

STATE OF UTAH

GARY R. HERBERT
GOVERNOR

OFFICE OF THE GOVERNOR
SALT LAKE CITY, UTAH
84114-2220

SPENCER J. COX
LIEUTENANT GOVERNOR

June 26, 2015

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

Dear Secretary Burwell:

In compliance with the special terms and conditions (STCs) set forth by the Centers for Medicare and Medicaid Services (CMS), the state of Utah is requesting an additional one-year extension of the 1115 Primary Care Network (PC) Demonstration Waiver. On December 19, 2014, CMS granted an extension of the waiver (Projects Nos. 11-W-00145/8 and 21-W-00054/8) until December 31, 2015. This extension request will permit Utah to continue operating this waiver through December 31, 2016.

As you know, Utah continues to work toward a compromise plan that will allow our state to provide coverage to more uninsured adults. This process will require legislative action, as well as additional amendments to our current waiver. The implementation of a compromise plan will likely take place in calendar year 2016. In the meantime, there are approximately 15,700 Utahns who continue to rely on the Primary Care Network Waiver for access to preventive and emergency health care. It is critical that we maintain this important safety net while the state of Utah addresses the important issue of how to cover the uninsured.

Thank you for considering our waiver extension request. We look forward to your response. Should you have questions about this matter, please contact Dr. David Patton, executive director of the Utah Health Department, at (801) 538-6111 or dpatton@utah.gov.

Sincerely,



Gary R. Herbert
Governor



State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

Joseph Miner, MD.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

November 2, 2015

Shanna Janu
Project Officer
Division of State Demonstrations and Waivers
Centers for Medicaid and Medicaid
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Shanna:

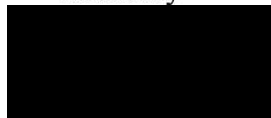
Re: Utah's "Primary Care Network" 1115 Demonstration Waiver (Projects Nos. 11-W-1145/8 and 21-W-00054/8)

In response to the letter from Angela Gardner to Michael Hales dated July 09, 2015, please find enclosed the following documents

1. An Historical narrative of the demonstration
2. A statement within the narrative indicating that there will be no changes to the demonstration and that the same waivers and expenditure authorities will apply to the extension period
3. A copy of our last EQRO report as documentation on the quality and access to care provided under the demonstration
4. A preliminary evaluation of the demonstration.
5. Documentation that the state has meet the public notice requirements.

Please let me know if you have any additional questions or require additional documents to complete our request for a one year extension of our Primary Care Network 1115 Demonstration Waiver.

Sincerely



Emma Chacon
Assistant Director
Division of Medicaid and Health Financing



UTAH DEPARTMENT OF
HEALTH

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Utah 1115 Demonstration Waiver

**1115 Demonstration Waiver
Extension Request**

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

**Extension Period
January 1, 2016 through December 31, 2016**

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Section 1: Extension Request

Utah is seeking a one-year extension of the Primary Care Network Demonstration Waiver. The Utah State Legislature continues to debate the issue of Medicaid expansion for the optional adults. Legislative Leadership indicates that this issue will be addressed further during the 2016 Legislative Session. The General session is scheduled to run from January 25, 2016 through March 10, 2016. In order to avoid any gap in coverage for the individuals currently covered under this waiver, Utah is asking for an additional one year extension. The State of Utah is not requesting any changes to the demonstration and the same waivers and expenditure authorities will apply in the extension period.

Should the Utah Legislature approve expansion for the optional adult population, Utah will seek to amend this waiver as mechanism to obtain CMS approval for Utah's expansion program. If the Utah Legislature chooses not to expand Medicaid, Utah will submit a request for a full renewal of this current waiver by summer 2016.

Letter from the Governor

The State has included the letter from Governor Gary R. Herbert to Secretary Sylvia Matthews Burwell, Department of Health and Human Services dated June 26, 2015, requesting an additional one year extension of Utah's 1115 waiver.

Section 2: History of Utah's 1115 Waiver

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

The 2014 Utah Health Status Survey indicates that 10.3% of Utahns (303,500 individuals) remained uninsured. Of those uninsured, 82% (249,000) are adults between the ages of 19 and 64. With regards to income, approximately 85,600 uninsured adults are between 0-138 percent FPL.

