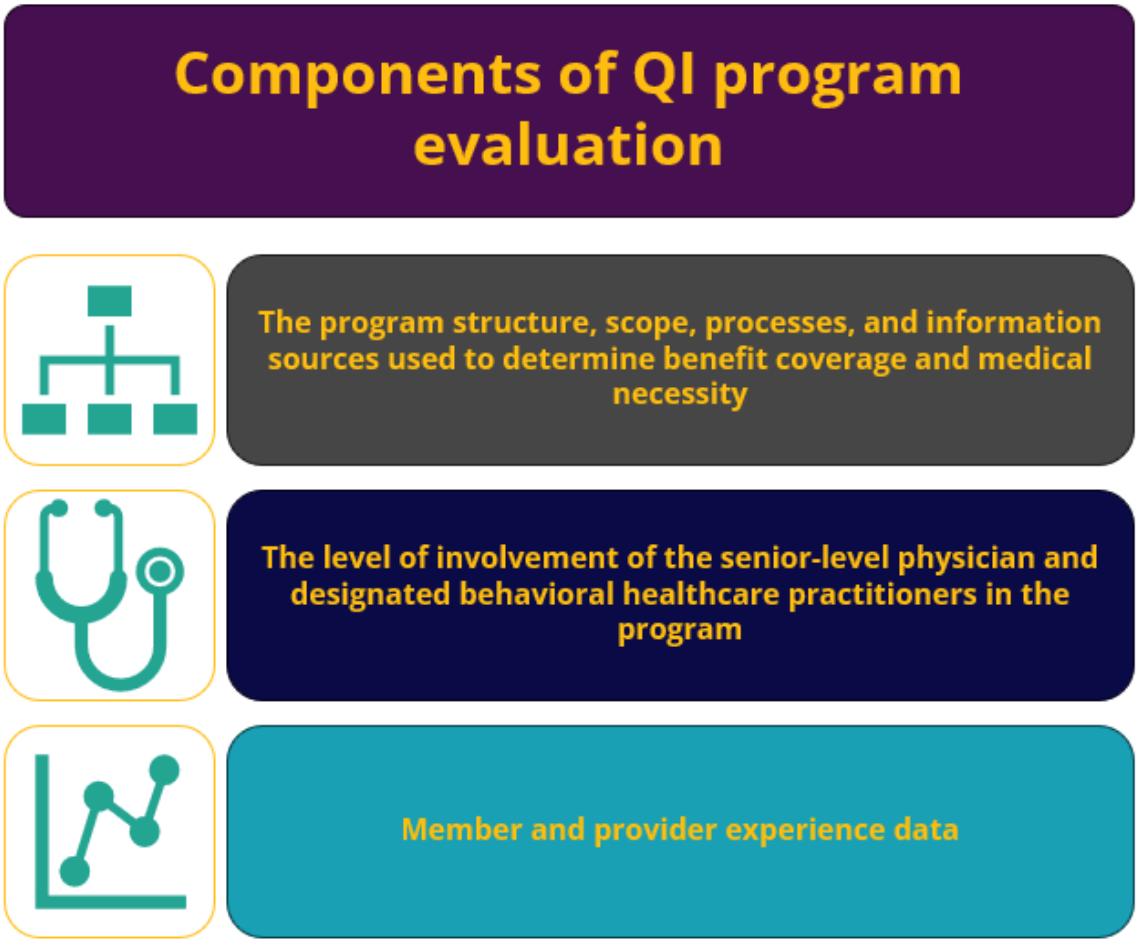
Figure 2.9: Health outcomes-based domains

The four health outcomes are accomplished by ensuring:

- Timely appointment access
- Network adequacy
- Member experience
- Credentialing and re-credentialing
- Utilization management
- Population health management (care coordination)

The behavioral health framework promotes active collaboration and participation of key stakeholders from UMICs, PMHPs, CHIP, and HOME to ensure continuity and coordination of care between medical and behavioral health, to ultimately establish fully integrated care models.

Figure 2.10: Components of QI program evaluation

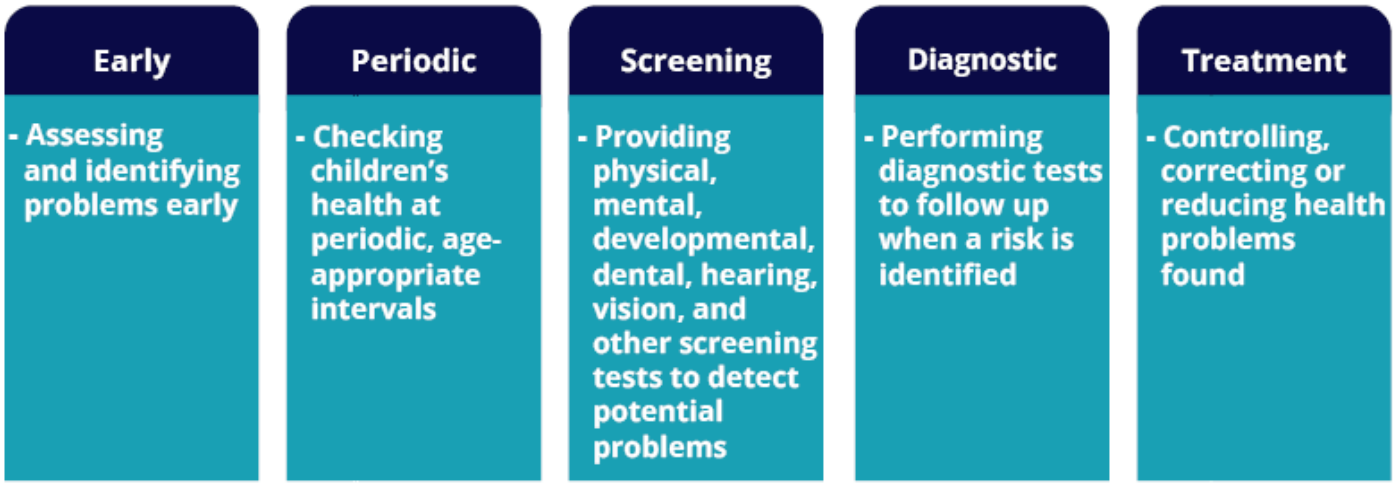


Early and periodic screening, diagnostics, and treatment framework

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

EPSDT is key to ensuring that children and adolescents receive appropriate preventive, oral, behavioral health and specialty services.

Figure 2.11: EPSDT framework



Oral Health is a key component with EPSDT and is integrated throughout the DIH Medicaid Quality Program. The continuity and coordination of care is monitored across practice and provider sites assuring good QOC, health outcomes, member safety and quality of service.

- MCEs must use measures to:
    - Analyze the delivery of services and QOC
    - Over and underutilization of services
    - Oral health disease management strategies
    - Outcomes of care

To monitor oral health, MCEs collect and use data from multiple sources such as dental records, encounter data, claims processing, grievances, utilization review, and member experience surveys.

- MCEs promote the delivery of dental services in a culturally responsive manner to all Medicaid members, including those with limited proficiency in English, deaf and hard of hearing, and diverse cultural and ethnic backgrounds
- The DIH Medicaid Quality Program work plan and evaluation includes dental activities in the access and quality of dental care and services

Reproductive health/maternity framework

The DIH Medicaid maternal and child health program is integrated in the population health, behavioral health and health equity framework. It is designed to improve maternal and birth outcomes through:

- Early identification and engagement of any mental or physical health issues
    - Post-partum depression
    - Gestational diabetes
    - Pre-eclampsia

- Sepsis and infection
- Other conditions

The reproductive health/maternity framework is designed to deliver QOC for prenatal and child services as well as education and support to promote healthy behaviors.

DIH Medicaid is committed to improving the CMS maternal and child core set measures as well as outcomes related to deliveries and ensuring healthy babies through:

Figure 2.12: Reproductive health/maternity framework

To focus on improving outcomes, addressing health related social needs and health outcomes, DIH Medicaid engages and partners with:

- Maternal and child services within DHHS such as WIC and early Intervention programs
- Local health departments
- Other community-based organizations and stakeholders

Rural health

Eleven of Utah's 29 counties are designated as rural, with 12% of the population (395,086) of Utahns living in non-metro areas[2].

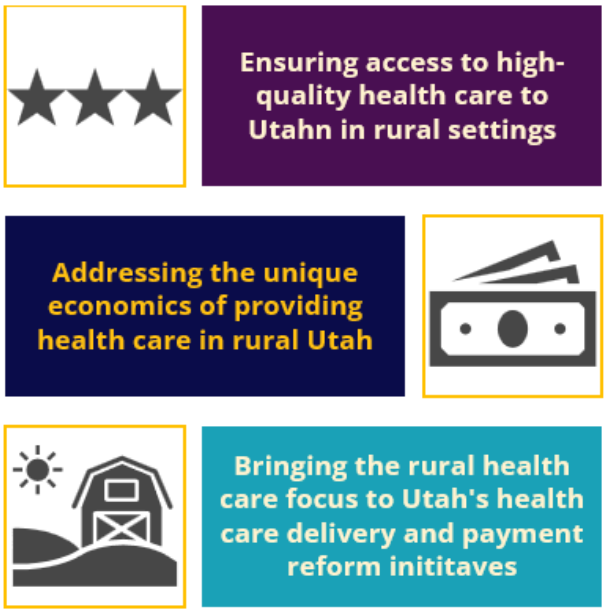
[2] *Rural health for Utah Overview - Rural Health Information Hub*. (n.d.). https://www.ruralhealthinfo.org/states/utah#:~:text=Selected%20Social%20Determinants%20of%20Health,overview%20of%20the%20United%20States.

Rural areas have more fragmented care with reduced access to primary and specialty care providers. Utahns living in rural areas, compared to urban areas, have a higher likelihood of:

- Experiencing poverty
- Being unhealthy
- Being older
- Being medically underserved

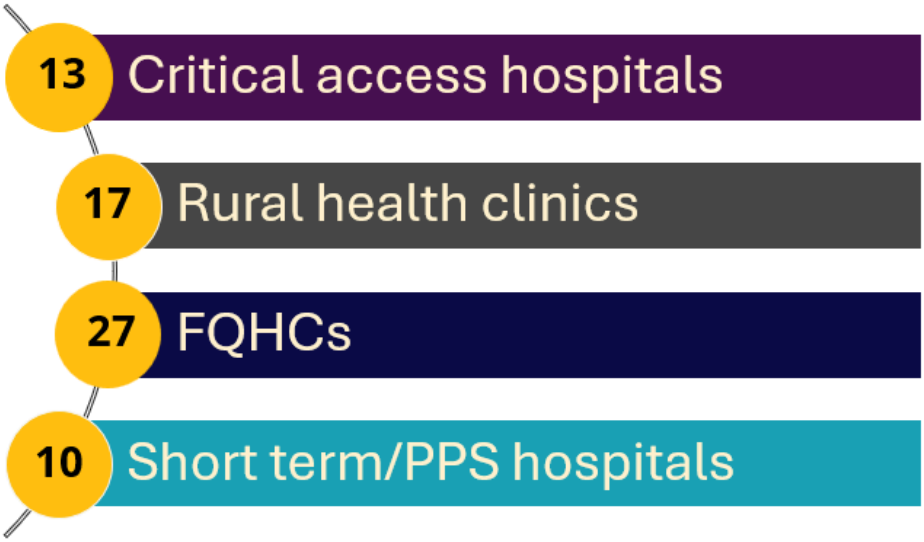
As such, DIH Medicaid plans to align its approach to the CMS Rural Health Strategy to focus on the same strategic areas as shown in Figure 2.13.

Figure 2.13: Strategic focuses for rural health



In rural Utah, there are the following health facilities listed in Figure 2.14.

Figure 2.14: Health facilities in rural Utah



Member experience framework

DIH Medicaid has moved toward a more person-centered approach to evaluate quality that incorporates the experiences of individuals, families, and caregivers to align with CMS' Quality Framework and with NCQA's member experience standards and guidelines. Assessing members' experience with services allows DIH to gain an understanding of individuals' interactions with the plans that members value:

- Timely appointments
- Access to care
- Easy access to information
- Good communication with health care providers

Key strategies for promoting the delivery of person-centered care include, but are not limited to, the following:

Key strategies for person-centered care:	
Collecting and assessing	• Member experience measures and person-reported outcomes through using standardized and approved survey tools, such as CAHPS, etc. • Appointment access data (e.g. wait time) to ensure members are receiving care when requested and needed for primary care, specialty care, behavioral health care, and dental care

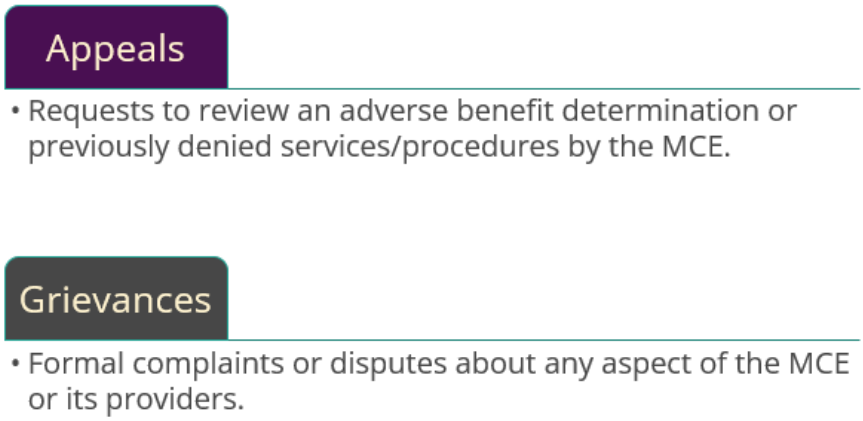
	• The accuracy and understanding of the materials provided to members • Ensuring directories provide members with accurate information about practitioners, providers, hospitals and pharmacies

Collecting, responding, and analyzing	• Member complaints to determine the areas that need improvement
	  ○ Compliance review of appeals and grievances
	  ○ Verification of information contained in member handbooks
	  ○ QAPIPs
	  ○ Quarterly reviews of reason/categorization of grievances

Engaging	• The BAC and member engagement panels to evaluate member experience with services to ensure they are provided in a manner consistent with the best interests of the members • Ensuring directories provide members with accurate information about practitioners, providers, hospitals and pharmacies • Quarterly reporting on member engagement panel activities, initial contact, and barriers experienced by members including steps to resolution.

Appeals and grievances framework

As part of its MCQS and to meet regulatory requirements set forth by 42 CFR §§ 438.400-483.424 and to meet accreditation requirements, DIH has a process to collect, investigate, resolve, assess and analyze appeals and grievances received from ACO, UMIC, PMHP, HOME, dental and CHIP plan members to meet regulatory and accreditation requirements.



The Medicaid appeals and grievances framework includes the following[3]:

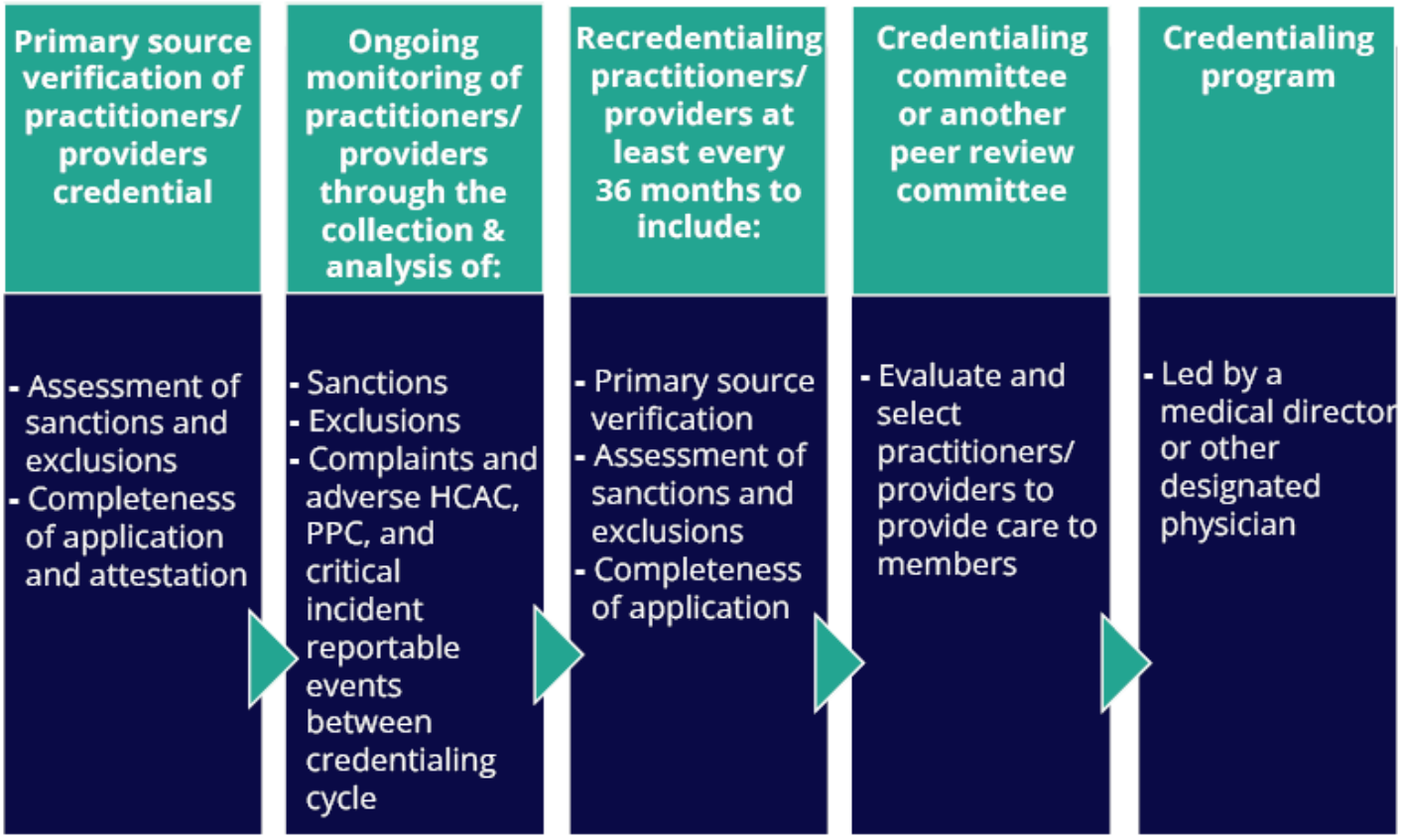
- Allowing members a specific timeframe to file an appeal with their MCE
- Defining the different types of appeals and grievances and determining resolution timeframes for each type while considering situations where a delayed response could be harmful to the member
- Determining the timeframe for a fair hearing request
- Providing members with reasonable assistance to file an appeal and or grievance, such as interpreter services
- Providing case files, including medical records, and any other evidence considered for the appeal and grievance
- Ensuring members can request to continue their services while an appeal or fair hearing is taking place
- Notifying members in writing on the resolution of the appeal and or grievance, explaining the resolution in easy-to-understand language and providing information about next steps
- Reviewing and trending of appeals and grievances that are reported to identify appropriate interventions and improvement opportunities
    - Appeals and grievance reporting is received quarterly
    - Trend Analysis and plan comparisons are conducted
    - Reported data is aggregated annually and reported to CMS based on various categories including appeal type, service/claim type and outcomes of the appeal/grievance.