The intent of Utah 's Primary Care Network Demonstration waiver is to allow up to 25,000 uninsured adults whose income is below 95% of the federal poverty level to access a limited health care benefit focused on preventative care. The Primary Care Network (PCN) provides these individuals with ongoing access to primary care, pharmacy (up to four prescriptions per month) and emergency room coverage as well as other limited services.

In order to fund the cost of providing services to a portion of uninsured adults, under 95 percent FPL, parent and care taker relatives with incomes below 46 percent FPL

receive a slightly reduced benefit package. While reduced, the benefit package is still comprehensive and meets essential benefit requirements.

HISTORY

- The Utah PCN 1115 demonstration waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.
- **Amendment #1** - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those age 19 and above who are eligible through sections 1925 and 1931) in the demonstration who become pregnant get the full Medicaid State plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform to changes to the benefits available under the State plan. Finally, it increased the co-payment for hospital admissions from \$100 to \$220, again to conform with changes to the State plan. (Approved on August 20, 2002, effective on July 1, 2002.)
- **Amendment #2** - This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the State subsidizes the employee's portion of the premium for up to 5 years. The employer-sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over 5 years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer-sponsored plan. With this amendment, the State was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the \$50 fee was prohibitive as they earn less than

\$260 per month. For this population, the State reduced the enrollment fee to \$15. (Approved on May 30, 2003, effective on May 30, 2003.)

- **Amendment #3** - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from \$50 to \$25. (Approved on July 6, 2004, effective on July 6, 2004.)
- **Amendment #4** - This changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the "Current Eligibles" ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the State provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005.)
- **Amendment #5** - This amendment implemented the adult dental benefit for the "Current Eligibles" population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005.)
- **Amendment #6** - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006.)
- **Amendment #7** - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from \$2.00 per prescription to \$3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #8** - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006.)
- **Amendment #9** - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (ESI) (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this amendment suspends Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006.)

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

and cost sharing between direct coverage and the ESI plan so that they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

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

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

percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the State under these STCs.

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

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

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

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

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

Section 1115(f) Extension – On December 28, 2012 the State of Utah formally requested an extension of their PCN 1115 Demonstration waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration was set to expire June 30, 2013. The request was to renew the waiver for the period of July 1, 2013-June 30, 2016. CMS never acted on the request for extension. The extension was informally placed on hold pending Utah’s decision to expand Medicaid to the optional adult population between 0-138 percent FPL.

Request for One Year Extension- Effective December 24, 2013, CMS extended the Waiver until December 31, 2014.

Request for One Year Extension- effective December 19, 2014, CMS extended the Waiver until December 31, 2015.

Section 3: Program Description and Objectives

Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration to expand Medicaid coverage to certain able-bodied adults who are not eligible for State plan services and to offer these adults and children eligible for CHIP an alternative to traditional direct coverage public programs. For State plan eligibles who are categorically or medically needy parents or other caretaker relatives, the Demonstration provides a reduced benefit package and requires increased cost-sharing. Savings from this State plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 to 64 with family incomes up to 95 percent of the Federal Poverty Level (FPL). This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also high-risk pregnant women, whose resources made them ineligible under the State plan, were covered under the Demonstration for the full Medicaid benefits package until January 1, 2014. The implementation of ACA eliminated the need for a waiver for this population.

The PCN Demonstration was amended in October 2006 to also use Demonstration savings to offer assistance with payment of ESI premiums through Utah's Premium Partnership for Health Insurance (UPP). The UPP program uses Title XIX funds to provide up to \$150 per month in ESI premium assistance to each uninsured adult in families with income up to 150 percent FPL. UPP also uses Title XXI funds to provide premium assistance up to \$120 per month per child for CHIP eligible children with family income up to 200 percent FPL. UPP children receive dental coverage through direct CHIP coverage or they receive an additional \$20 per month if they receive dental coverage through the ESI.