Credentialing framework

To meet the requirements set forth in 42 C.F.R. § 438.214 and to align with NCQA accreditation standards and guidelines for credentialing and re-credentialing of practitioners and providers, DIH requires that all practitioners and providers who render services to members are appropriately credentialed. At a minimum, the credentialing framework requires the following components:

[3] Managed Care Program Annual Report Technical Guidance (2024). Retrieved from Managed Care Program Guidance Topic: Appeals & Grievances

Figure 2.15: Provider credentialing framework



DIH ensures that the credentialing process does not discriminate based on practitioners'/providers' race, ethnic/national identity, gender, age, SOGI or insurance coverage and ensures the confidentiality of the information.

Provider network framework

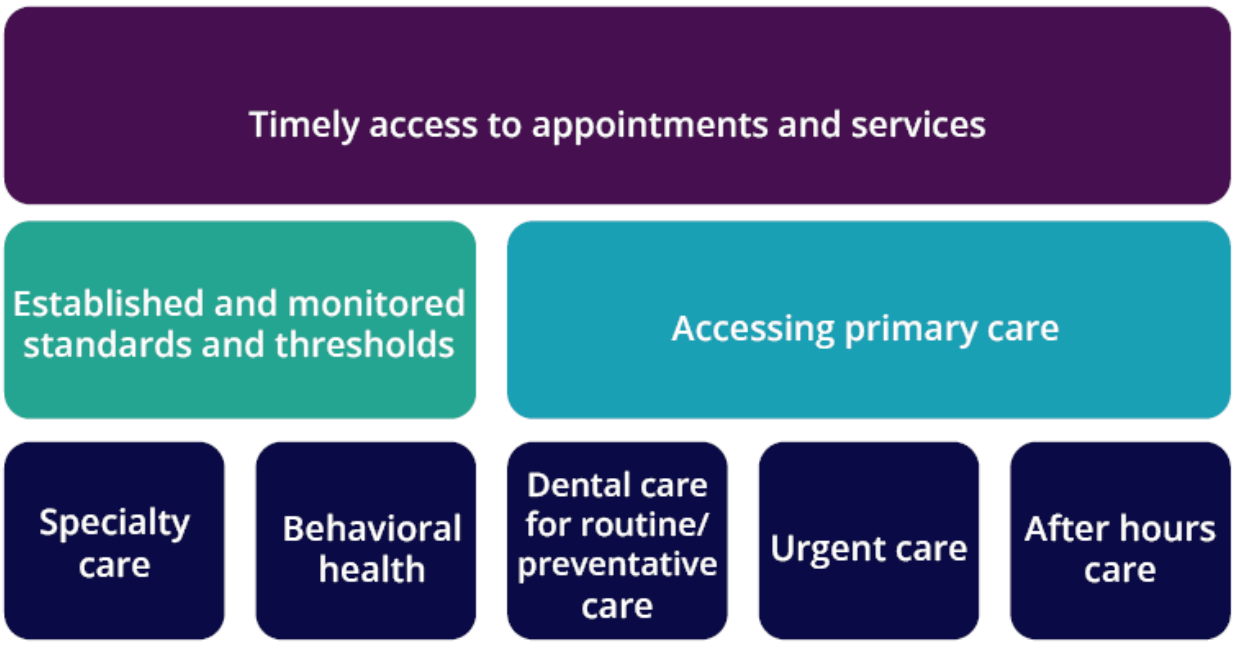
To meet requirements set forth by CMS and NCQA, all MCEs must have enough practitioners/providers within a geographic area to ensure access to care for individuals needing services. DIH establishes network adequacy standards and thresholds for time and distance for the different county types and monitors all MCEs for compliance against them. DIH is in the process of planning for new Network Adequacy Standards outlined in the Managed Care final rule [§438.68], with portions set to be implemented 2027 and 2028. General updates will include CMS-defined appointment wait time standards, expanded exceptions process standards, and Secret Shopper Surveys.

This roadmap will impact DIH, MCEs, and EQRO activities.

Per 42 C.F.R. § 438.358 DIH works with a contracted EQRO to validate MCE network adequacy. Each plan must have specific network adequacy policies and mechanisms to monitor and

analyze network adequacy to include evaluation of out-of-network requests and utilization to identify opportunities for improvement and appropriate interventions. DIH has also committed to:

Figure 2.16: Provider network framework



All MCEs must have specific appointment access policies and mechanisms to monitor and analyze access.

Plans are required to follow the Adequate Capacity and Availability of Services standards, outlined in the EQRO managed care requirements Standard V. Utah's EQRO conducts a compliance review of each MCE every three years to determine compliance with federal health care regulations and contractual requirements.

Population care model

To enable the transition of primary care clinicians to value based care and provide transformative focused support, Utah's Population Care model continues to be our focus by elevating best practices to ensure appropriate coordination between primary care, specialists and other providers optimizing continuity of care and ultimately improving health outcomes.

This model is a 10.5-year model which aims to:

- Improve care management and care coordination
- Equip primary care clinicians with tools to form partnerships with health care specialists
- Leverage community-based connections to address patients' health needs
- Leverage HRSNs, including housing and nutrition

ThePopulation Care Model will provide a pathway for primary care clinicians with varying levels of experience in value-based care to:

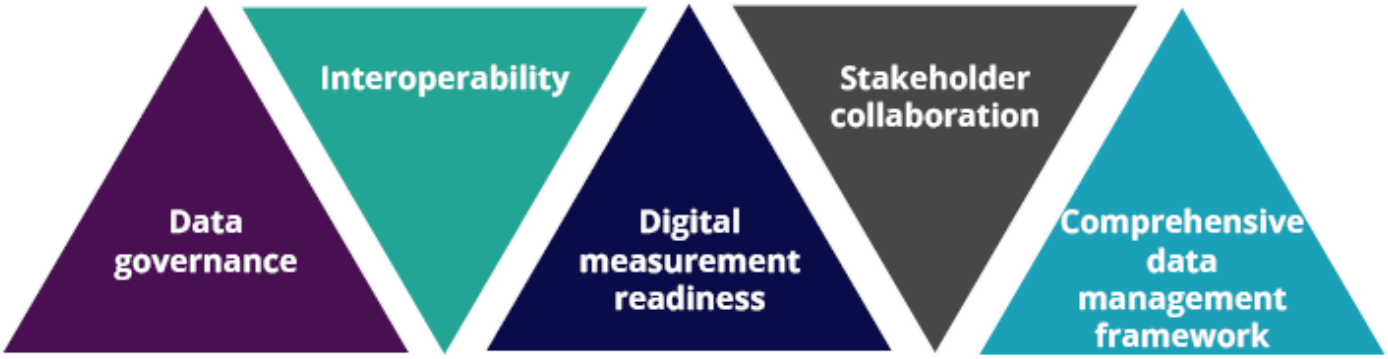
Figure 2.17: Population Care framework

Although Utah is not one of the participating states in this program, DHHS will explore future initiatives to engage with the progress and outcomes of this model. This model could help DIH anticipate and plan for key learnings to enhance the contract language framework within the state.

Data Quality Management (DQM) framework

To meet the upcoming CMS 2027 Advancing Interoperability and Prior Authorization Rule and NCQA's 2030 transition to digital measurement, DIH is integrating a comprehensive data management framework within their quality strategy. See Figure 2.18 DQM framework.

Figure 2.18: DQM framework



The state is aligning data governance policies with Fast Healthcare Interoperability Resources (FHIR) and other federally mandated interoperability standards, ensuring all data handling complies with the requirements. This alignment will allow for:

- Seamless integration of data
    - Maintains privacy protections under the Health Insurance Portability and Accountability Act (HIPAA)
    - Enables compliant, standardized data exchange

The state will work to support the upgrade of the legacy data collection and provide training and technical support to MCEs throughout the transition.

Cross-entity collaboration is crucial to successful implementation. DIH will work closely with MCEs, providers, and EHR vendors and other key stakeholders to coordinate data exchange protocols, ensuring all entities are prepared for interoperability and digital measurement requirements.

These efforts will include:

- Implementing a continuous monitoring process
    - Supported by feedback loops from stakeholders
    - Enabling iterative improvements and prompt responses to emerging challenges

Interoperability framework

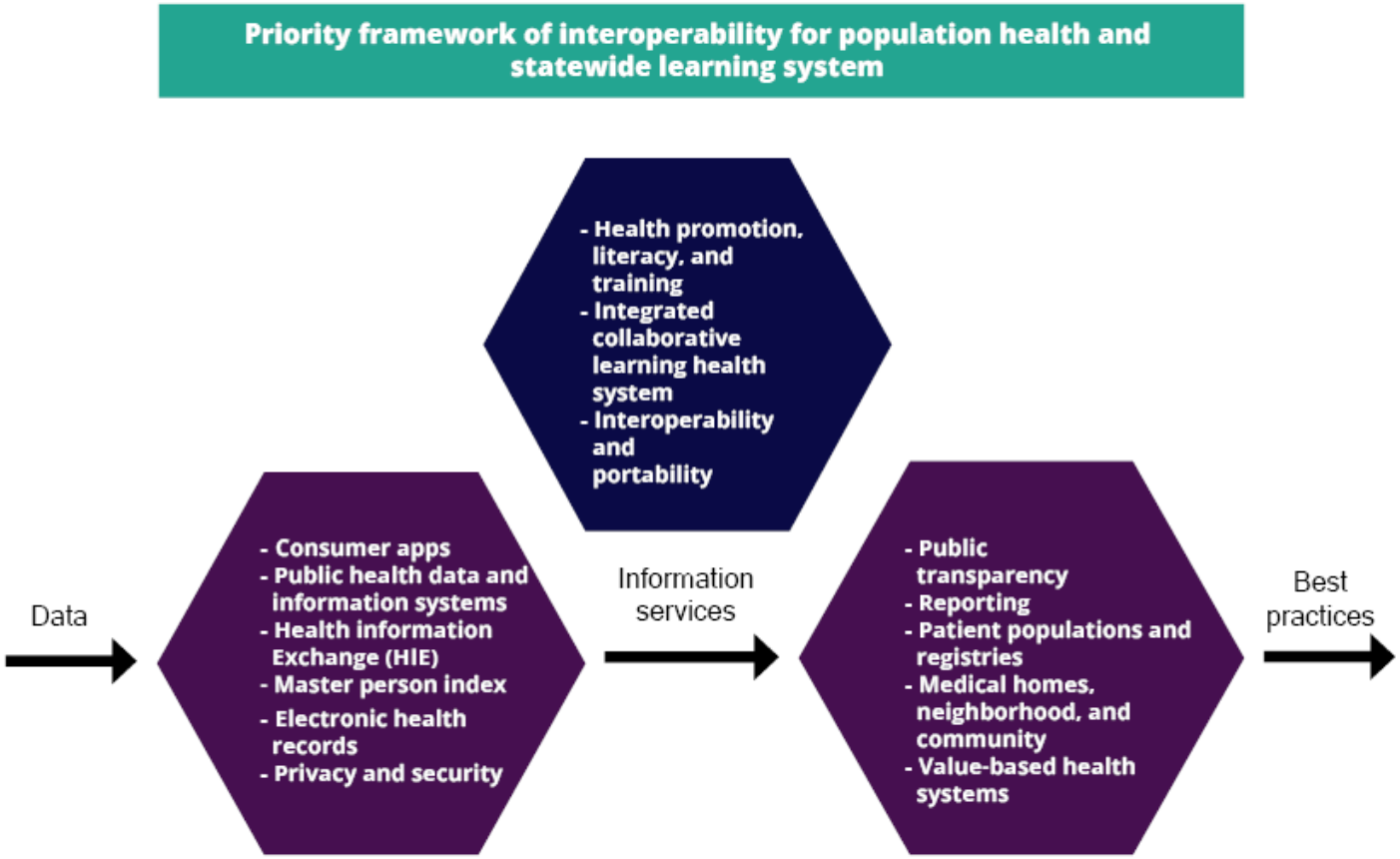
The interoperability of systems and initiatives support the overall MCQS. Data will play a crucial role in DIH's Medicaid transformation, including driving a continuous QI process.

The interoperability framework which was originally based on the Utah State Medicaid Health Information Technology Plan, promotes:

- Secure and efficient use and exchange of electronic information will result in improved health status, better health care, lower cost, and healthier communities related to:
    - Social health

- Behavioral health
- Physical health

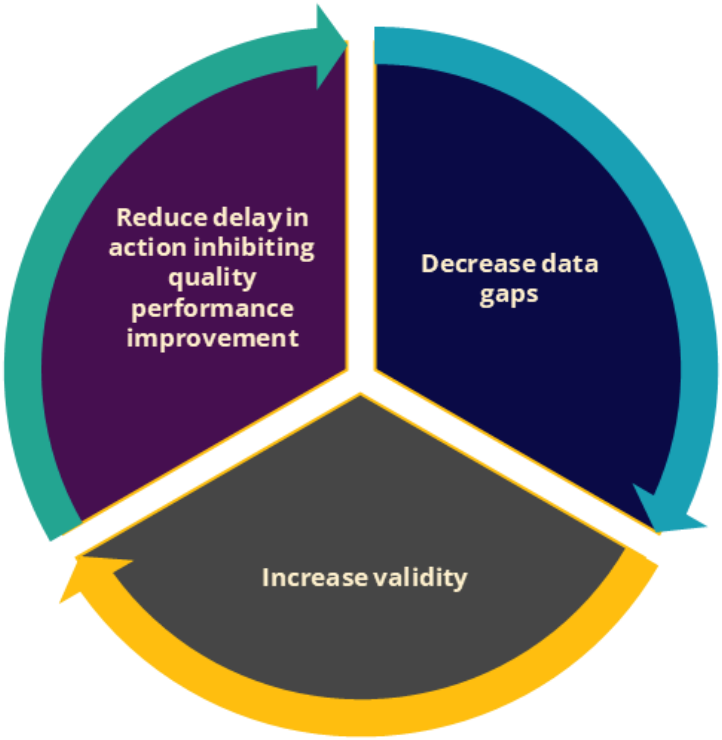
Figure 2.19: Interoperability priority framework for population health



DIH interoperability data framework establishes the data sources and types necessary for comprehensive understanding of the state's population and quality metric performance and serves as the foundation for the UPHMS.

In alignment with DIH, and to achieve the highest performance in quality metrics, MCEs are advised to anticipate and plan for improved operability of data exchange with provider organizations to the goals outlined in Figure 2.20 below.

Figure 2.20: Goal of interoperability of data exchange improvement



It also reduces provider administrative burden and improves health outcomes, thus aligning with the quintuple aim.

Figure 2.21: Examples of current DIH high-level interoperability data framework

Data types	Data elements	Potential sources
Administrative claims	1. HEDIS 2. CAHPS 3. Core set measures	Provider Reimbursement Information System for Medicaid (PRISM) data warehouse
Provider information	Provider accessibility accepting new patients	Provider Reimbursement Information System for Medicaid (PRISM) data warehouse

In looking at the future of interoperability there are a number of ways interoperability could be expanded which are included in Figure 2.22. This list of activities could be considered for future development of interoperability.

Figure 2.22: Examples of potential DIH high-level interoperability data framework

Data Types	Data Elements	Potential Sources
Clinical	1. Demographics 2. Encounters 3. Medication lists 4. Problem list/diagnoses 5. Vital signs 6. Vaccinations 7. Laboratory 8. Clinical tests 9. Procedures 10. Diagnostic imaging 11. Assessments 12. Care plans 13. Social history 14. Referrals 15. Allergies 16. Risk scores 17. Disability	• Health Information Exchange (HIE) • Provider EHR • Utah Statewide Immunization Information System (USIIS) • PHM platform
ADT	1. Admission 2. Discharges 3. Transfers	• HIE • EHR • ADT platform • PHM platform
Public health	1. Syndromic surveillance	• Indicator-Based Information System for Public Health (IBIS-PH)
Paid claims	1. Pharmacy 2. Laboratory 3. Behavioral health 4. Professional 5. Institutional	• PBM • Payer claims systems • PHM platform • All-Payer Claim Database (APCD)
Provider rosters	1. Providers	• Payer credentialing systems • Provider directories • PHM platform • EHR
Payer eligibility	1. Attributed members	• Payer membership attribution roster • PHM platform

Provider calculated/ reported quality measures	1. HEDIS 2. CAHPS 3. electronic Clinical Quality Measure (eCQM) 4. Core measures	• Provider EHR • Provider PHM platform
Payer calculated APM, quality, medical, behavioral health, dental measures	1. HEDIS Adult/Child Core Set 2. Universal measures 3. Behavioral health 4. Pharmacy 5. HRSN 6. Case/care coordination 7. Utilization measures	• UHIN HIE • USIIS • Onpoint PHM platform • PRISM • Payer information systems

The Interoperability and Patient Access Final Rule (CMS-9115-F) focuses on driving interoperability and patient access to health information by liberating patient data. It uses CMS authority to regulate Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs).

CMS has released the Interoperability and Prior Authorization final rule (CMS-0057-F), which requires the following effective January 1, 2026:

- Medicaid and contracted MCEs must send prior authorization decisions within:
    - 72 hours for expedited requests
    - Seven days for standard requests
- These payers must also:
    - Provide a specific reason for all prior authorization request denials
    - Publicly report certain prior authorization metrics annually

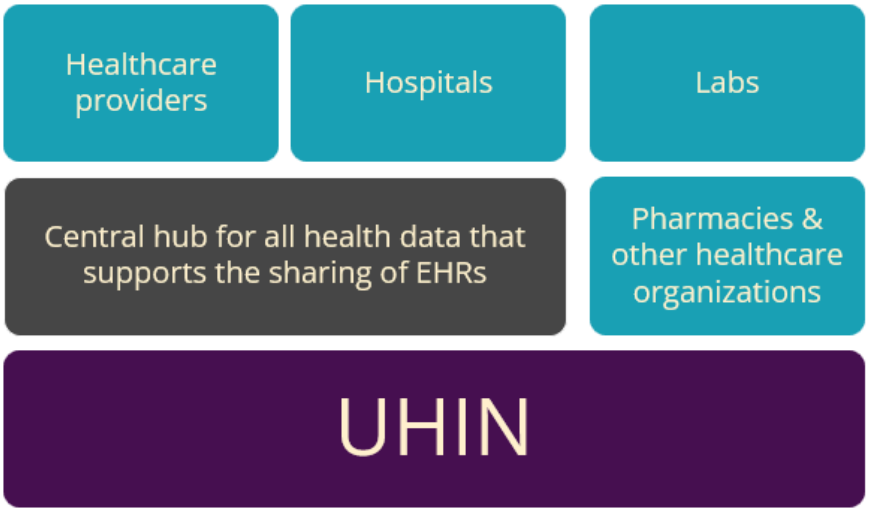
In addition, the final rule takes aim at improving the electronic exchange of healthcare data through application programming interfaces (API).

By January 1, 2027
1. Payers must add prior authorization information to the data available via their Health Level 7® Fast Healthcare Interoperability Resources® API
2. Impacted payers to implement and maintain provider access and payer-to-payer APIs
3. New electronic prior authorization measure to be added to the HIE objective for the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category and the Medicare Promoting Interoperability Program a. MIPS eligible clinicians will report this new measure beginning with the calendar year (CY) 2027 performance period/CY 2029 MIPS payment year

4. Critical access hospitals and other eligible hospitals will report the new measure beginning with the CY 2027 EHR reporting period

Health information exchange in Utah is facilitated through a statewide health information network called UHIN (Utah Health Information Network).

Figure 2.23: Utah Health Information Network



Initiatives promoting interoperability through partnerships aimed at improving the exchange of electronic health information	
Utah Health Information Network (UHIN):	UHIN is a non-profit organization that provides secure electronic exchange of health information among various healthcare providers, payers, and other stakeholders in Utah. UHIN's services include electronic claims processing, clinical document exchange, electronic prescribing, and clinical data sharing.
Statewide health information Exchange (HIE):	The State of Utah has established a statewide HIE to facilitate the secure exchange of patient health information among different healthcare organizations. This HIE allows healthcare providers to access and share patient health

Initiatives promoting interoperability through partnerships aimed at improving the exchange of electronic health information	
	information across multiple systems and platforms. Mandatory participation is required of all hospitals.
Participation in national initiatives:	Utah actively participates in national initiatives such as the eHealth Exchange and Commonwell® Health Alliance, which promote interoperability standards and facilitate the exchange of healthcare data across different systems. They have also successfully completed the Qualified Health Information Network® (QHIN™) onboarding process and are recognized as Designated QHINs for TEFCA™ exchange.
Collaboration with other states:	Utah is part of the Western States Consortium, which enables collaboration on health IT efforts with neighboring states, including sharing best practices for interoperability.
Health information technology (HIT) certification:	The state requires all EHR vendors to be certified by an Office of the National Coordinator for Health IT (ONC) Authorized Certification Body (ACB) to ensure that their products meet national standards for interoperability.
Education and training:	The state offers resources and training programs to educate healthcare providers on best practices for using EHRs and achieving interoperability.
Utah Statewide Immunization Information System (USIIS):	USIIS is a secure, confidential immunization information system that helps healthcare providers, schools, childcare centers and Utah residents maintain consolidated immunization histories.

DHHS expects MCEs to use clinical data available in the HIE to support health care coordination and care management operations.

DHHS requires all MCEs to:

- Operate and maintain information systems sufficient to support state program participation requirements
- Be capable of collecting and transmitting required data and reports in a format specified by DHHS
- Improve the interoperability with providers through an interoperability improvement plan
    - Include bidirectional sharing of data with providers and improve in each of the following domains:
        - Timeliness
        - Accuracy of payer attribution to provider empanelment
        - Reconciliation of MCE calculated quality measures to Provider calculated to improve data validity

DHHS expects MCEs to comply with:

- Effective July 1, 2021
    - Provider Directory API
      Effective March 31, 2026
    - New policies put into place in CMS-9115-F regarding Patient Access API
- Effective January 1, 2023
    - Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges
- Effective January 1, 2024
    - Public Reporting and Information Blocking
    - Digital Contact Information
    - Event Notifications
        - Admission
        - Discharge
        - Transfer
- Effective January 1, 2027
    - Payer-to-Payer Data Exchange

3

Section 3: Utah's quality initiatives

SFY 24 ACO quality incentives

DIH recognizes paying for performance as a key component of its Quality Strategy.

In State Fiscal Year (SFY) 2024, DIH introduced a Quality Incentive program in partnership with Utah's ACOs. This initiative aimed to achieve the following objectives:

- Better Care by annually evaluating plan performance on both ACO Quality Measures and the Non-ACO Quality Measures Table
- Better Health by promoting preventive care for women and children

The Quality Incentive program was an initiative to transition from FFS to pay-for-performance model for the (ACOs) by creating a quality incentive poll to be earned by the ACOs based on performance.

ACOs earned these funds by meeting established performance targets as outlined in their contracts and achieving specified performance goals.

SFY 25 ACO Quality Capitation Withhold

To further the transition to a pay-for-performance model, DIH has implemented a quality capitation withhold as one of its primary interventions.

DIH established a quality withhold on capitations for SFY 2025. The amount of the withhold is a percentage of the risk adjusted base capitation rates. Based on performance on HEDIS benchmarks and encounter data timeliness and accuracy standards, ACOs can earn back up to the entire amount of the withhold.

HEDIS Measures:

- Improvement on HEDIS W30 (well-child visits in the first 15 and 16th to 30th months of life)
- Improvement on HEDIS WCV (child and adolescent well-care visits for children 3-21 years of age)
- Improvement on HEDIS CIS (childhood immunization status) combination 3
- Improvement on HEDIS IMA (immunizations for adolescents)
- Improvement on HEDIS PPC2-AD (prenatal and postpartum care for individuals 21 and older) [new measure for SFY 2025 contract]

HEDIS measure performance will be evaluated in the same manner as the evaluation used in the SFY 2024 Quality Incentive program and articulated in the SFY 2024 ACO contracts. ACOs can earn withheld amounts based on HEDIS measure performance.

SFY 26 ACO and UMIC Quality Capitation Withholds

DIH will expand quality capitation withholds for SFY 2026 to include the UMIC plans. ACO and UMIC plans who meet HEDIS benchmarks and other indicators of quality improvement can earn back withheld amounts based on performance. HEDIS measures for the ACO quality withhold will continue to focus in the same areas of maternal and child health and the UMIC population, which is limited to Medicaid adult expansion, will emphasize behavioral health for these integrated health members.

DIH's withhold programs will set aside a percentage of risk-adjusted base capitations for ACO and UMIC which will be tied to performance on select quality measures that align the payment incentives to desired quality outcomes. The UMIC performance measures, once finalized, will focus on the adult expansion population and emphasize behavioral health as well as adult preventative care, chronic condition management and care coordination between physical and behavioral health.

SFY 26 ACO and UMIC Quality-Based Auto-Assignment

DIH will introduce quality-based auto-assignment for the ACO and UMIC plans in SFY 2026. This non-financial incentive builds on the quality withholds, aiming to promote continuous QI and advance NCQA Accreditation for all ACOs by July 1, 2027.

The quality-based auto-assignment seeks to enhance access to high-quality care and improved health outcomes by allocating more members to higher performing plans. This approach fosters a more efficient, patient-centered care system, delivering significant benefits to members and providers. The performance measures incorporated into this program will include HEDIS measures as well as other possible indicators of health plan quality.

Hospital quality project:

In SFY 2024, Utah implemented the hospital quality project. The hospital quality project links performance on quality measures to hospital directed payments, and imposes penalties of up to 3% on a hospital's total SFY directed payment amount, based on performance on the select quality measures aimed to reduce unnecessary care, improve care coordination, and improve patient health outcomes.

For the SFY 2025 performance period, the performance focus was on the HEDIS measure Plan All-Cause Readmissions (PCR). Hospital performance will be evaluated at the individual hospital level. Additional performance measures are being considered and evaluated for inclusion in the next and subsequent performance periods.

4

Section 4: Review, updates, and submission of the MCQS

Update process

Per 42 CFR § 438.340 C.2.i, all states are required to submit a MCQS to CMS every three years. The Utah MCQS will be reviewed periodically and updated as necessary to report on implementation and effectiveness.

DIH has implemented previous managed care quality strategies, which are briefly summarized in Figure 4.1.

Figure 4.1: DIH quality strategies over time

Stakeholder feedback on the MCQS is a critical part of the MCQS development process and a specific federal requirement (42 CFR § 438.340).

Local and State Stakeholders include:

- Association of Utah Community Health Centers

- Center for Medicare and Medicaid Services (CMS)
- CHIPAC
- DHHS
    - QI managers
    - Office and Division management staff
- Disability Law Center
- Internal DHHS Offices, including but not limited to:
    - Division of Family Health and Preparedness
        - Office of Maternal
        - Office Child Health
        - Office of Children with Special Health Care Needs
        - Office of Health Promotion
        - Office of Health Equity
- Health Care Information and Analysis Program (HIA)
- Homecare and Hospice Association of Utah
- Utah Indian Health Advisory Board
- I/T/U
- MAC
- Managed Care Entities
- Medicaid Fraud Control Unit (MFCU) Attorney General's Office
- Medical Care Advisory Committee (MCAC)
- Office of Management and Budget
- Office of Recovery Services (ORS)
- Utah Office of Inspector General (OIG)
- Voices for Utah Children
- United Way
- Utah Behavioral Health Committee
- Utah Health Policy Project (UHPP)
- Utah Healthcare Association
- Utah Hospital Association
- Utah Medical Association

Public comment

The MCQS has an intentional stakeholder participation process. When a final draft of the MCQS is ready, it is provided to a variety of stakeholders, including the MCEs, for a 30-day public comment period. The MCQS is also made available for public comment through DHHS' website (required under 42 CFR § 438.10(c)(3)), and public stakeholder meetings.

DHHS follows a more formal communication process for Consultation with tribal governments and Conferment with Urban Indian Organizations (UIO) and IHS. The Utah DHHS Office of American Indian/Alaska Native Health and Family Services facilitates the initial discussions

through the Utah Indian Health Advisory Board (UIHAB). If this Board requests more formal individual Consultation and/or Conferment with any tribe, the UIO, or IHS, the Office facilitates those meetings.

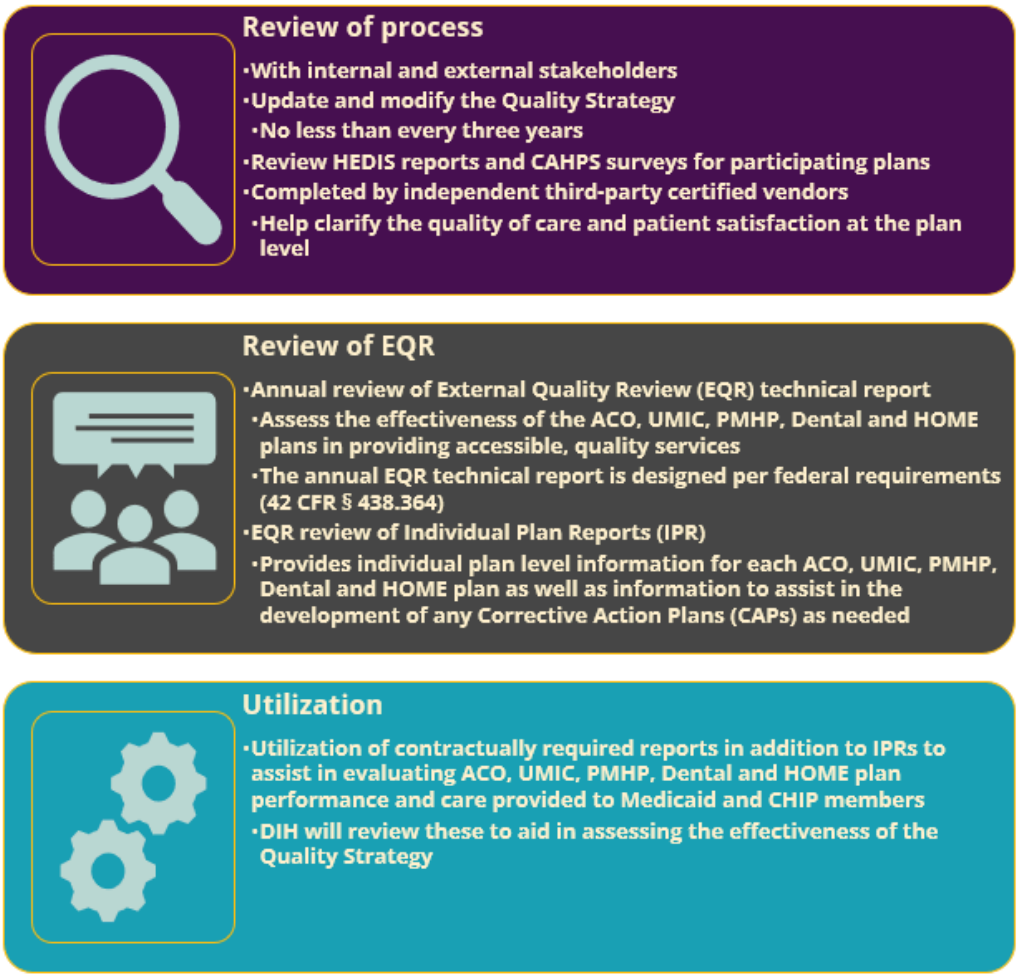
5

Section 5: Timelines

Timeline for assessing the effectiveness of the MCQS

DIH will engage in various activities to assess the effectiveness of the MCQS. These include the activities in Figure 5.1.

Figure 5.1: MCQS activities

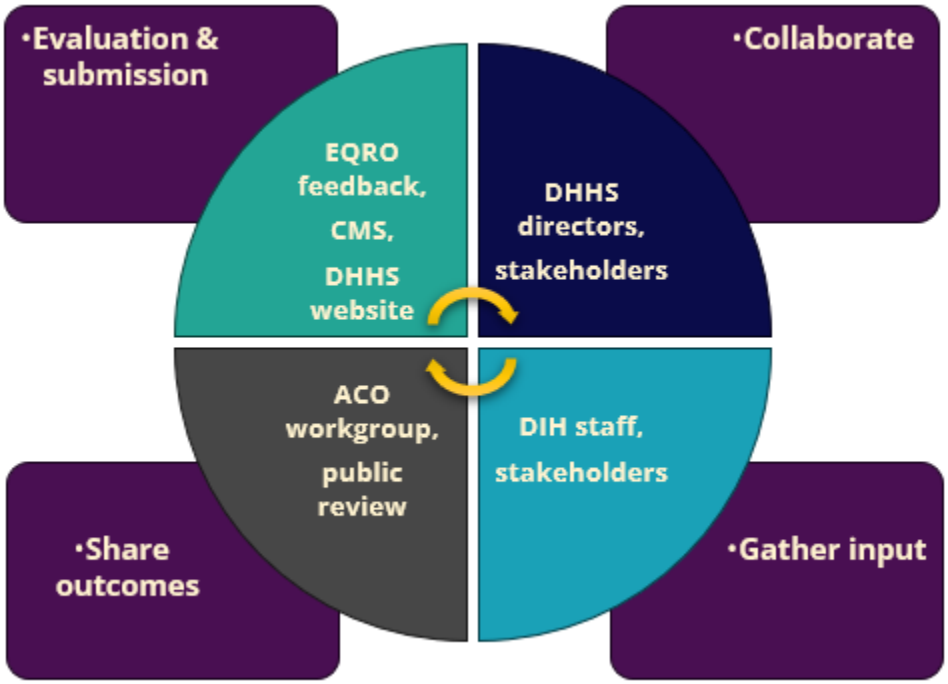


An evaluation of the MCQS is included in the Annual External Quality Review Report (pages 1-4) . The annual EQR report provides DHHS with detailed information and analysis on how each health plan performed over the previous year. In this report, each of the required EQR activities are assessed, strengths and weaknesses are identified, and recommendations for each plan are made.

Timeline for modifying or updating the MCQS

The MCQS will be reviewed periodically and updated no less than once every three years or whenever significant changes, as defined in the MCQS, are made and/or whenever significant changes occur within the state's Medicaid program. A significant change is defined as any change to the MCQS that may be foreseen to materially affect the delivery or measurement of the quality of health care services. The review of the MCQS can be found in the EQR Technical Report, located under the Resources tab on the Utah Managed Care site.

Figure 5.2: Steps for updating the MCQS



https://medicaid.utah.gov/managed-care

6

Section 6: Assessment

Quality and appropriateness of care

Per 42 CFR § 438.330, DIH has quality assessment and performance improvement strategies to ensure the delivery of quality health care by all MCEs. These strategies assist DIH in assessing the quality and appropriateness of care furnished to all Medicaid and CHIP members enrolled with the MCEs. Utah Medicaid contracts with a third-party EQRO to perform EQR activities required by federal managed care regulations. Information from all state and EQR related activities is used to assess the performance of the MCEs.

Figure 6.1: External quality review activities

Quality framework	PIPs
	Performance measurement data
	Under/over utilization
	Special health care needs
PHM framework	Assessment of the population
	Select and analyze cost/utilization measures
	Select and analyze of member experience
	Identify opportunities for improvement
	Measure the effectiveness of interventions
Quality and safety of care framework	Health-Care-Acquired conditions (HCAC)
	Critical incidents
	QOC grievances/complaints

Health equity framework	Understanding member composition
	Assess disparities and gaps in care
	Assessment and provision of adequate language services/resources
	Collect and analyze workforce data
Annual evaluation	HEDIS performance measures
	Assess cost and utilization
	EPSDT/Dental performance measures
	Maternal and reproductive health measures
	Rural healthcare access
	Results of member experience surveys
	Timeliness and analysis of grievance process
	Assess timeliness of credentialing
	Assess timeliness of re-credentialing
	Assess timeliness of notifications
	Network adequacy

Figure 6.2: Quality framework

Performance Improvement Projects (PIPs)

PIPs are a required EQR activity for each MCE. The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical care and nonclinical service areas. Detailed information related to compliance monitoring can be found on the Utah Managed Care website, in the resources tab, within the Annual EQR Technical Report in the compliance section and the Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement - Medicaid sections. These sections of the EQR Technical report address more detailed information specific to evidence-based clinical practice guidelines and requirements. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs are designed, conducted, and reported using a sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member experience.