Effective December 18, 2009, the PCN Demonstration was further amended to enable the State to provide premium assistance to children and adults for coverage obtained under the provisions of COBRA.

Effective September 2012, the waiver was further amended to allow adults up to 200% of the FPL be eligible for premium assistance for ESI or COBRA continuation coverage. Effective January 1, 2014, the PCN Demonstration was amended to reduce the eligibility income level for Demonstration Population I to 100 percent FPL consistent with the changes in eligibility with the implementation of ACA. In addition, this extension required Utah to use MAGI based methodologies for determining income. Further the extension approved a transition plans to move Demonstration I individuals with incomes at 100 percent FPL or greater off of the PCN program and to the federal marketplace. Finally this extension also amended the waiver to require cost sharing for all demonstration populations, where applicable, consistent with the Utah Medicaid state plan.

Section 4: Compliance with Special Terms and Conditions

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

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

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

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

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

Utah remains within the budget neutrality expenditure cap for all populations.

Section 6: Compliance with Budget Neutrality Requirements

See Attachment

Section 7: Program Evaluation

See Attachment

Section 8: Public Notice and Tribal Consultation

Public Notice of the State's request for renewal and amendment and notice of Public Hearing was published in the Utah State Bulletin on October 15, 2015

On October 22, 2015 the State held a public hearing from 3:30 PM to 5:30 PM to take public comment on the extension request.

On September 11, 2015, a presentation regarding the request for renewal of Utah's 1115 Waiver and amendments was provided to the Utah Indian Health Advisory Board. This is the first step in our approved consultation process. The Tribes did not request additional consultation.

On June 16, 2015, the State the States's request for an additional one year extension of the PCN Waiver was discussed during the Medical Care Advisory Committee from 1:30PM to 3:30 PM and took public comment on the PCN Demonstration Waiver extension request.

Section 9: Quality Initiatives

State plan eligibles in thirteen counties receive physical health services through full risk capitated Medicaid Accountable Care Organizations (ACO) managed care plans.

Mental health and Substance Use Disorder services for populations covered under this waiver are also provided through pre-paid mental health plans (PAHPs). A copy of the State's latest External Quality Review Organization report is included with this request for renewal.

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



UTAH DEPARTMENT OF
HEALTH

Preliminary Evaluation of Utah's 1115 Primary Care Network Demonstration Waiver

Information about the Demonstration

Title: 1115 Primary Care Network Demonstration Waiver

Awardee: Utah Department of Health

Timeline:

December 11, 2001	Waiver submitted
February 8, 2002	Approved
July 1, 2002	Implemented
June 30, 2007	Original expiration date
June 30, 2010	Extension expiration date
June 30, 2013	Extension expiration date
December 31, 2014	Extension expiration date
December 31, 2015	Extension expiration date

A Brief History of the Demonstration

Utah's 1115 waiver is a statewide demonstration to cover previously uninsured individuals through alternative benefit packages. This demonstration uses increased flexibility with current State plan eligibles to fund a Medicaid expansion for uninsured adults age 19 and older with incomes up to 95 percent of the Federal poverty level (FPL). It is known as the Primary Care Network (PCN). The waiver also includes coverage for High-Risk pregnant women whose assets exceed the current Medicaid asset limit.

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

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

The original Utah 1115 waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire

on June 30, 2007. On December 21, 2006, the waiver was extended through June 30, 2010. On June 23, 2010, the waiver was extended through June 30, 2013. The waiver continues to be extended on a yearly basis pending the State of Utah determining whether or not it will expand Medicaid for optional adults.

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

Population Groups impacted

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

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

Demonstration Population #2 – Pregnant women with High-Risk pregnancies: Previously uninsured women who face a \$5,000 asset co-pay to enroll in traditional Medicaid. With the implementation of ACA and the elimination of Utah's asset test, this population is no longer covered under the waiver.

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

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

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

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

Purposes, aims, objectives, and goals of the demonstration

Overarching strategy, principles, goals, and objectives

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

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

State's hypotheses on outcomes of the demonstration

There are five hypotheses in this demonstration that will be evaluated

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

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

- a. Reducing the number of Utahns without coverage for primary health care.
- b. Improving PCN enrollees' access to primary care.
- c. Improving the overall well-being in the health status of PCN enrollees.