PIP topic selection involve the following:

- Plan PIP topics may be selected by DIH; collaborative or plan specific
- If not otherwise instructed by DIH, plans identify their own clinical and a non-clinical topics to run concurrently, and submit the PIP topics to DIH for approval using DIH specified forms

PIPs are developed according to 42 CFR 438.330 and are designed to correct significant systemic issues and/or achieve significant improvement in member health outcomes as well as member experience.

PIP validation is conducted by an EQRO with the primary objective of determining a health plan's compliance with the requirements of 42 CFR § 438.330(d) including:

- Measurement of performance using objective quality indicators
- Implementation of systematic interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities for increasing or sustaining improvement

For CY 2023, the EQRO validated a total of 25 PIPs.

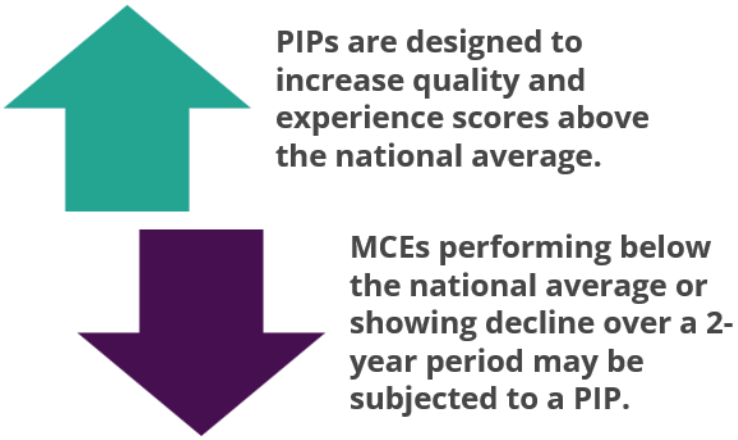
For the list of verified PIPs, see table CY2023 PIP topics by plan.

Performance measurement data

DIH monitors MCEs for compliance in meeting contractual requirements related to the delivery of care and services to members by selecting, evaluating and providing calculation methodologies for performance measures that are aligned with CMS Adult and Child Core Sets, NCQA, and associated technical specifications. DIH selects measures to assess the quality performance of all MCEs against established benchmarks for the MCQS, MCE quality withholds and MCE quality incentives.

All MCEs must report on selected performance measures to the Health Care Information and Analysis Program (HIA) at DHHS. DIH monitors the measures, with results trended over time.

Figure 6.3: Performance and PIPs



DIH may also incorporate performance measures required for Medicaid accreditation as well as long- term care hospital quality reporting program (QRP) measures. DIH may use other performance measures and/or methodologies, such NCQA's HEDIS or may develop other methodologies for measurement.

In addition, effective December 31, 2028, all states that contract with MCEs for the delivery of services covered under Medicaid or CHIP are required to establish a Medicaid and CHIP Quality Rating System (MAC QRS). The MAC QRS includes a list of mandatory measures that will be publicly displayed on websites to allow members and caregivers the opportunity to compare performance and select the best available plan for them. To prepare for MAC QRS implementation, DIH will engage MCEs and other stakeholders through collaborative planning, data readiness assessments, training, technical assistance, and pilot testing.

Under/over utilization

DIH will develop and establish mechanisms to detect under and over utilization for medical, behavioral health, and oral health, and will set performance thresholds to analyze the data against these thresholds. DIH may use external or internal sources that provide distribution of performance data to set performance thresholds.

DIH expects all MCEs to monitor under and over utilization by:

- Collecting data on length of stay, inpatient days, discharges, and unplanned readmissions and present by percentiles or mean rates
- Conducting quantitative analysis of monitored data against the established thresholds
- Conducting qualitative analysis to identify potential barriers to improvement
- Assessing the possibility of under and over-utilization and identifying opportunities for improvement and appropriate interventions

DIH monitors performance of MCEs reviewing results and determining the appropriateness of interventions for improvement.

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

DIH requires MCEs to do the following:
1. Have policies and procedures to identify adults and children with special health care needs and those in vulnerable populations
2. Conduct an initial screening within 90 days of enrollment to assess the needs of adults and children with special health care needs
3. Use the information collected through the initial screening to develop an individualized care plan containing self-management goals and objectives to achieve improvement and barriers to meeting goals
4. Have care transition protocols to coordinate the delivery of care to adults and children with special health care needs

DIH requires MCEs to meet EQRO standards (42 CFR 438 and 42 CFR 457):
Standard VI - Coordination and continuity of care The Contractor implements mechanisms to assess members with special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.
Standard VI - Coordination and continuity of care For members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs
Standard XII - Quality Assessment and Performance Improvement Program The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

DIH requires ACO and UMIC plans to do the following activities:
1. Provide information about primary care providers with training for members with special health care needs
2. Provide training to providers who care for members with special health care needs that includes use of clinical practice guidelines and care transition protocols
3. Ensure there is access to appropriate specialty providers and assist with case management and coordination of care for members with special health care needs
4. Ensure the inclusion of QI goals and objectives into the DIH Medicaid Quality Program and must establish quality performance measures to improve the ability to deliver health care services and benefits to members with special health care needs in a high-quality manner

HOME is an example of how DIH serves members with special health care needs. HOME is a MCE that provides physical and behavioral health services for members with developmental disabilities and mental illness. There is no age limit for participation in the HOME program. HOME uses a "medical HOME" model and emphasizes coordination of care between behavioral and physical health care in the same setting. The program provides primary care, referrals to specialty care, psychiatric evaluations, psychotherapy, psychosocial rehabilitation, care coordination, and other needed services.

Population health management (PHM) framework

MCEs are required to evaluate their PHM framework annually. The annual evaluation must include, at a minimum, the following:

- Assessment of the population to determine the need to revise programs and resources
- Selection and analysis of cost/utilization measures to assess PHM programs
- Selection and analysis of member experience with population health programs and services
- Identification of opportunities for improvement and appropriate interventions
- Measurement of the effectiveness of interventions

MCEs are recommended to submit the evaluation quarterly to DIH.

Quality and safety of care framework

To assess the quality and safety framework, DIH uses measures to review and investigate PQOC concerns to ensure the quality and safety of the care members receive from practitioners and providers. DIH requires all MCEs to review, investigate and report on the following:

DIH requires all MCEs to review, investigate and report on the following:
1. Health-Care-Acquired Conditions (HCAC), which are medical conditions a patient can develop during health care encounters that were not present on admission (POA)
2. Critical Incidents, which are incidents that occur while under the direct responsibility of the Medicaid program
3. QOC grievances/complaints are expressed instances of dissatisfaction by the member and/or caregiver related to potential harm to the health of members due to poor clinical or safety care
4. MCEs are required to receive, investigate and resolve these complaints within a specified timeframe and have processes in place to refer QOC grievances/complaints for further review when deviation of standards of care have been identified

DIH assesses the severity of issues and determines the appropriate action at the MCE and/or practitioner/provider level.

Monitoring and compliance

42 CFR § 438.66 requires DIH to have a monitoring system for all MCEs. DIH requires MCEs to submit reports at established frequency and format in specific areas to include, but not limited to, the following areas below. See Required reports and frequency table for a list of the required reports and the frequency of reporting.

- QOC
- Access to care
- Availability of services
- Provider qualifications
- Utilization of services
- Timeliness of services
- Grievances and appeals
- Network adequacy

External quality review

DIH contracts with a third-party vendor to conduct the EQR as described in 42 CFR § 438 subpart E. The EQRO has the responsibility for the mandatory review that must be conducted every three years to ensure all plans comply with federal managed care standards related to access to care, structure and operations, and quality measurement and improvement. The EQRO produces an Individual Plan Report (IPR) for each MCE used by MCEs to develop a Corrective Action Plan (CAP) as needed.

EQRO mandatory activities:
1. Performance measure validation
2. PIP validation
3. A compliance review, conducted within the previous 3-year period, to determine the MCE's compliance with the standards set forth in subpart D
4. Network Adequacy Validation (NAV)

DIH reviews the EQR reports and analyses from the EQRO reviews related to their recommended corrective actions to determine if DIH concurs. If CAPs are needed, the EQRO and DIH review the CAPs to ensure the plans have identified appropriate corrective actions. Please see the Proposed 2025 compliance review schedule for the MCEs.

EQR technical report

The annual EQR technical report is the public facing end-product of the annual EQR. The EQRO produces the technical report for the state which includes:

1. For each EQR-related activity, a description of the way the data was aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCEs.
2. The results of each EQR-related activity, including a summary of the:
    - Objectives
    - Technical methods of data collection and analysis
    - Description of data obtained, including validated performance measurement data. CMS 2439-F establishes the requirement for EQR technical reports to include outcomes data and results from quantitative assessments in addition to validation information, for each mandatory EQR-related activity conducted in accordance with § 438.358(b)(1)(i), (ii) and (iv), relating to the validation of PIPs, validation of performance measures, and NAV (Protocols 1, 2, and 4). CMS must update the protocols to support this requirement. After CMS publishes the updated protocols, states have one year to begin implementation.
    - Conclusions drawn from the data
3. The EQRO's assessment of each MCEs strengths and weaknesses related to quality, timeliness, and access.
4. Recommendations for improving the quality of health care services furnished by each MCE and recommendations for how the state can target goals and objectives in the MCQS.
5. Methodologically appropriate, comparative information about all MCEs.
6. An assessment of the degree to which each MCE has addressed the recommendations for QI

made by the EQRO during the previous year's EQR.

7. The names of the MCEs exempt from external quality review by the State, including the beginning date of the current exemption period, or that no MCEs are exempt, as appropriate.

NCQA Accreditation

As of July 1, 2027, Utah will require each ACO plan to achieve health plan accreditation by NCQA. NCQA accreditation is formal recognition that a healthcare organization meets specific standards for quality, performance, and accountability and is a widely respected evaluation process designed to ensure that healthcare organizations deliver high-quality care and continuously improve their operations. DIH believes requiring NCQA accreditation lays the framework for health plans serving Medicaid members to improve care, enhance service, and reduce costs. Accredited plans are still subject to EQRO review of the required activities as set forth in 42 CFR § 438.358.

Nonduplication of mandatory activities

42 CFR § 438.360 allows accreditation reviews to be utilized by external quality review for single quality review activities. Section 438.360 has provided an option for states to exempt MCOs from EQR activities that would be duplicated as part of either a Medicare review of a Medicare Advantage plan or a private accreditation review. The non-duplication option was developed to remove the administrative burden of providing the duplicative information when the same information could be collected by accreditation. The State of Utah does not currently utilize the non-duplication option but may in the future if appropriate.

7

Section 7: State standards

Network Adequacy Standards

All health plans are required to maintain and monitor a network of appropriate network providers that is supported by written agreements and is sufficient to provide adequate access to all services covered in the plan contracts. Provider crosswalks are used to describe how to identify a variety of providers in the following categories; primary care providers (PCPs), specialists, behavioral health providers, health care facilities, and dental providers. Provider categories are identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree. In establishing a plan's availability of services, contracted plans must consider the following when applicable:

- The anticipated Medicaid enrollment
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the contractor's service area
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services
- The number of network providers who are not accepting new Medicaid patients
- The geographic location of network providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

Network Adequacy requirements vary by plan and are detailed in the individual plan contracts and can be found on the Utah Managed Care website under the Managed Care Contracts section.

- ACOs Network Adequacy standards and review can be found in Attachment B, Article 5 of the ACO contract.
- UMIC Network Adequacy standards and review can be found in Attachment B, Article 5 of the UMIC contract.
- PMHPs Network Adequacy standards and review can be found in Attachment B, Article 5 of the PMHP contract.
- Dental Plans Network Adequacy standards and review can be found in Attachment B, Article 5 of the Dental contract.
- HOME Network Adequacy standards and review can be found in Attachment B, Article 5 of the HOME Contract.

DIH contracts require MCEs (physical health, behavioral health, dental, integrated) to meet (as appropriate) the following federal managed care requirements:

Regulatory requirements	Standards	MCE contract language
Access and availability		
§438.206(b)(1)	Network Adequacy Services	Contractor shall maintain provider network adequacy time and distance standards to ensure Enrollee access. The standards will be different for the different county designations of the state (Frontier, Rural and Urban), if applicable, and for the different specialty types.
§438.206(b)(2)	Access to Women's Health	Contractor shall provide female members with direct access to a women's health specialist within the Provider Network for covered care necessary to provide women's routine and preventative health care services.
§438.206(b)(3)	Second Opinions	Contractor shall provide for a second opinion from a qualified Network Provider or arrange for the member to obtain one from a Non-Network Provider, at no cost to the member.
§438.206(b)(4) §438.206(b)(5)	Out-of-Network Services	If Contractor is unable to provide medically necessary covered services to a member in-network, the Contractor must adequately and timely cover these services using out of network providers for as long as the Contractor is unable to provide them. The contractor must coordinate with out-of-network providers with respect to payment and ensure that the cost to the member is no greater than it would be if the services were furnished within the network.
§438.206(b)(7)	Access to family planning	Contractor shall demonstrate that its network includes sufficient family planning Network Providers to ensure timely access to Covered Services.
§438.206(c)(1)(i)	Timely Access	Contractor and its Network Providers shall meet the Department's standards for timely access to Covered Services, as described in Article 10.2.6, considering the urgency of the need for services.

Regulatory requirements	Standards	MCE contract language
§438.206(c)(1)(ii)	Hours of Operation Parity	Contractor shall ensure its Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or are comparable to Medicaid FFS enrollees, if the Network Provider serves only Medicaid Enrollees.
§438.206(c)(1)(ii)	24-hour Availability	The contractor shall make all Covered Services available 24 hours a day, 7 days a week, when Medically Necessary.
§438.206(c)(2)	Cultural Competence	Contractor shall have methods to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
Coordination of care		
§438.62(b)	Transition of Care Policy	Contractor shall implement a transition of care policy that is consistent with federal requirements and at least meets DHHS' defined transition of care policy. The state makes its transition of care policy publicly available to members and potential members in the Utah Medicaid Provider Manual, including how to access continued services upon transitioning. If a member's enrollment is changed to a different MCE or Fee-for-Service, approved prior authorizations for medical care from the previous MCE will be honored for the member until: • A prior authorization (PA) has been evaluated for medical necessity of the service and the MCE has made a determination that the PA is no longer medically necessary; or • The member is discharged from an inpatient hospital setting. When a provider receives a PA, the provider must submit the associated claim for the authorized service to the entity that issued the PA (i.e., ACO, PMHP, HOME, dental plan, or DIH).
§438.208	Coordination and	Contractor shall implement procedures to deliver care and to

Regulatory requirements	Standards	MCE contract language
	Continuity of Care	coordinate Covered Services for all members
Structure and operations		
§438.206(b)(6) §438.214	Credentialing	Contractor credentials its network providers.
§438.214	Provider Selection	Contractor shall have written policies and procedures for selection and retention of Network Providers.
§438.10	Enrollee Information	Contractor shall write all member and potential member informational, instructional, and educational materials, in a manner that may be easily understood, and to the extent possible, at a sixth grade reading level.
§438.224	Confidentiality	Individually identifiable health information is disclosed in accordance with Federal privacy requirements
§438.56	Enrollment / Disenrollment Process	DHHS or its designee shall determine eligibility for Enrollment and will offer Potential Members a choice among all Health Plans available in the Service Area.
§438.228	Grievance and Appeal System	Contractor shall have a Grievance and Appeal System for an Aggrieved Person that includes: (1) a Grievance process whereby an Aggrieved Person may file a Grievance; (2) an Appeal process whereby an Aggrieved Person may request an Appeal of an Adverse Benefit Determination; and (3) procedures for an Aggrieved Person to access the State's fair hearing system
§438.230	Subcontractor Relationships	Contractor shall maintain the ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, notwithstanding any relationship(s) that the Contractor may have with any Subcontractor.
§438.608	Program Integrity	Contractor or Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of Claims, shall implement and maintain arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Waste, and Abuse on the part of the Providers, Enrollees, and other patients who falsely present themselves as being Medicaid eligible.

Regulatory requirements	Standards	MCE contract language
Measurement and improvement		
§438.236	Practice Guidelines	Contractor and its Network Providers shall adopt practice guidelines consistent with current standards of care.
§438.330	QAPI	Contractor shall have an ongoing comprehensive QAPI Program for the services it furnishes to its members.
§438.242	Health Information Systems	The contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, Claims, Grievances and Appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

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Section 8: Improvement initiatives

DIH quality framework

DIH recognizes that having standards is a first step in promoting safe and effective healthcare. To ensure standards are followed, DIH regularly monitors the MCEs to identify opportunities for improvement to ensure delivery of the highest-quality, most cost-effective services. Based on monitoring activities, DIH has implemented several interventions to support the seven pillars of the quality framework for optimizing health system performance. DIH's goal is to simultaneously improve (1) maternal health, (2) adult and child physical health, (3) adult and child behavioral health, (4) health equity to address health related social needs, (5) community support via community base organization, (6) member and provider journey, experience and satisfaction and (7) financial stewardship to control cost while optimizing quality for improved health outcomes.

Figure 8.1: Pillars of quality framework

Improvement initiatives supporting the pillars of quality framework	
Pillar	**Initiatives**
Maternal health	Initiatives related to prenatal/postpartum rates
	Initiatives related to breast cancer and/or cervical cancer screening
	Determine/implement incentive arrangements (e.g., withhold, incentive, capitation arrangement, etc.)
	Determine the percent of withhold or incentive for existing HEDIS measures
Adult and child physical health	Determine/implement incentive arrangement (e.g., withhold, incentive, capitation arrangement, etc.)
	MCE quality based auto assignment
	Determine the percent of withhold or incentive for existing HEDIS measures
	Initiatives related to improving access to well child visits, adolescent visits, and Immunizations
Adult and child behavioral health	**Outcomes project** The Utah Public Behavioral Health system participates in a state-of-the-art initiative designed to assess the outcomes of behavioral 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 behavioral health clinicians' immediate feedback on the effectiveness of the treatment provided. These tools also provide clinical guidance to improve care, when needed.
	Possible NCQA MBHO accreditation for PMHPs
	Withholds for behavioral health measures to improve coordination of care
Accreditation	NCQA health plan accreditation
Member and provider experience	**Behavioral health surveys:**

	To review quality issues such as performance and timely access, PMHPs administer member experience surveys under the direction of the Division of Substance Abuse and Mental Health. These include the Mental Health Statistics Improvement Program, Youth Services Survey and Youth Services Survey-Family. The data gathered from these surveys provide valuable information to assist PMHPs in delivering more effective care.
	Consumer Assessment Healthcare Provider Satisfaction and Systems (CAHPS)
	Member Advisory Committee (MAC) or timely feedback to improve access, care and service
Financial stewardship	Healthcare plans ensure financial stewardship by managing resources efficiently, controlling costs, and maintaining accountability while delivering high-quality care. Key strategies include:
	• Utilization Management: Ensuring medical services are necessary and cost-effective through prior authorizations, concurrent reviews, and retrospective evaluations.
	• Value-Based Payment Models: Shifting from fee-for-service to models like bundled payments, accountable care organizations (ACOs), and pay-for-performance to reward quality and efficiency.
	• Network Management: Optimizing provider contracts and networks to balance cost and quality, often through tiered or narrow networks.
	• Data Analytics: Using predictive modeling and cost trend analysis to identify inefficiencies, high-cost members, and opportunities for intervention.
	• Care Management Programs: Managing chronic conditions, complex cases, and preventive care to reduce unnecessary costs and improve outcomes.
	• Member Engagement: Empowering members with cost transparency tools, wellness programs, and education to make informed healthcare decisions.
	• Fraud, Waste, and Abuse Prevention: Detecting and addressing improper claims and suspicious patterns through audits and monitoring.
	• Administrative Efficiency: Streamlining operations with technology, automation, and lean management practices to reduce overhead.
	• Regulatory Compliance: Adhering to federal and state requirements, such as medical loss ratio (MLR) rules, to avoid penalties and ensure proper fund allocation.
	MCE contracts can be found in the Managed Care Contacts tab on the Utah Managed Care site. The contracts contain remedies like sanctions and liquidated damages as recourse to ensure MCE contract compliance.

	• ACOs remedy details can be found in:
	  ○ Attachment A
	  ■ Article 14
	  ■ Article 22.10
	  ○ Attachment B
	  ■ Article 3.7.3
	  ■ Article 4.14
	  ■ Article 5.3.3
	  ■ Article 5.5.1
	  ■ Article 5.6.1
	  ■ Article 12.3.4
	  ■ Article 12.4.1
	  ■ Article 14
	  ○ Attachment E
	  ■ Article 2.5
	• HOME remedy details can be found in:
	  ○ Attachment B
	  ■ Article 3.7.1
	  ■ Article 5.3.3
	  ■ Article 5.5.2
	  ■ Article 12.4
	  ■ Article 14
	• UMIC remedy details can be found in:
	  ○ Attachment B
	  ■ Article 3.7.2
	  ■ Article 4.12
	  ■ Article 5.3.3
	  ■ Article 5.5.2
	  ■ Article 5.6
	  ■ Article 12.3.4
	  ■ Article 12.4.1
	  ■ Article 14

	○ Attachment E ■ Article 2.4 ● PMHPs remedy details can be found in: ○ Attachment B ■ Article 5.3.3 ■ Article 5.5 ■ Article 14 ○ Attachment E ■ Article 2.5 ● Dental Plans remedy details can be found in: ■ Article 14

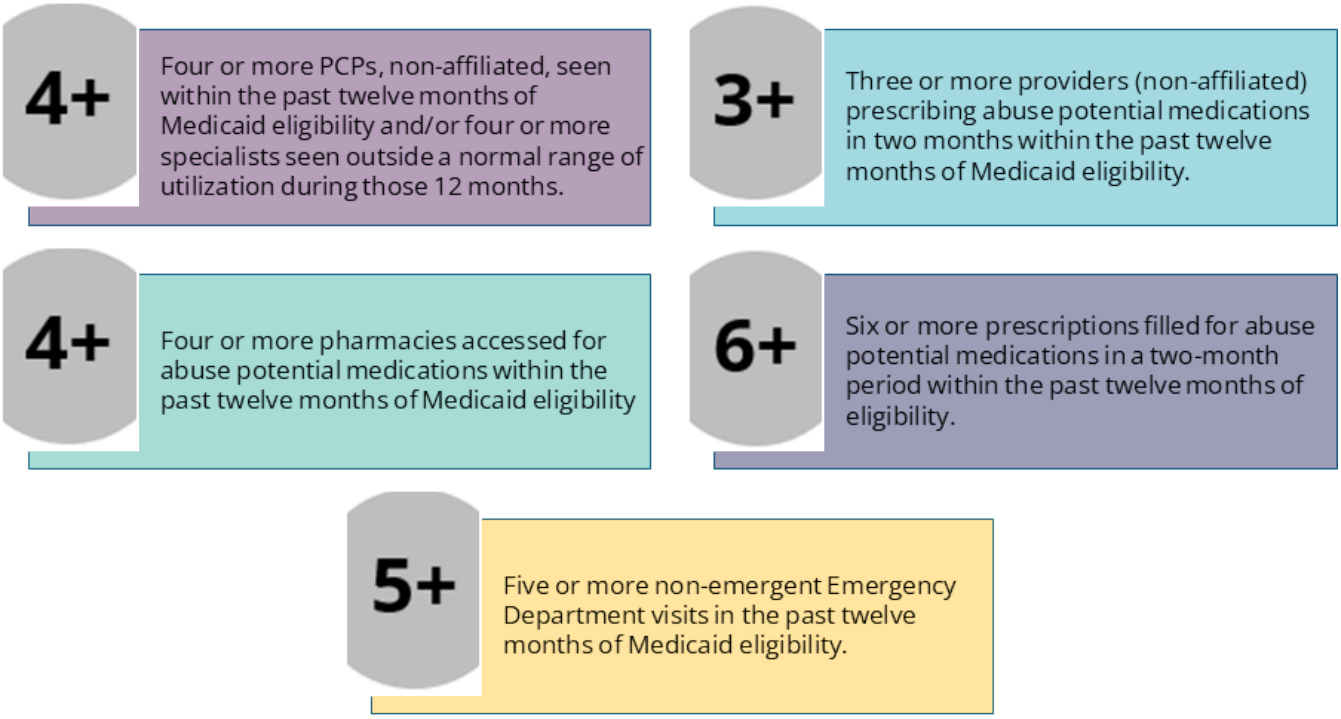
Additional initiatives

Restriction program:

DIH manages a restriction program which safeguards against inappropriate and excessive use of Medicaid services.

Members meeting one or more of the following criteria may be referred to and enrolled in the restriction program.

Figure 8.2: Restriction program criteria



Members enrolled in the restriction program are assigned to one PCP, one pharmacy, and PCP-approved specialty providers. Payments to unassigned or unapproved providers are denied by the ACO, UMIC plan, and/or Medicaid FFS. Emergency department services are not restricted, but members receive education regarding urgent care as an available alternative to emergency department care when members' needs are non-emergent.

PCPs participating in the restriction program manage the restricted member's medical care, approving of secondary prescribers and referring members to necessary specialty providers as needed.

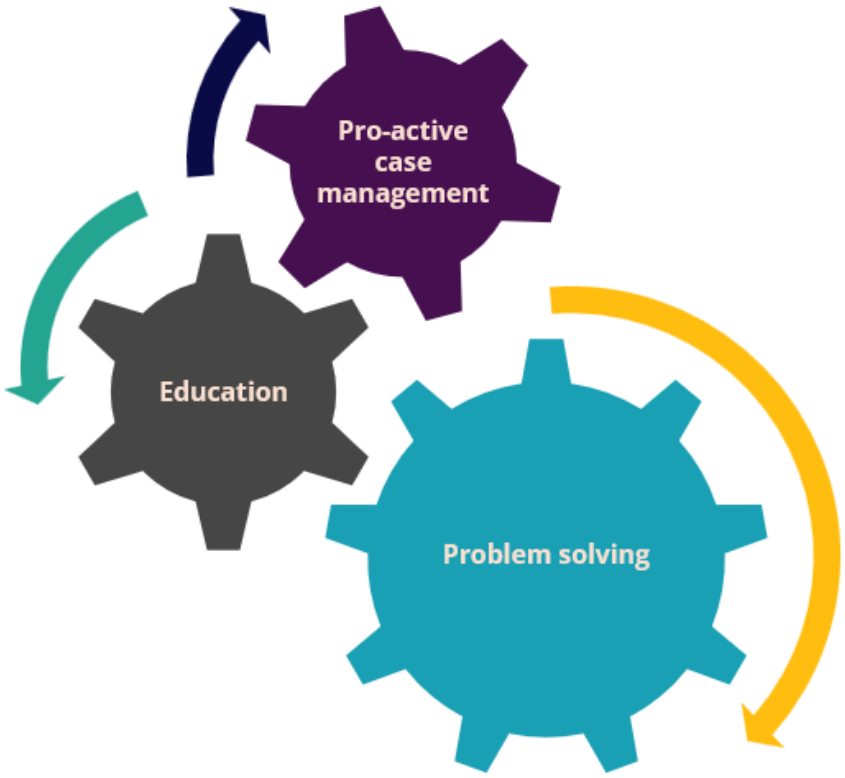
PCPs:

- Provide education regarding appropriate use of healthcare services

- Are available by phone 24x7 for emergencies or assure telephonic access to other similarly skilled clinicians
- Provide management of acute and/or chronic long-term pain through a variety of modalities
    - Referral to pain management specialty providers and other specialty providers as needed
    - Coordination of care by sharing pertinent information regarding the member with:
        - Mental health providers
        - Pain management providers
        - Other approved medical specialty providers

ACOs and UMIC plans provide contact information to restricted members to facilitate access to appropriate restriction staff. Assistance to restricted members is provided throughout the duration of the members' restriction program enrollment as detailed in the figure below:

Figure 8.3: Assistance provided to restricted members



ACOs and UMIC plans review member placement on the restriction program on an annual basis. Members who have followed restriction program guidelines and no longer meet restriction criteria are discharged from the restriction program. Members found to continue to meet one

or more of the restriction criteria remain enrolled in the restriction program.

The restriction program effectively implements the quality strategy goal to deliver more affordable care through innovative strategies in partnership with ACOs, UMIC plans, and other stakeholders. It does this by managing high-cost members through electronically restricting payments to only those providers approved by the PCP and assisting members in more effectively managing their health care, thereby decreasing excessive use of Medicaid services and driving down healthcare costs of.

Interoperability

DIH uses a variety of informatics sources and systems to conduct managed care operations and evaluate the effectiveness of care and services provided to Medicaid and CHIP members. DHHS has requirements to ensure that contracted entities also have effective information systems, data gathering, and integration processes to conduct ongoing and annual self-evaluation activities. DIH is responsible for ensuring its vendors are communicating and coordinating among all stakeholders to create a well-integrated system. Data will play a crucial role in Utah's Medicaid transformation, including driving a continuous QI process. In the overall strategy to improve QOC, DIH is leveraging existing technology tools and considering new capabilities.

The Provider Reimbursement Information System for Medicaid (PRISM) supports the administration of all Medicaid and CHIP plans. This includes support with:

- Enrollment
- Disenrollment
- Capitations
- Encounter processing
- Contract management
- EPSDT

All plans have access to PRISM so that they can produce reports on their members. Data from PRISM is also shared in the state's data warehouse. The state's data warehouse holds information about MCE encounters, FFS claims and provider and member information. DIH intends to continuously improve the self-serviceability, validity, and timeliness of data in the state's data warehouse.

The All-Payer Claims Database (APCD) provides another source of data review. Payers submit claims data to the APCD through HCS. The APCD enables the calculation of a patient's TCC, which is a key metric in the evaluation of most healthcare reform pilots. DIH is also able to produce a variety of quality-related reports that assist in the ongoing operation and review of the MCQS. This further enhances the use of this database in assisting with QI for Medicaid's MCEs and the health care system throughout Utah.

DHHS also hasF to integrate public health data from across the Department. The Indicator-Based Information System for Public Health (IBIS-PH) includes 180+ indicator reports

which are regularly updated to provide information on important public health measures. DHHS and other public health partners regularly analyze these measures to track and evaluate their progress towards goals. The MCEsadvise on the prioritization of initiatives for improvement based on measure analysis. IBIS-PH will serve to enhance the MCQS by providing important information about public health measures that will assist DIH in the quality strategy goals of coordination of care, preventive care, and improved quality of services.

Medicaid promoting interoperability program initiatives

In addition to utilizing current data systems, DIH is engaged in innovative interoperability initiatives that support the objectives of the MCQS and ensure DIH is progressing towards the quality strategy goals. DIH is participating in the Medicaid Promoting Interoperability Program (formerly the Electronic Health Record Incentive Program) through CMS and the ONC. This program aims to improve the quality of patient care coordination, ensure patient safety and facilitate patient involvement in treatment options by encouraging adoption and meaningful use of certified EHR technology.

In October 2011, Utah received approval from CMS to make incentive payments to eligible Medicaid providers as they adopt, implement, upgrade or demonstrate meaningful use of EHR technology. Meaningful use includes electronically capturing health information and using it to track conditions and communicate information for care coordination. As of December 31, 2019, 44 hospitals and almost 1,200 unique providers have participated in the program.

Utah Medicaid has also coordinated federal funding for several initiatives that align with the Promoting Interoperability goals. These projects include:

- A pediatric patient portal to provide clinicians and parents with access to enhanced health information exchange for children with special healthcare needs
- Enhancements to Utah's Controlled Substance Database, which facilitates care coordination for patients who receive controlled substance medications such as opioids
- Improvements to Newborn Screening infrastructure to assist with early identification and timely clinical management of babies born with life-threatening disorders
- USIIS: The state's USIIS is a secure, confidential immunization information system that helps healthcare providers, schools, childcare centers and Utah residents maintain consolidated immunization histories.

Utah's participation in the promoting interoperability program helps DIH progress towards the quality strategy objective of improving the quality of services provided to members by ensuring timely and accurate data through EHRs, improving patient and family engagement, and improving care coordination between Medicaid providers.

Other interoperability initiatives to support the MCQS Include:

- Implementing a statewide patient portal: UHIN is working on creating a secure online platform where patients can access their EHRs from multiple providers across the state.
- Integrating with other healthcare systems: UHIN is actively collaborating with other

healthcare systems in Utah, including Intermountain Healthcare and University of Utah Health, to improve the integration and sharing of patient data between different EHR systems.
- Enhancing interoperability: UHIN is working towards improving interoperability among different health information systems, making it easier for healthcare providers to securely access and share patient data.
- Facilitating secure communication: UHIN is implementing new tools and technologies that enable secure communication between healthcare providers, such as Direct Messaging and Secure Messaging.
- Advancing PHM: UHIN is utilizing health data analytics tools to help healthcare organizations better understand patterns and trends in population health, which can aid in improving patient outcomes and reducing healthcare costs.
- Supporting telehealth initiatives: With the rise of telehealth services during the COVID-19 pandemic, UHIN has expanded its capabilities to securely transmit patient data between remote locations, making it easier for patients to receive virtual care from their providers.

Provider Reimbursement Information System for Medicaid (PRISM)

In 2023, DIH transitioned to a new state-of-the-art Medicaid Management Information System (MMIS), called PRISM. The PRISM system supports functional requirements for the Medicaid and CHIP programs and helps maximize efficiency and cost-effectiveness.

PRISM is now fully operational with the following components: Managed Care Processes, Prior Authorization, Member MCE Enrollment, Claims Adjudication, Claims Payments, Member Web Portal, Audit Studio (Fraud and Abuse System). These components have also replaced and streamlined some previous paper systems.

Additionally, PRISM enables DIH to produce managed care operational measures that will support continued QI for the MCEs.

Utah Health Information Network (UHIN) and Clinical Health Information Exchange (CHIE)

The CHIE is Utah's electronic HIE and is operated by UHIN. In September of 2012, as the result of House Bill 46, Medicaid and CHIP members were automatically enrolled in the CHIE. These families are notified about how to opt-out if they do not wish to participate during their application/renewal process for benefits.

The four major Utah healthcare systems, several large clinics, some rural hospitals, some payer organizations, care management teams, and many independent practices are participating in the CHIE to exchange shared information for patients to improve QOC and reduce costs. Others

are still in the process of joining the CHIE. Subsequent updates to the MCQS will include an update on enrollment and progress with the CHIE. Through the CHIE, the Department envisions that plans will access clinical data needed for quality measurement instead of collecting data directly from providers. Additionally, the CHIE will serve as a central point for providers to access and make decisions based on members' clinical records, particularly during transition between plans or managed care/Medicaid to ensure that members do not have interruptions in essential services during these transitions. Member enrollment and data sources are tracked in order to set and monitor metric targets.

Beyond data collection, the CHIE:

- Provides longitudinal health data on patients to help providers and care managers have information when they need it to inform treatment decisions and to reduce costs by reducing unnecessary duplication of services.
- Provides admit, discharge, and transfer alerts for care management teams and primary care to be able to follow up with patients. This includes both LACE risk scores and falls risk scores for entities that subscribe to these
- Provides access to data via a portal or via interfaces which allow the data to be integrated into their EHR

The CHIE is run by UHIN, a private non-profit company designated as Utah's Health Information Exchange (HIE). The state is not involved with running the CHIE. The CHIE contains various sources of captured data such as medical and pharmacy claims, UHIN HIE, provider EMR, labs, vision, dental and all payers claims. These also include medication files from Medicaid that are sent to help augment the data. The CHIE works to transform and normalize these data as they are sent to UHIN in a variety of ways from different sources. UHIN in turn works collaboratively with the CHIE to help assess the data quality. To better assess data quality, UHIN has moved to a new platform that allows more aggregated querying and works to establish queries. UHIN will also work with data sources on improvements. Due to the information exchange, DIH requires MCEs to safeguard the information entered into its information systems by performing regular audits and implementing interventions when required.

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Section 9: Delivery system reforms

The mission of the managed care delivery system in Utah is to provide timely access to quality and cost-effective health care to achieve optimal health and well-being for all eligible Utahns. Populations served through managed care in the Utah Medicaid program include the aged, blind, and disabled, uninsured children in families who qualify, children with special health care needs, pregnant women, caretaker adults, adults without dependent children, and dual eligible individuals. Services include dental, behavioral health, and substance use services. The Utah Medicaid program does not currently include managed care long-term care services and supports.