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

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

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

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

Key interventions

Implementation and administration of the Primary Care Network program (PCN.)

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

Evaluation Design

General Approach to Evaluation

Data Sources

Claims Data: The State has access to claims data for PCN through the State's fee for service system. We will use that data to monitor utilization patterns and costs. The State also has access to claims and encounter data for Current Eligibles who are affected by this demonstration. Current Eligibles in Weber, Davis, Salt Lake and Utah counties are enrolled in managed care. Effective July 1, 2015, Current Eligibles in nine (9) additional counties are now required to enroll in a MCO for their health care except for specific carved out services.

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

Comparison groups

Where possible, the State compares PCN enrollee utilization and health status to similar populations within traditional Medicaid and eligibles.

Introduction

Historically, Utahns age 19 to 64 have the highest rate of un-insurance in the state. The rate of un-insurance is highest among adults with family incomes below 100 percent of the Federal Poverty Level (FPL)—the working poor—a group that, even though employed, is not able to acquire or afford health insurance through their employers.

In 2011, 18.7 percent of all Utahns age 19-64 declared that they were uninsured. During that same year (2011), 13.2 percent of Utahns employed full-time were uninsured while 41.3 percent of Utahns with a household income below 95 percent FPL were uninsured. As of 2014, the rate of uninsurance in this group dropped to 14.7%. This is still too high and this leaves many Utahns at risk. It is this group that Utah's Primary Care Network (PCN) was designed to serve by offering limited benefits to cover their day-to-day needs and to encourage them to appropriately use the health care system. The basic goal of PCN is to serve a larger percentage of this income group with basic benefits than could be served if the coverage were more comprehensive.

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

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

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

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

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

Evaluation of Hypotheses

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

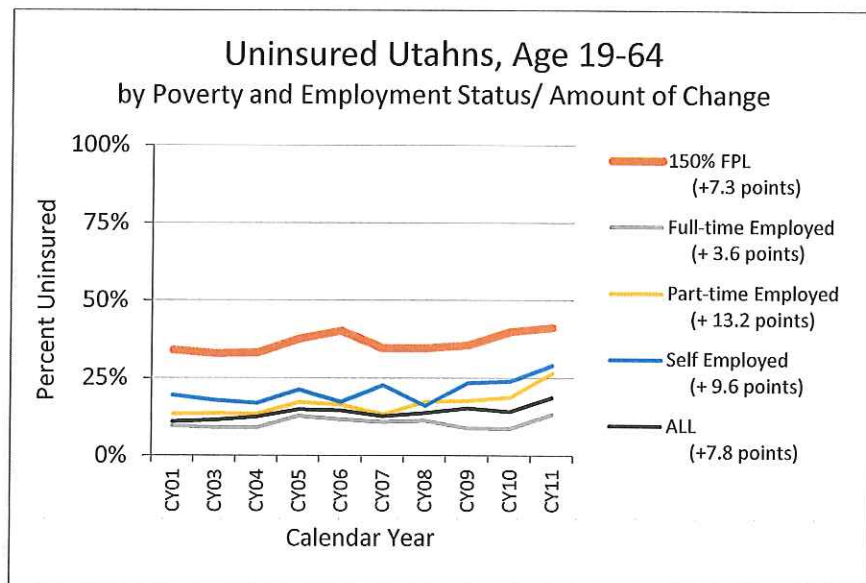
According to insurance claims filed with Utah medical assistance programs, during the first five years of the PCN program, many enrollees took advantage of the ability to see a primary care provider (PCP) as they had not access to basic health care for many years. The rate of individuals who accessed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

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

During SFY 2009 and 2010, the Utah converted to a new eligibility enrollment system and PCN again experienced an increase in participants accessing a PCP, although not the degree experienced with the implementation of the PCN program (up to 68 percent in SFY 2011). At the same time, access to a PCP among Current Eligibles maintained an even rate between 38 percent and 40 percent. Again, there was no negative impact to the Current Eligibles as a result of the increase of PCN enrollees seeking PCP care. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

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

Between 2001 and 2011, the percent of Utahns without health insurance increased among all adults age 19 to 64. This increase in uninsurance affected not only the PCN target group,)— but the three major employment groups as well: full-time, part-time, and self-employed.