Reform of the managed care delivery system aligns with the 4 priorities of the MCQS:

Outcomes and alignment

The Utah Medicaid program initiated the design and implementation of UPHMS consisting of dashboards, reports, tools, and other resources designed to monitor the quality of healthcare delivered to Utah Medicaid members against national standards and measure care across time, population demographics, and providers to identify and address gaps in healthcare delivery and compliance. UPHMS will allow for the identification, collection, validation, calculation, analysis, and reporting of a variety of health outcomes measures identified by DHHS, as well as those required by CMS or other federal bodies, including but not limited, to requirements surrounding the CMS Core Set.

Equity and engagement

To deliver upon the MCQS in alignment with the quintuple aim, DIH made a data informed decision based on evidence that integrating physical health, behavioral health, and substance use disorder services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs. Therefore, DHHS implemented the UMIC plans for integrated management of physical and behavioral benefits to get the best health outcomes for members while managing the cost of services. This plan went into effect on January 1, 2020 and represents a significant delivery system reform for the Adult Expansion population. CHIP MCEs have been integrated for several years.

Safety and resiliency

Through the QIC, the DHHS monitors and reviews plan performance across quality efforts. DIH

will leverage the ACO Quality Workgroup to support key decision-making and ongoing assessment of plan performance against the Aims, Goals and Objectives previously noted.

Interoperability and scientific achievement

To enhance Utah's interoperability structure, the Utah Digital Health Service Commission (DHSC) has the following objectives in their 2021-2025 Strategic plan:

1. Endorse basic guidelines for interoperability standards that align with and strengthen national certification requirements to increase effective HIE
2. Protect privacy and security of electronic health information by increasing adherence to federal electronic health information security guidelines in independent facilities and practices
3. Increase functionality and effectiveness of state-wide HIE and support increased connections with other data sources including integrated delivery systems (IDS), HIEs, and providers
4. Increase ability to exchange public health information with providers through various exchange methods to improve population health
5. Develop governance, access, and support for health data to be made available for analysis and use
6. Increase Utah's influence on the national forums related to effective delivery of care through interoperability
7. Attend conferences to promote interoperability work

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Section 10: Conclusions and opportunities

Achievements

- For contract year 2023, the state, through the EQRO, validated a total of 25 performance improvement projects (PIPs). Of these 23 PIPs received an overall 'Met' status.
    - The MCEs demonstrated a thorough application of the PIP design principles and use of appropriate QI activities to support improvement of PIP outcomes
    - Five of the 16 health plans that reported remeasurement data demonstrated statistically significant improvement in all the performance indicator rates over the baseline in the most recent remeasurement period
- Based on the EQR audit results for measurement year 2022, the state saw improvement on its performance measures with the majority of MCEs exceeding the established goals:

- Three of the four ACOs exceeded the NCQA Quality Compass average for the following performance measures:
    - Adults' Access to Preventive/Ambulatory Health Services
    - Antidepressant Medication Management—Effective Acute Phase Treatment
    - Appropriate Treatment for Upper Respiratory Infection (URI)—3 months–17 years
    - Controlling High Blood Pressure
    - Use of Imaging Studies for Low Back Pain
- Three of the four UMIC plans exceeded the NCQA Quality Compass average for the following performance indicators:
    - Antidepressant Medication Management—Effective Acute Phase Treatment
    - Controlling High Blood Pressure
    - Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total
    - Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total
- Both CHIP MCEs exceeded the NCQA Quality Compass average for the following performance indicators:
    - Appropriate Treatment for URI—3 months–17 years
    - Immunizations for Adolescents—Combination 1
    - Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months
- Both Medicaid Dental PAHPs exceeded the NCQA Quality Compass average for the following performance indicators:
    - Annual Dental Visit—2–3 Years
    - Annual Dental Visit—4–6 Years
    - Annual Dental Visit—7–10 Years
    - Annual Dental Visit—11–14 Years
    - Annual Dental Visit—15–18 Years
    - Annual Dental Visit—Total
- Based on performance measure outcomes, four PMHPs exceeded the statewide PMHP average for both Follow-Up After Hospitalization for Mental Illness measure indicators.

- Thus far, the full risk managed care model has been successful in providing access to QOC and care coordination for Medicaid and CHIP members. The state will continue to work with decision makers, stakeholders, the community and our managed care partners to improve the QOC for Medicaid and CHIP members while acting as responsible stewards of taxpayer funds.
- Utah developed quality measures to track and monitor each MCE's performance. See Figure 10.1 below for an example of the quality measures. Utah's MCEs aim to perform at or above the national average for each quality measure. Continued focus on these measures serves to further improve the quality of services provided to Medicaid and CHIP members.

Figure 10.1: Example of quality measures

Population	Measure	Condition
(A) Maternity care		
(1)	Postpartum Care Rate (PPC)	Preventive services
(2)	Timeliness of Prenatal Care (PPC)	Acute care
(B) Newborn/infant care		
(1)	Childhood Immunization Status - Combo 3 (CIS)	Preventive services
(2)	Well-Child Visits in the First 30 Months of Life (W30)	Preventive services
(C) Pediatric care		
(1)	Immunizations for Adolescents (IMA Combo 2)	Preventive services
(2)	Child and Adolescent Well-Care Visits (WCV)	Preventive services
(3)	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: BMI Assessment (WWC)	Preventive services
(4)	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Acute care
(5)	Getting Needed Care (Child CAHPS) (annually)	Access
(6)	Getting Care Quickly (Child CAHPS) (annually)	Access
(7)	Customer Service (Child CAHPS) (annually)	Access
(8)	How Well Doctors Communicate (Child CAHPS) (annually)	Access
(9)	Satisfaction with Health Care (Child CAHPS) (annually)	Satisfaction
(10)	Satisfaction with Health Plan (Child CAHPS) (annually)	Satisfaction
(11)	Satisfaction with Personal Doctor (Child CAHPS) (annually)	Satisfaction
(12)	Satisfaction with Specialist (Child CAHPS) (annually)	Satisfaction
(D) Adult care		
(1)	Breast Cancer Screening (BCS)	Preventive services
(2)	Cervical Cancer Screening (CCS)	Preventive services
(3)	Access to Ambulatory Care (AAP)	Preventive services
(4)	Use of Imaging for Low Back Pain (LBP)	Acute care
(5)	Antidepressant Medication Management (AMM)	Acute care
(6)	Hemoglobin A1c Control for Patients With Diabetes (HBD)	Chronic care
(7)	Eye Exam for Patients With Diabetes (EED)	Chronic care

Population	Measure	Condition
(8)	Controlling High Blood Pressure (CBP)	Chronic care
(9)	Getting Needed Care (Adult CAHPS) (annually)	Access
(10)	Getting Care Quickly (Adult CAHPS) (annually)	Access
(11)	Customer Service (Adult CAHPS) (annually)	Access
(12)	How Well Doctors Communicate (Adult CAHPS) (annually)	Access
(13)	Satisfaction with Health Care (Adult CAHPS) (annually)	Satisfaction
(14)	Satisfaction with Health Plan (Adult CAHPS) (annually)	Satisfaction
(15)	Satisfaction with Personal Doctor (Adult CAHPS) (annually)	Satisfaction
(16)	Satisfaction with Specialist (Adult CAHPS) (annually)	Satisfaction
(E) Behavioral health care		
(1)	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS-IET/ NQF 0004)	Access
(2)	Follow-up After Hospitalization for Mental Illness (HEDIS-FUH/ NQF 0576)	Access
(3)	Follow-Up After Emergency Department Visit for Mental Illness (HEDIS-FUM/ NQF 3489)	Access
(4)	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (HEDIS-FUA/ NQF 3488)	Access
(5)	Diabetes Screening for People With Schizophrenia or Bipolar Disorder (HEDIS-SSD/ NQF 1932)	Preventative services
(6)	Diabetes Monitoring for People With Schizophrenia or Bipolar Disorder (HEDIS-SMD/ NQF 1934)	Chronic care
(7)	Cardiovascular Disease Screening and Monitoring for People With Schizophrenia or Bipolar Disorder (HEDIS-SMC/ NQF 1927)	Preventative services and chronic care
(F) Dental care (0-18)		
(1)	OED: Oral Evaluation, Dental Services TFC: Topical Fluoride for Children	Access
(2)	CAHPS: Getting Needed Care; Getting Care Quickly; Customer Service; How Well Doctors Communicate	Satisfaction

Population	Measure	Condition
(3)	CAHPS: Health Care; Dental Plan; Primary Dental Provider; Specialist Provider	Satisfaction

- DIH 's transition to PRISM has included the following functional components: Managed Care Processes, Prior Authorization, Member Eligibility, Claims Adjudication, Claims Payments, Member Web Portal, and Audit Studio (Fraud and Abuse System). PRISM enables DIH to produce managed care operational measures that will support continued QI for the MCEs.
- The interoperability incentive provided another avenue to help achieve quality strategy goals by improving the quality of services provided to members by ensuring timely and accurate data transmission through EHRs.
- The state's healthcare clearinghouse cHIE service allows DIH MCEs to exchange clinical records for real-time care coordination resulting in better outcomes.
- In January 2020, DIH created the UMIC integrated health plans to manage both physical and behavioral health services for the adult expansion populations in Davis, Salt Lake, Utah, Washington, and Weber counties.

Ongoing challenges

At least one required action was identified for all compliance monitoring standards during the annual evaluation of included MCEs performed by the EQRO. Of the six standards that were evaluated, four were determined to have opportunities for improvement:

  - Standard II—Member Rights and Confidentiality
  - Standard IV—Emergency and Post stabilization Services
  - Standard VII—Coverage and Authorization of Services
  - Standard XIII—Grievance and Appeal System
- MCEs in Utah should consider conducting an audit of their compliance monitoring policies and procedures reconciled with the federal requirements and State contract language to ensure accurate definitions and timelines.
- After conducting a policy audit, health plan leadership should ensure that adverse determination and appeal processes align with internal policies.

Fragmented care between physical and behavioral health continues to be a challenge for DIH and its MCEs. Behavioral health services for Medicaid members in Utah are primarily provided through PMHPs under the supervision of individual counties. Physical health services for Utah Medicaid members enrolled in managed care are received through the ACOs. The separation of these delivery models presents ongoing challenges in providing seamless and coordinated care to Medicaid members. The initiation of the UMIC plans is one of the major efforts OMH is

pursuing to address these gaps of care. DIH also sees several opportunities for improved integration of physical and behavioral health services and has included these opportunities in the MCQS through different objectives and interventions. Review and analysis of these will reflect the success of DIH and the MCEs in addressing this important challenge.

As DIH continues to manage many major initiatives including continued oversight of the MCEs, PRISM development and implementation, and health care reform, organizational resources will be used at full capacity. DIH will have to continue to prioritize the goals and objectives of the MCQS to continue to move the work of QI forward. This will ensure improved care for members through higher-value MCEs.

Current and future initiatives

Utah Medicaid/CHIP will improve in the areas of care coordination, preventive care for women and children, access to and quality of services provided, and innovative strategies for controlling costs while maintaining and improving QOC. DIH and its contracted MCEs are actively engaged in the following:

- Working with partners and stakeholders to explore behavioral health services funding to allow greater flexibility to implement additional integrated care models
- Exploring reimbursement policies to encourage and support care integration at the clinical level
- Participating in new and more effective ways to better address social determinants of health
- Attain NCQA HE Accreditation by December 31, 2027

Utilization Management (UM) framework

In the future, DIH shall establish and maintain a UM Program that aligns with CMS and with NCQA standards and guidelines to expand access for:

- Health information
- Improve prior authorization
- Ensure coordination of care

The goal is to improve the electronic exchange of health information and prior authorization processes for health services and reduce burden on members, providers, and MCEs, resulting in improvements in care delivery and managing the TCC.

The UM Program shall be structured to measure and monitor processes assuring that utilization decisions affecting the health care of members are fair, impartial, and consistent and are made by appropriate licensed professionals to:

- Improve the effectiveness
- Increase efficiency
- Promote value of care and services provided to members

Furthermore, the UM program, in conjunction with population health, promotes continuity and coordination of care by ensuring health information exchange:

- Between practitioners and providers (primary care, specialty care, and behavioral health care)
- Between different care settings (from hospital to home, from hospital to long- term care facility)
- Among MCEs (coordination between ACOs and PMHPs)

DIH shall assess the effectiveness of the UM program annually for the following components as part of the QI Program evaluation.

The Utah DIH MCQS demonstrates a commitment to improving the health and well-being of Medicaid and CHIP members through a comprehensive, data-driven, and stakeholder-informed approach. By prioritizing health equity, whole-person care, and innovative initiatives, the MCQS aims to create a more equitable and effective healthcare system for all Utahns.

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Appendix A: Proposed 2025 Utah compliance review schedule

Health plan	Compliance review dates	Draft to DIH	Draft to plan	Final report
Central Utah Counseling Center	May 24-25	June 22	July 15	August 9
Bear River Mental Health	May 24-25	June 24	July 19	August 11
Northeastern Counseling Center	May 26-27	June 24	July 19	August11
Weber Mental Health	May 26-27	June 29	July 22	August 16
Davis Behavioral Health	June 14-15	July 13	August 5	August 30
Wasatch Behavioral Health	June 16-17	July 15	August 9	September 1
Southwest Behavioral	June 21-22	July 20	August 12	September 6

Health plan	Compliance review dates	Draft to DIH	Draft to plan	Final report
Health				
Four Corners Community Behavioral Health	June 23-24	July 23	August 17	September 10
Salt Lake County Division of Behavioral Health/Optum	July 12-13	August 10	September 2	September 27
Healthy U	July 12-13	August 16	September 8	October 1
Optum/Tooele	July 14-15	August 16	September 8	October 1
HOME	July 14-15	August 17	September 10	October 5
Steward Health Choice Utah	August 2-4	September 1	September 24	October 19
Molina Healthcare of Utah	August 2-4	September 2	September 27	October 21
SelectHealth	August 2-4	September 3	September 28	October 21
Premier Access	August 5-6	September 6	September 29	October 25
MCNA	August 5-6	September 8	September 30	October 25

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Appendix B: SFY 2024 Quality incentive program domains, measures, and weights

Domain	Measure	Performance measure share (percent)*	Portion of overall capitation (percentage points)
Member engagement	Member engagement panel	9.30%	0.4%
	Contract element	9.30%	0.4%
	Contract element	9.30%	0.4%
Encounter data	Data timeliness and	13.95%	0.8%

	accuracy		
Accreditation	Completed accreditation or commitment to become accredited	11.63%	0.5%
Improvement on HEDIS measures	HEDIS W30 – 0-15 months	5.81%	0.25%
	HEDIS W30 – 16-30 months	5.81%	0.25%
	HEDIS WCV	11.63%	0.5%
	HEDIS CIS	11.63%	0.5%
	HEDIS IMA	11.63%	0.5%
Total		**100%**	**4.5%**

**Performance measure weights are rounded for the purposes of demonstration in this document*

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Appendix C: CY2023 PIP topics

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
Medicaid ACOs			
Health Choice	Well-child visits in the first 30 Months of life	• Implement interventions in a timely manner to impact the Remeasurement 1 rates • Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis • Consider seeking member input for	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		identification of barriers to better understand member-related barriers to access to care • Develop an evaluation process and determine evaluation results for each individual intervention listed in the barriers/interventions table • Implement intervention-specific evaluation results to guide the next steps for each individual intervention	
Healthy U	Improving access to well visits in the first 15 and 30 months of life	• Implement interventions in a timely manner to impact the Remeasurement 1 rates • Revisit causal/barrier analysis at least annually • Include evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Implement Intervention-specific evaluation results to guide the next steps for each individual intervention	Same
Molina	Well-child visits in the first 30 months of life	• Continually work on its PIP throughout the year • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Use intervention-specific evaluation results to guide next steps for each individual intervention	Same
Select Health	Well-child visits in the first 30 months of life for Medicaid legacy members	• Ensure all documentation in the PIP Submission Form is documented correctly and completely to address each applicable evaluation element • Begin intervention testing in a timely manner to impact the Remeasurement 1 rates • Document the process and steps used to determine barriers to improvement	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		and attach completed QI tools used for the causal/barrier analysis • Use QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. Consider seeking member input during the identification of barriers • Have an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Use intervention-specific evaluation results to guide next steps for each individual intervention • Address improvements in the narrative interpretation of data and reporting of factors affecting the validity of the data in the next annual PIP submission	
Medicaid MCEs providing physical health, behavioral health, and substance use disorder services			
UMIC	Follow-up after hospitalization for mental illness	• Given demonstrated sustained improvement in this PIP for two consecutive remeasurement periods, should determine a new PIP topic for next year's submission with consultation and approval from DHHS • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as it determines and designs the new PIP for next year's submission	Same
HOME	Impact of interventions on improving rate of annual physical examinations performed in the	• Continue with its improvement efforts to sustain the improvement achieved in PIP outcomes • Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
	clinic	barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Identify intervention-specific evaluation results to guide next steps for each individual intervention	
Health Choice UMIC	Follow-up after hospitalization for mental illness	• Has demonstrated sustained improvement in this PIP for two consecutive remeasurement periods. The health plan should determine a new PIP topic for next year's submission with consultation and approval from DHHS. • Should apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization.	Adults' access to preventive/ambulatory health services (AAP)
Healthy U Integrated	Improving adults' access to preventive/ ambulatory care services	• Continually work on the PIP throughout the year • Revisit its causal/barrier analysis at least annually • Conduct an evaluation process and document evaluation results for each intervention listed in the barriers/interventions table • Identify intervention-specific evaluation results to guide next steps for each individual intervention	Same
Molina UMIC	Follow-up after hospitalization for mental illness	• Consider retiring this PIP and initiating a new PIP topic for next year's submission with consultation and approval from DHHS • Continue to expand the successful intervention to realize improvement in the overall performance indicator	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		rate • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as Molina UMIC determines and designs the new PIP	
SelectHealth CC UMIC	7-Day follow-up after hospitalization for mental illness for medicaid integration members	• Consider retiring this PIP and initiating a new PIP topic for next year's submission in consultation with and approval from DHHS • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as SelectHealth CC UMIC determines and designs the new PIP • Provide appropriate intervention evaluation data linked to programmatic improvement	Same
Medicaid PIHP, PMHPs, MCEs, providing mental health and substance use disorder services			
Bear River	Youth outcome questionnaires (YOQ) or outcome questionnaires (OQ)	• Continually work on the PIP throughout the year • Ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period • Revisit the causal/barrier analysis at least annually • Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis • Implement an evaluation process and document evaluation results for each individual intervention listed in the barriers/interventions table • Implement intervention-specific evaluation results must guide next	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		steps for each individual intervention	
Central	Inpatient readmission rates	• Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Determine a new PIP topic for next year's submission in consultation and approval from DHHS • Reach out to HSAG for technical assistance as it determines and designs the new PIP	Same
Davis	Access to care	• Determine a new PIP topic for next year's submission with consultation and approval from DHHS • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as Davis determines and designs the new PIP for next year's submission	Reducing diagnosis conflicts in member EHR
Four Corners	Improving the completion of substance use recovery evaluator (SURE)	• Continually work on the PIP throughout the year • Consider using QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis. Additionally, member input should also be considered while determining barriers • Implement interventions in a timely manner to impact the Remeasurement 1 rates • Develop a process for evaluating each PIP intervention and its impact on the PIP indicator and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. • Ensure that intervention-specific	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		evaluation results guide the next steps of each intervention	
Healthy U Behavioral	Improving follow-up after hospitalization for mental illness	• The health plan documented programmatic improvement with its interventions; however, the performance indicator rates continued to decline. Due to an extremely small PIP denominator population, HSAG recommends that the health plan retire this PIP and initiate a new PIP for next year's submission with consultation and approval from DHHS. • Healthy U Behavioral should apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Healthy U Behavioral should reach out to HSAG for technical assistance as it determines and designs the new PIP	Same
Northeastern	Inpatient post discharge engagement and suicide intervention	• Determine a new PIP topic for next year's submission with consultation and approval from DHHS • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as Northeastern determines and designs the new PIP for next year's submission	Same
Optum/Tooele	Increasing youth engagement in Treatment services in Tooele County	• Continually work on the PIP throughout the year • Ensure that the data reported in the PIP Submission Form are accurate and in accordance with the PIP design • Revisit the causal/barrier analysis at least annually • Develop an evaluation process and	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		evaluation results for each individual intervention listed in the barriers/interventions table • Implement intervention-specific evaluation results to guide the next steps for each individual intervention	
Salt Lake	FUH for adults aged 18–64	• Revisit its causal/barrier analysis at least annually • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Implement intervention-specific evaluation results to guide the next steps for each individual intervention • Implement interventions in a timely manner to impact PIP outcomes during the remeasurement period	Same
Southwest	Increased number of PMHP clients receiving peer support services	• Document in the data narrative whether there were any threats to the validity and comparability of the remeasurement data to the baseline • Continue with its improvement efforts to sustain the improvement achieved in the performance indicator results • Revisit its causal/barrier analysis at least annually • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Consider that intervention-specific evaluation results must guide next steps for each individual intervention	Same
Wasatch	Increasing SURE utilization in SUD	• Revisit its causal/barrier analysis at least annually • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		• Implement intervention-specific evaluation results to guide the next steps for each individual intervention	
Weber	Treating anxiety and depression with evidence-based treatment (EBT)	• Revisit its causal/barrier analysis at least annually • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Implement intervention-specific evaluation results to guide the next steps for each individual intervention	Same
Medicaid PAHPs providing dental services			
Premier Access Dental	School based care for Medicaid members	• Continually work on the PIP throughout the year • Consider revisiting the current QI process and use QI science-based tools, such as process mapping, causal/barrier analysis, or FMEA, to identify barriers to improvement • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Ensure that it has accurate member contact information. Success of member outreach through mailers and text interventions is dependent on the accuracy of member contact information	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
MCNA Dental	Annual dental visits	• Initiate a new PIP topic for next year's submission with consultation and approval from DHHS • Continue to expand successful interventions to realize improvement in the overall performance indicator rate • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as MCNA determines and designs the new PIP	Same
CHIP MCEs providing physical health, behavioral health, and substance use disorder services (Healthy U became a CHIP plan in July 2024, PIP topics are in development)			
Molina CHIP	Assessment and counseling for nutrition and physical activity—BMI screening	• Molina CHIP reported Remeasurement 4. Should retire this PIP and initiate a new PIP topic for next year's submission with consultation and approval from DHHS. • Continue to expand successful interventions to realize improvement in the overall performance indicator rate • Apply any lessons learned and knowledge gained through this PIP to other QI processes within the organization • Reach out to HSAG for technical assistance as it determines and designs the new PIP	Same
Select Health CHIP	Well-child visits for CHIP members	• Continually work on the PIP throughout the year • Begin intervention testing in a timely manner to impact the Remeasurement 1 rates • Revisit the causal/barrier analysis at least annually	Same

Health plan	CY2023 PIP topic	PIP recommendations	Current PIP topic
		• In the barriers/interventions table, include details about the nature of the incentive, how the incentive information will be shared with the members, and how the barrier of members not having an assigned PCP will be addressed • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Implement intervention-specific evaluation results that guide the next steps for each individual intervention	
CHIP PAHP providing dental services			
Premier Access CHIP	School based care for CHIP members	• With significant decline in performance, consider revisiting the current QI process and use QI science-based tools, such as process mapping, causal/barrier analysis, or a FMEA, to identify barriers to improvement • Continually work on the PIP throughout the year • Develop an evaluation process and evaluation results for each individual intervention listed in the barriers/interventions table • Ensure that it has accurate member contact information. Success of member outreach through mailers and text interventions is dependent on the accuracy of member contact information.	Same

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Appendix D: Performance measures for MCEs

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Getting needed care (adult)	CAHPS	X	X	X	X	✔		✔				At or above the NCQA National 50th Percentile
Getting needed care (child	CAHPS	X	X			✔	✔	✔				At or above the NCQA National 50th Percentile
Getting care quickly (adult)	CAHPS	X	X	X	X	✔		✔				At or above the NCQA National 50th Percentile
Getting care quickly (child)	CAHPS	X	X			✔	✔	✔				At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Rating of primary care doctor (adult)	CAHPS	X	X	X		✔		✔				At or above the NCQA National 50th Percentile
Rating of primary care doctor (child)	CAHPS	X	X			✔	✔	✔				At or above the NCQA National 50th Percentile
Rating of specialist (adult)	CAHPS	X				✔		✔				At or above the NCQA National 50th Percentile
Rating of specialist (child)	CAHPS	X				✔	✔	✔				At or above the NCQA National 50th Percentile
Rating of health plan (adult)	CAHPS	X	X	X	X	✔		✔				At or above the NCQA National 50th Percentile
Rating of health plan (child)	CAHPS	X	X			✔	✔	✔				At or above the NCQA National 50th Percentile
Rating of all health care (adult)	CAHPS	X	X	X		✔		✔				At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Rating of all health care (child)	CAHPS	X	X			✔	✔	✔				At or above the NCQA National 50th Percentile
How well doctors communicate (adult)	CAHPS	X			X	✔		✔				At or above the NCQA National 50th Percentile
How well doctors communicate (child)	CAHPS	X				✔	✔	✔				At or above the NCQA National 50th Percentile
Customer service (adult)	CAHPS	X			X	✔		✔				At or above the NCQA National 50th Percentile
Customer service (child)	CAHPS	X				✔	✔	✔				At or above the NCQA National 50th Percentile
Childhood immunization (CIS)-combo 10	HEDIS		X									At or above the NCQA National 50th Percentile
Childhood immunization (CIS)-combo 3	HEDIS	X				✔	✔					At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Immunizations for adolescents (IMA)-combo 2	HEDIS	X	X			✔	✔					At or above the NCQA National 50th Percentile
Well-child visits in the first 30 months of life (W30)-0-15 months	HEDIS	X			X	✔	✔					At or above the NCQA National 50th Percentile
Weight assessment & counseling for nutrition and physical Activity for children/adolescents (WCC)-BMI percentile-total	HEDIS	X	X			✔	✔					At or above the NCQA National 50th Percentile
Prenatal and postpartum care (PPC)-timeliness of prenatal care-total	HEDIS	X	X		X	✔		✔				At or above the NCQA National 50th Percentile
Prenatal and postpartum care (PPC)-postpartum care-total	HEDIS	X	X		X	✔		✔				At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Breast cancer screening (BCS)	HEDIS	X	X	X	X	✔		✔				At or above the NCQA National 50th Percentile
Cervical cancer screening (CCS)	HEDIS	X	X	X	X	✔		✔				At or above the NCQA National 50th Percentile
Adult access to preventive and ambulatory health services	HEDIS	X				✔		✔				At or above the NCQA National 50th Percentile
Appropriate treatment for children with upper respiratory infection	HEDIS	X				✔	✔					At or above the NCQA National 50th Percentile
Controlling high blood pressure (CBP)	HEDIS	X	X	X	X	✔		✔				At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Follow-up after hospitalization for mental illness (FUH)- 7 days-total	HEDIS	X	X						✔		✔	At or above the NCQA National 50th Percentile PMHP- At or above the NCQA National 75th Percentile
Follow-up after hospitalization for mental illness (FUH)-30 days-total	HEDIS	X							✔		✔	At or above the NCQA National 50th Percentile PMHP- At or above the NCQA National 75th Percentile
Follow-up after emergency department visit for mental illness (FUM)-7 days-total	HEDIS	X	X					✔				At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Follow-up after emergency department visit for mental illness (FUM)-30 days-total	HEDIS	X						✔				At or above the NCQA National 50th Percentile
Follow-up after emergency department visit for substance use (FUA)-7 days-total	HEDIS	X	X					✔				At or above the NCQA National 50th Percentile
Follow-up after emergency department visit for substance se (FUA)-30 days-total	HEDIS	X						✔				At or above the NCQA National 50th Percentile
Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	HEDIS	X	X	X				✔				At or above the NCQA National 50th Percentile

Measure name	Data source	Program				Applicable to						Target Percentile
		State*	NCQA HPR*	CMS*	QRS*	ACO	CHIP	UMIC	PMHP	Dental	Home	
Diabetes screening and monitoring for people with Schizophrenia or bipolar disorder (SMD)	HEDIS	X						✔				At or above the NCQA National 50th Percentile
Cardiovascular disease screening and monitoring for people with Schizophrenia or bipolar disorder (SMC)	HEDIS	X						✔				At or above the NCQA National 50th Percentile
Initiation and engagement of substance use disorder treatment (IET)—engagement-total	HEDIS	X	X	X				✔				At or above the NCQA National 50th Percentile

Appendix E: Required reports and frequency table

Report	Monitoring	Frequency
MCEs		
Appeals and grievances reports	• Summary and count • Outliers and improvement action plans • Timeliness of resolution and notification • Appeals overturn rates	Semi-annual
Summaries of corrective actions on participating providers	• Corrective actions	Semi-Annual
Claims management	• Encounter data report • Adjudicated claims inventory summary • Pharmacy claims monitoring report • Report of percent of denied or rejected claims.	Monthly
Provider network attribution, access and availability reports	• Provider to member ratios • Time and distance reports • Appointment access reports for routine, urgent, and after-hours care	Annual
Case management reports	• Timeliness of HRA completion • Timeliness of care plan completion • Care coordination effectiveness summary report • Care gap plan • Outreach summary report • Enrollee engagement metrics • Transition of care plan, initially and as revised	Annual
Over/under utilization reports	Reported in percentiles or mean rates:	Annual

Report	Monitoring	Frequency
	• Length of stay • Inpatient days • Discharges • Unplanned admissions • Unplanned readmissions	
Utilization management reports	• Prior authorization report • Timeliness of UM decisions	Monthly
Credentialing/recredentialing reports	• Credentialing/recredentialing rosters • Timeliness of decisions • Prohibited Affiliations with Individuals Debarred by Federal Agencies • Excluded Providers	Monthly
Member experience reports	• CAHPS results • Complaints volume • Complaints per thousands • Customer service telephone line *(call volume, % of call answered within XX seconds, average speed of answer, abandonment rate)*	Annual
Quality and safety of care reports	• HCAC • Critical incidents to include fraud, Waste or Abuse • QOC complaints timeliness	Quarterly
Evidence of accreditation	Accreditation certificates (as applicable) for: • Health plan • Health equity • Utilization management • Credentialing • Provider Network	Within 90 days of notice

Report	Monitoring	Frequency
Appeals and grievances reports	• Summary and count • Outliers and improvement action plans • Timeliness of resolution and notification • Appeals overturn rates	Semi-annual
Provider network attribution, access and availability reports	• Network Adequacy • Provider to member ratios • Time and distance reports • Appointment access reports for routine, urgent, and after-hours care	Annual
Reports on performance measures	• Quality measure results by plan (HEDIS, CAHPS)	Annual
Performance Improvement Projects (PIPs)	• Clinical and non-clinical topics	Annual
Finance, including Medical Loss Ratio (MLR) reporting	• Administrative costs	Annual

DIH's contracts with the MCEs also allow for additional audits of financial records and inspections. DIH may request other reports as necessary to continue to assess QI.

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Appendix F: Resources

Resources
CMS Framework for health equity
CMS meaningful measures initiative
CMS national quality strategy: CMS quality in motion
CMS universal foundation
DHHS critical incident reporting guide ❖ 2023-2024 - Google Docs
Health coverage for American Indians & Alaska Natives
HEDIS: Utah Medicaid and CHIP health plans
Medicaid and CHIP quality rating system
Medicaid manage care plans
Required HEDIS, CAHPS and HOS measures reporting year 2025)
Roadmap to better care - tribal version
2010 Performance audit of Utah Medicaid managed care
2025 Core set of adult quality measures for Medicaid (adult core set)
2025 Core set of children's health care quality measures for Medicaid and CHIP (child core set)

Resources
Utah Health Plan Data The Utah health plan data links to the comprehensive list of metrics that will be published at least annually.
Utah Medicaid Integrated Health
Utah Medicaid Managed Care
Utah Medicaid and CHIP Annual Reports
Utah Medicaid Provider Manuals

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Appendix G: Acronyms and definitions

Acronym & term	Definition
ACB: Authorized certification body	An organization that is accredited by the Office of the National Coordinator for Health Information Technology (ONC) to certify health IT products (such as Electronic Health Records, or EHRs) for compliance with federal standards. These certifications are essential for healthcare providers who participate in Medicaid and Medicare programs, particularly for meaningful use and incentive programs related to health IT.
ACO: Accountable care organization	MCEs that contract with DHHS to provide medical services to Medicaid members.
AI/AN: American Indian/Alaska Native	Any person who is a member of an Indian tribe, irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second

Acronym & term	Definition
	degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary. Medicaid programs and benefits for AI/AN populations have specific provisions designed to address the unique needs and circumstances of these communities.
APCD: All-payer claims database	A system that collects, analyzes, and reports health insurance claims data from a variety of payers, including Medicaid, Medicare, private insurance, and sometimes self-pay individuals. The goal of an APCD is to provide a comprehensive view of healthcare utilization, costs, and outcomes across all populations in a given region, enabling more effective healthcare policy development, cost containment, and quality improvement.
API: Application programming interfaces	A set of rules, protocols, and tools that allow different software applications to communicate with each other. APIs define the methods and data structures that developers can use to interact with the functionality of a system, service, or platform without needing to know the internal workings of that system.
APM: Alternative payment model	An alternative payment model (APM) incentivizes providers to deliver higher-quality, cost-effective care though alternative reimbursement methodologies. While APMs are designed to incentivize value-based care, they are versatile and can be adapted to work under the more widely used fee-for-service care model.
BAC: Beneficiary Advisory Council	A group formed to represent the interests and concerns of Medicaid members (individuals receiving Medicaid benefits) to provide feedback, advice, and recommendations on how Medicaid services and policies can be improved from the perspective of the members.
CAHPS: Consumer assessment of healthcare providers and systems	A nationally utilized survey that measures patient experiences with healthcare services and providers. The surveys are used to improve the quality of health care and to help consumers choose health plans.
CAP: Corrective action plan	A formally documented strategy developed to address deficiencies or non-compliance with program requirements or performance standards identified during an audit, review, or performance assessment. Medicaid agencies or managed care entities (MCEs) may be required to implement a CAP if there are issues related to quality of care, operational processes, or legal/regulatory requirements.

Acronym & term	Definition
cHIE: Clinical health information exchange	A type of Health Information Exchange (HIE) that allows individuals (consumers) to access, share, and manage their health data across different healthcare providers and settings. cHIEs are designed to empower patients by giving them more control over their own health information and facilitating communication between healthcare providers.
CHIP: Children's Health Insurance Program	CHIP is an all-encompassing benefit program for nearly 6.7 million uninsured children nationwide. Eligibility for the program is most often determined financially, and is federally required to provide primary care, dental care, behavioral health services, and vaccinations for children from birth to age 19.
CHIPAC: CHIP Advisory Committee	A committee regulatorily required to advise and provide guidance on the Children's Health Insurance Program (CHIP). CHIP Advisory Committees serve as a platform for input and feedback from a range of stakeholders to improve the effectiveness and accessibility of the CHIP at the state level.
CLAS: Culturally and linguistically appropriate services	Healthcare services that are designed and delivered in a way that is respectful of, and tailored to, the cultural, linguistic, and social needs of patients from diverse backgrounds. The goal of CLAS is to reduce health disparities, improve patient outcomes, and enhance the patient experience by providing care that is sensitive and responsive to cultural and language differences.
CMS-9115-F: Interoperability and patient access final rule	A set of regulations issued by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC). It was designed to improve interoperability (the ability for health IT systems to work together and exchange data) and patient access to their health information across the U.S. healthcare system.
CMS: Centers for Medicare and Medicaid Services	The Centers for Medicare and Medicaid Services (CMS) is a federal organization that provides services and programs funded under Medicare, Medicaid, and Children's Health Insurance Program (CHIP). CMS works with payers and providers on the state level to help deliver these programs properly through research, administration, and guidance.
CY: Calendar year	A calendar year is a one-year period that begins on January 1 and ends on December 31, based on the commonly used Gregorian calendar.
DHHS: Department of Health and	The Utah state department is responsible as the single state agency for overseeing Medicaid and CHIP, as well as other health and human service programs.

Acronym & term	Definition
Human Services	
DHSC: Digital Health Service Commission	A state-level body in Utah focused on advancing the use and implementation of digital health technologies and services within the state. This commission aims to support the growth of digital health initiatives, such as telemedicine, electronic health records (EHRs), health information exchange (HIE), and other technology-driven solutions in healthcare.
DIH: Division of Integrated Healthcare	The Division within the Utah Department of Health and Human Services (DHHS) responsible for managing Utah's Medicaid and Children's Health Insurance Program.
DWS: Department of Workforce Services	The state agency responsible for providing a variety of services and programs related to employment, workforce development, and economic assistance in Utah. DWS determines eligibility for Medicaid and CHIP programs. The department's mission is to help individuals and families achieve economic self-sufficiency and support the state's economic growth through various services and initiatives.
eCQM: Electronic clinical quality measure	A type of quality measure that is used to assess the quality of care provided to patients, with the data being collected and reported electronically from a healthcare provider's electronic health record (EHR) system or other health information technology (HIT) systems.
EHR: Electronic health record	An electronic health record (EHR) is a real-time patient health record that supports the collection of data for clinical care and decision-making as well as billing, quality management, outcome reporting and public health surveillance and reporting. EHRs are a type of health information technology.
EQR: External quality review	A process used to evaluate the quality of care provided by Medicaid managed care entities (MCEs). This review is conducted by an independent entity, separate from the Medicaid program itself, to ensure that the care delivered meets certain standards and complies with Medicaid requirements. The goal of the EQR process is to ensure that Medicaid beneficiaries receive high-quality, effective, and efficient care.
EQRO: External quality review organization	An independent entity responsible for evaluating the performance and quality of Medicaid managed care entities (MCEs). EQROs provide an objective, third-party assessment of how well MCEs are meeting the standards and requirements set forth by CMS and the corresponding federal Medicaid managed care regulations.