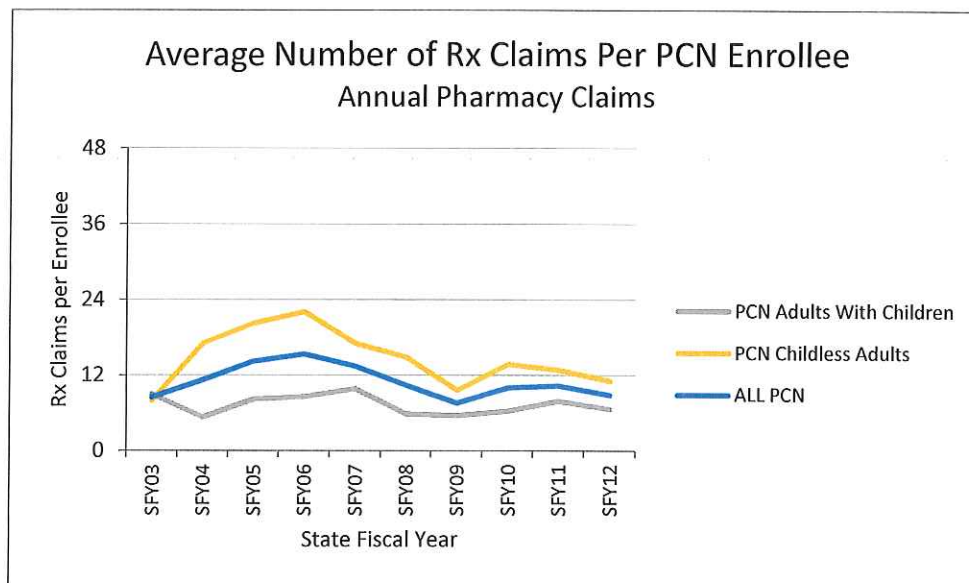
The PCN target group continues to have the highest rate of uninsurance, but the increase in the rate of uninsurance in the PCN target group is lower than for all of the employment groups except for adults employed full time. The PCN target group experienced an increase of 7.3 percentage points in uninsurance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

It is postulated that lower rate of increase in the target group is due, at least in part, to the availability of PCN insurance. Since the implementation of ACA, the rate of uninsurance in this group has decreased but, still remains at 27.8%. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

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

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

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



Through PCN, approximately 24,000 individual lives each year since July 1, 2002 have been improved by having access to basic primary medical care and a limited number of prescriptions. This is coverage that is not available through any other source for this group of people. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

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

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

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

Between April 2005 and June 2014, PCN Specialty Care Coordinators received a total of 19,360 referrals from PCPs. The Care Coordinators voluntarily tracked and categorized the outcomes of these referrals. Those tracked outcomes have been summarized into four categories.

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

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

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

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

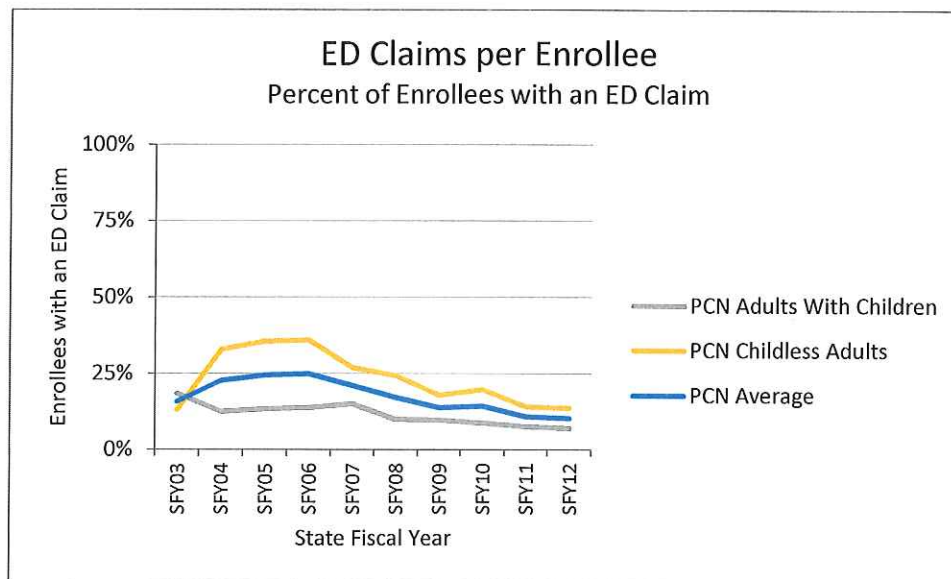
The majority of outcomes (those with the greatest proportion) falls in the "Services Rendered" category. Indeed, Specialty Care Coordinators have been able to report 37 percent (SFY 2010) to 47 percent (SFY 2014) of the referrals they have received have resulted in services being rendered.

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

Outcomes identified as “In Process” in most cases were resolved in the following quarter. The group of outcomes categorized as “Client’s Action” were out of the Specialty Care Coordinator’s control, with the majority of them being a non-response from the client, even after the Coordinator attempted to contact them at a variety of times and using all available contact information. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

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

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

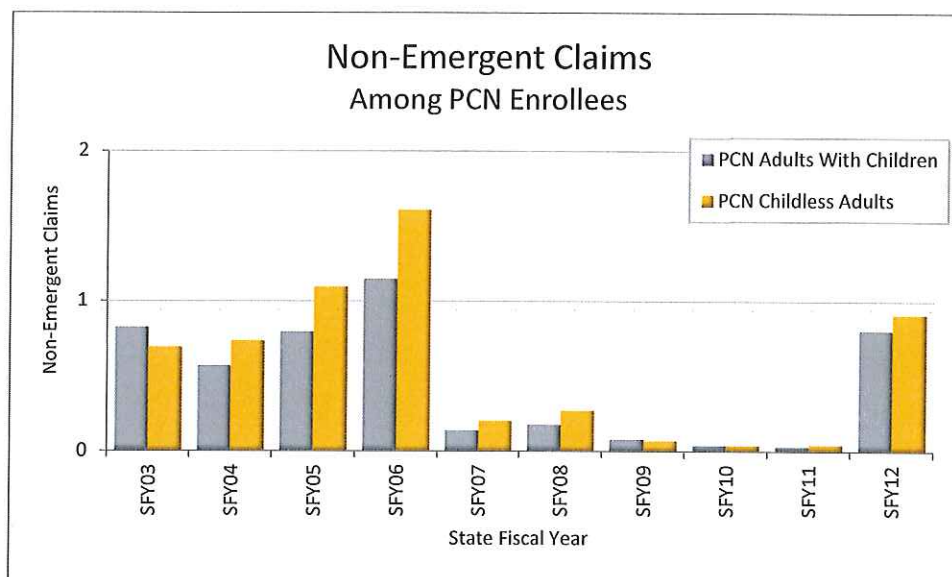


Looking deeper at the status of ED claim—whether they were coded as emergent or non-emergent by the provider—reveals that 0.8 claims per PCN adult with children and 0.7 claims per PCN childless adult were non-emergent in SFY 2003. That rate continued to increase and

reached a high in SFY 2006 with 1.1 non-emergent claims per PCN adult with children and 1.6 non-emergent claims per PCN childless adult.