Acronym & term	Definition
FFE: Federally facilitated exchanges	An online marketplace established by the federal government under the Affordable Care Act (ACA), where individuals, families, and small businesses can shop for and purchase health insurance coverage. The exchange serves as a platform to help consumers compare plans, access subsidies (financial assistance), and enroll in coverage. FFEs are one of the three types of Health Insurance Marketplaces created by the ACA.
FFS: Fee for service	A traditional health care model where providers are reimbursed for each service they provide for Medicaid members who are not enrolled with an MCE.
FHIR: Fast healthcare interoperability resources	A standard for electronic health information exchange designed to improve interoperability and enable easier sharing of health data across different systems and platforms. FHIR was developed by HL7 International, a leading organization in health data standards, to address the challenges of sharing medical information in a way that is both secure and standardized across the healthcare industry.
HAC: Hospital-acquired condition	Medical conditions or complications that a patient develops during a stay in a healthcare facility, which were not present or incubating when they were admitted and are typically considered preventable through proper hospital protocols, patient care, and infection control measures.
HCAC: Health-care-acquired conditions	Medical conditions a patient can develop during health care encounters that were not present upon admission to an inpatient facility.
HEDIS: Healthcare effectiveness data and information set	A set of performance measures used to assess the quality of care provided by health plans. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is widely used by health plans, regulators, and policymakers to evaluate and compare the effectiveness of healthcare services.
HIA : Health care information and analysis	A program within the Utah Department of Health and Human Services (DHHS), Data Systems and Evaluation unit that is responsible for collecting, analyzing, and disseminating healthcare data.
HIE: Health information exchange	Health information exchange (HIE) is the act of electronic sharing of patient information between legally authorized health care providers or an individual/entity that enables exchange of electronic health information for a limited set of purposes. HIEs are a type of health information technology.

Acronym & term	Definition
HIPAA: Health Insurance Portability and Accountability Act	The Health Insurance Portability and Accountability Act is a U.S. law designed to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers.
HIT: Health information technology	Health information technology (HIT) that supports the exchange of health information in an electronic environment.
HOME: Healthy Outcomes Medical Excellence	A coordinated care program for people with developmental disabilities that provides medical and behavioral health care. Enrollees in this MCE program receive comprehensive and coordinated care services.
HRSN: Health-related social needs	The social and environmental factors that can influence an individual's overall health, well-being, and access to healthcare services. These are the non-medical factors in a person's life that can impact their ability to stay healthy, manage chronic conditions, or access quality healthcare. Addressing health-related social needs is critical for improving health outcomes, reducing health disparities, and promoting health equity, particularly in vulnerable populations.
I/T/U: Indian health service, tribal 638, and urban Indian organizations	The system that provides healthcare services to American Indian and Alaska Native populations, encompassing care delivered through the Indian Health Service (IHS), Tribal 638 organizations, and Urban Indian organizations.
IBIS-PH: Indicator-based information system for public health	A public health data system that provides access to health-related data and indicators for tracking health outcomes, identifying trends, and supporting public health decision-making. IBIS-PH is designed to help public health professionals, researchers, policymakers, and the public to access and interpret data on a wide range of health topics.
IDS: Integrated delivery systems	Networks of healthcare providers and organizations that work together to offer a continuum of care across different levels and settings. These systems are designed to coordinate and integrate various aspects of healthcare services, from prevention and primary care to acute care and rehabilitation, with the goal of improving health outcomes, enhancing efficiency, and reducing overall healthcare costs.
IHI: Institute of Healthcare Improvement	is a leading nonprofit organization that works to improve the quality, safety, and efficiency of healthcare systems worldwide. It does this by developing and promoting innovative improvement methodologies,

Acronym & term	Definition
	providing education and training, and supporting collaborative projects to enhance patient outcomes.
IHS: Indian Health Service	A federal agency within the U.S. Department of Health and Human Services (HHS) that provides comprehensive health services to American Indian and Alaska Native populations. Its mission is to raise the health status of these populations to the highest possible level.
Indian tribe	Any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
IPR: Individual plan report	Typically refers to documents or reports that are created for individual beneficiaries to track their health care services, treatment plans, progress, and outcomes. These reports are especially relevant in managed care settings, where Medicaid beneficiaries receive care through managed care entities (MCEs) or other health plans that provide Medicaid benefits. The purpose of these reports is to document and monitor the specific care needs of individual beneficiaries to ensure they receive the appropriate services and that their care is coordinated effectively.
LACE risk score	An assessment that identifies patients who are at risk for readmission or death within thirty days of discharge. ● "L": The length of stay of the admission ● "A": The acuity of the admission (emergency or elective) ● "C": Co-morbidities (the Charlson Co-Morbidity Index) ● "E": The number of Emergency Department visits within the last 6 months LACE scores range from 0 to 19: ● 0–4: Low probability of readmission or death within thirty days of discharge ● 5-9: Moderate probability of readmission or death within thirty days of discharge ● ≥10: High probability of readmission or death within thirty days of discharge
LAN: Learning and Action Network	An initiative designed to promote the adoption of Alternative Payment Models (APMs) and Value-Based Care. The Learning and Action Network is part of a broader strategy to shift the healthcare system away from traditional fee-for-service models to ones that focus on improving patient

Acronym & term	Definition
	outcomes, reducing costs, and increasing efficiency.
LTSS: Long-term services and supports	Coordinated across providers and settings, long-term services and supports include a range of services that assist individuals with functional limitations on their ability to carry out daily activities. Among the millions of children, adults, and seniors making use of long-term services and supports in the United States, Medicaid is the leading payer.
MAC QRS: Medicaid and CHIP Quality Rating System	A standardized tool developed by the Centers for Medicare & Medicaid Services (CMS) to assess and rate the quality of care provided by Medicaid and the Children's Health Insurance Program (CHIP). The system aims to provide transparent, comparable information to help beneficiaries, Medicaid and CHIP beneficiaries, health plans, and policymakers evaluate the quality of care within these programs.
MAC: Medicaid Advisory Committee	A group established by a state's Medicaid agency to provide guidance and recommendations on the design, implementation, and operation of the state's Medicaid program. These committees are typically composed of individuals with expertise in healthcare, public policy, and community needs, as well as representatives from the beneficiary population and stakeholders, such as providers, advocacy organizations, and health plans.
MCE: Managed care entity	An organization identified as an MCO, PIHP, PAHP under contract with DHHS to manage the delivery of health care benefits to Medicaid and CHIP members.
Population Care	An innovative healthcare delivery model that focuses on strengthening primary care as the foundation for improving health outcomes, enhancing patient experience, and reducing healthcare costs. Developed by the Centers for Medicare & Medicaid Services (CMS), the Population Care model aims to transform the way care is delivered by creating a more patient-centered, comprehensive, and coordinated approach to primary care.
MCQS: Managed care quality strategy	A comprehensive framework developed by state Medicaid programs to monitor, improve, and ensure the quality of care provided to Medicaid and CHIP members. It outlines the state's approach to enhancing healthcare delivery, improving health outcomes, and meeting federal and state requirements for quality in managed care services.
MIPS: Merit-based Incentive Payment System	A component of the Quality Payment Program (QPP) established by CMS under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MIPS aims to improve the quality of care for Medicare beneficiaries by

Acronym & term	Definition
	linking reimbursement rates to the performance of healthcare providers.
MMIS: Medicaid Management Information System	An automated system that manages Medicaid claims processing and information retrieval. It contains claims, eligibility and provider data.
NCQA: National Committee for Quality Assurance	An independent 501(c)(3) nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. The National Committee for Quality Assurance operates on a formula of measure, analysis, and improvement and it aims to build consensus across the industry by working with policymakers, employers, doctors, and patients, as well as health plans.
OEH: Office of Health Equity	The Office within the Utah Department of Health and Human Services (DHHS) Office of Health Equity (OHE) charged with reducing health disparities and improving health equity in Utah. The OHE's vision is that everyone has a fair chance to reach their highest health potential.
OMH: Office of Managed Healthcare	The Office within the Division of Integrated Healthcare (DIH) within the Utah Department of Health and Human Services (DHHS) responsible for oversight of the managed care model of health care delivery for Medicaid and CHIP services.
ONC: Office of the National Coordinator for Health IT	A U.S. government office within the Department of Health and Human Services (HHS). The ONC is responsible for advancing the use of health information technology (health IT) to improve the quality, safety, and efficiency of healthcare in the United States. It is a key entity in the federal government's efforts to promote interoperability and the secure exchange of electronic health information across the healthcare system.
OPPC: Other provider preventable conditions	A category of conditions or events that are preventable and occur due to the actions or negligence of healthcare providers during medical care. These conditions include complications, errors, or adverse events that could have been avoided with proper care, adherence to established standards, and quality practices.
OQ: Outcomes questionnaire©	A tool used to measure the behavioral health outcomes of individuals receiving behavioral health services, including those enrolled in Medicaid. It is designed to track the progress of patients receiving treatment for behavioral health conditions and assess the effectiveness of care provided.

Acronym & term	Definition
PDSA: Plan-Do-Study-Act	Plan-Do-Study-Act (PDSA) is a four-step method for testing changes and improving processes: Plan: Develop a plan to test a change; Do: Carry out the test; Study: Observe and learn from the results; Act: Determine what modifications should be made to the test. It is a problem-solving model that can be used in many contexts, including healthcare, education, and business. It's a valuable tool for continuously learning and improving, and it's often used throughout the life of a project.
PHM: Population health management	A proactive and data-driven approach to improving the health outcomes of a specific group or population. The goal of population health management is to improve the health and well-being of entire communities or populations by focusing on preventing disease, managing chronic conditions, reducing healthcare disparities, and enhancing the overall quality of care. PHM typically involves collecting and analyzing data to identify health trends, target interventions, and coordinate care across various healthcare providers and services.
PIP: Performance improvement project	A structured plan developed by each MCE aimed at improving the quality of care and services provided to Medicaid beneficiaries.
PMHP: Prepaid mental health plan	A managed care entity under contract with DHHS to manage the delivery of behavioral health services to Medicaid members.
PQOC: Potential quality of care	The theoretical or expected quality of care that a patient might receive under ideal circumstances or conditions, based on best practices, clinical guidelines, and available resources. It is a concept used to assess how well a healthcare system or provider could deliver care if there were no barriers such as financial constraints, lack of resources, or other challenges. PQOC focuses on the capacity and infrastructure to provide high-quality care, rather than the actual outcomes experienced by patients.

Acronym & term	Definition
PRC: Purchased/referred care	A program within the Indian Health Service (IHS) that helps American Indian and Alaska Native (AI/AN) individuals access specialized healthcare services that are not available through the Indian Health Service or tribal health programs. When AI/AN individuals need care that exceeds the capabilities of local IHS clinics or hospitals, the PRC program provides funding for medical services purchased from private providers or other healthcare facilities. Formerly known as Contract Health Services (CHS).
PRISM: Provider Reimbursement Information System for Medicaid	Utah's Medicaid Management Information System (MMIS) designed to support the administration and operations of Medicaid.
QAPIP: Quality assessment and performance improvement plan	An ongoing comprehensive quality assessment and performance improvement program each MCO, PIHP, and PAHP contracted with the Utah Department of Health and Human Services must establish per 42 CFR 438.330.
QHIN™: Qualified Health Information Network®	A term used in the context of health information exchange (HIE) and interoperability in the United States healthcare system. A QHIN is an entity or network that facilitates the secure exchange of electronic health information across different health systems, organizations, and healthcare providers. These networks are designed to enable better access to health data to improve care coordination, patient outcomes, and the overall healthcare system's efficiency.
QHP: Qualified health plan	A health insurance plan that meets the requirements of the Affordable Care Act (ACA) and is certified by the Health Insurance Marketplace.
QI: Quality improvement	Efforts to enhance the effectiveness, efficiency, and safety of healthcare services.
QIC: Quality Improvement Council	A group or committee established by Medicaid agencies, managed care entities (MCEs), or other stakeholders to oversee and guide efforts to improve the quality of care provided to Medicaid beneficiaries. The council typically plays a key role in ensuring that Medicaid programs meet or exceed standards for quality, efficiency, and effectiveness of healthcare services.
QOC: Quality of care	The degree to which healthcare services provided to individuals or populations improve the likelihood of desired health outcomes, consistent with professional knowledge, patient preferences, and standards of care.

Acronym & term	Definition
	It encompasses multiple dimensions, including the effectiveness, safety, accessibility, and patient-centeredness of healthcare services.
QRP: Quality reporting program	A structured system designed to collect, track, analyze, and report data related to the quality of care and services provided to Medicaid beneficiaries. The primary goal of such systems is to measure the effectiveness of Medicaid programs, ensure accountability, and improve the quality of healthcare provided to recipients.
RBA: Results-based accountability	A simple data-driven framework that can give organizations across sectors a common language for describing the impact they are seeking. This has been a particularly helpful framework for collaboration between public health and the private sector.
REH: Rural emergency hospital	A type of healthcare facility created to provide emergency care and certain essential medical services in rural areas, particularly in regions where traditional full-service hospitals may no longer be financially viable or where access to emergency services is limited. REHs are part of an effort to address the unique challenges faced by rural communities in maintaining access to emergency care and basic healthcare services, while also offering a model that allows rural facilities to continue to operate in a sustainable manner.
REL: Race/ethnicity, language	A set of categories and factors used in healthcare systems to collect, analyze, and understand data related to the race, ethnicity, and primary language of patients or beneficiaries.
SFY: State fiscal year	A 12-month period (July 1-June 30) used by state governments for budgeting, accounting, and financial reporting purposes. It marks the time frame during which a state's budget is planned, allocated, and tracked. This period can differ from the calendar year and is crucial for managing and reporting state finances.
SMARTER: specific, measurable, achievable, relevant, timebound, evaluate and review	An expanded version of the widely used SMART goals framework. The SMART framework is commonly used in healthcare, business, project management, and personal development to set clear, actionable goals. The SMARTER model builds on this by adding two additional steps—Evaluate and Review—to encourage ongoing assessment and continuous improvement.

Acronym & term	Definition
SOGI: Sexual orientation, gender identity	Terms used to describe an individual's sexual preferences and their understanding or expression of gender. Collectively, SOGI is used to encompass both sexual orientation (who someone is attracted to) and gender identity (how someone personally experiences and expresses their gender).
SSDI: Social Security Disability Insurance	A federal benefits program that provides income to those who are unable to work due to a disability.
TJC: The Joint Commission health equity accreditation	The Joint Commission health equity accreditation, also known as "The Joint Commission Health Care Equity Certification," is a voluntary advanced certification program offered by The Joint Commission that recognizes healthcare organizations actively working to achieve health equity by addressing disparities in care across patient populations, including through staff diversity, data collection practices, and leadership initiatives aimed at closing gaps in access and quality of care; essentially, it signifies a commitment to providing equitable care to all patients regardless of background.
TCC: Total cost of care	The complete sum of all healthcare expenses incurred by an individual beneficiary for the full range of services they receive. This includes the direct costs of medical care as well as any administrative or service-related costs associated with their treatment.
UHIN: Utah Health Information Network	The Utah Health Information Network is a non-profit organization that provides secure electronic exchange of health information among various healthcare providers, payers, and other stakeholders in Utah. UHIN services include electronic claims processing, clinical document exchange, electronic prescribing, and clinical data sharing.
UIHAB: Utah Indian Health Advisory Board	A state-level advisory board established to represent the interests of Utah's tribes in matters related to health care and public health. The board provides guidance and recommendations to the state and other health organizations about the health needs, priorities, and concerns of Utah's American Indian and Alaska Native populations.
UIO: Urban Indian Organization	A type of healthcare provider that serves American Indians and Alaska Natives (AI/ANs) living in urban areas, offering a range of medical, dental, behavioral health, and other social services.

Acronym & term	Definition
UM: Utilization management	A set of processes used by healthcare providers, insurers, and organizations to ensure that patients receive medically necessary, appropriate, and cost-effective care. Utilization management is designed to evaluate the use of healthcare services, such as hospital stays, medical procedures, and prescription medications, and determine whether the care provided is consistent with established guidelines and protocols. The goal is to balance quality care with cost containment, ensuring that resources are used efficiently without compromising patient outcomes.
UMIC: Utah Medicaid Integrated Care	A type of MCE under contract with DHHS to manage physical health and behavioral health services delivered to Adult Expansion Medicaid members.
UPHMS: Utah's Population Health Management System	A DIH initiative designed to enhance the management and integration of population health information across Medicaid and CHIP. The goal is to improve the delivery of healthcare services through better data management, information sharing, and technology use. As of summer 2024, Utah's vendor for UPHMS is Onpoint Health Management.
USIIS: Utah Statewide Immunization Information System	An electronic health information system managed by the Utah Department of Health and Human Services (DHHS) designed to track and maintain comprehensive records of immunizations for individuals in Utah, helping ensure that people receive the right vaccines at the right times and facilitating access to immunization information for healthcare providers, parents, and public health officials.
VBP: Value-based purchasing	A healthcare strategy that incentivizes healthcare providers (such as hospitals, physicians, and other health systems) to deliver high-quality services while controlling costs. Unlike traditional fee-for-service (FFS) models where providers are paid based on the volume of services they deliver, value-based purchasing focuses on rewarding healthcare providers for the value of the care they provide, as measured by outcomes, patient satisfaction, and efficiency.
YOQ: Youth Outcomes Questionnaire©	A tool used to measure the mental health outcomes of children and adolescents receiving behavioral health services, including those enrolled in Medicaid. It is designed to assess the effectiveness of treatment for youth with emotional and behavioral issues, helping providers track changes in the youth's psychological well-being, functioning, and overall progress during treatment.