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

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

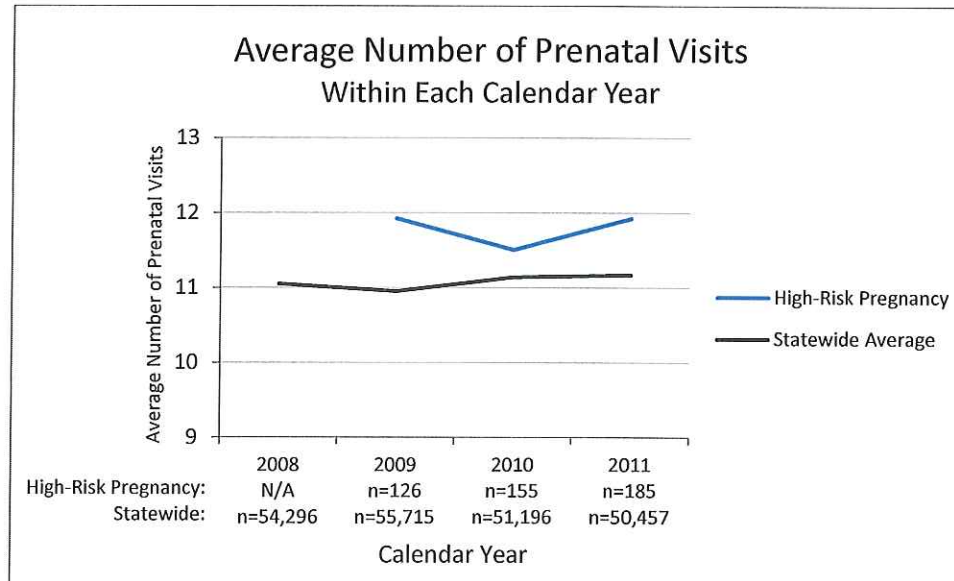


Hypothesis 4: *The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.*

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

The average number of prenatal visits for the High-Risk Pregnancy group has been consistently higher than the statewide average, with an average of 11.93 prenatal visits in 2009 (compared to 10.95 statewide). The rate of prenatal visits for the High-Risk Pregnancy

group dipped to 11.51 in 2010 and rebounded to 11.93 in 2011. It should be noted, however that the number of births under the 1115 Waiver (3-year average: 155) is significantly smaller than the total number of births in Utah (3-year average: 52,456).



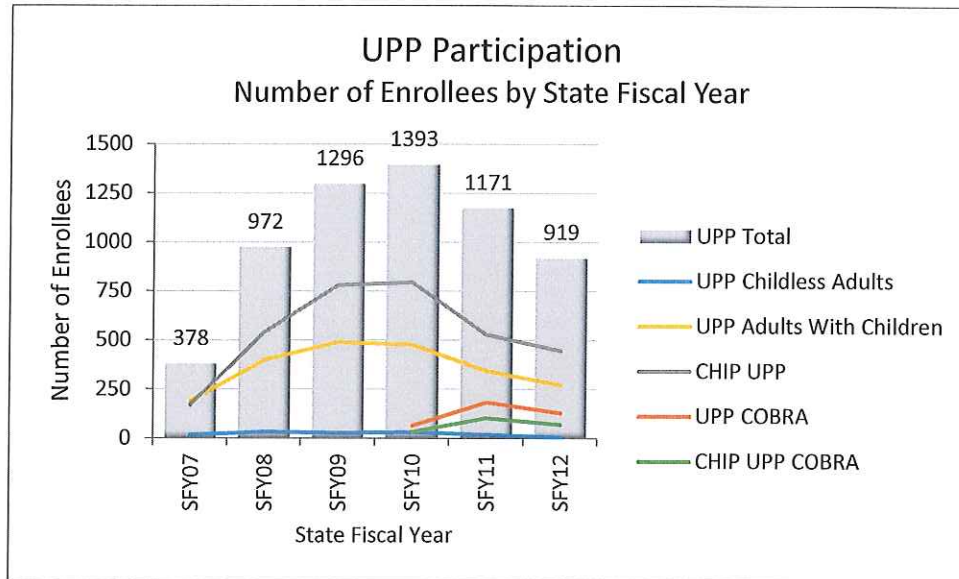
This hypothesis is no longer relevant with the elimination of the high risk pregnant woman’s program.

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

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

The Utah Department of Health implemented a marketing push for UPP in SFY 2008 and SFY 2009, when total enrollment in UPP reached its peak of 1,393 participants. Then in March 2010, President Obama issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to the new health insurance exchanges. It was determined that the Executive Order in conjunction with the intent of the state law created new expectations for the UPP subsidy. In April 2010, an emergency rule was filed to prohibit UPP from reimbursing participants who were enrolled in plans covering abortion

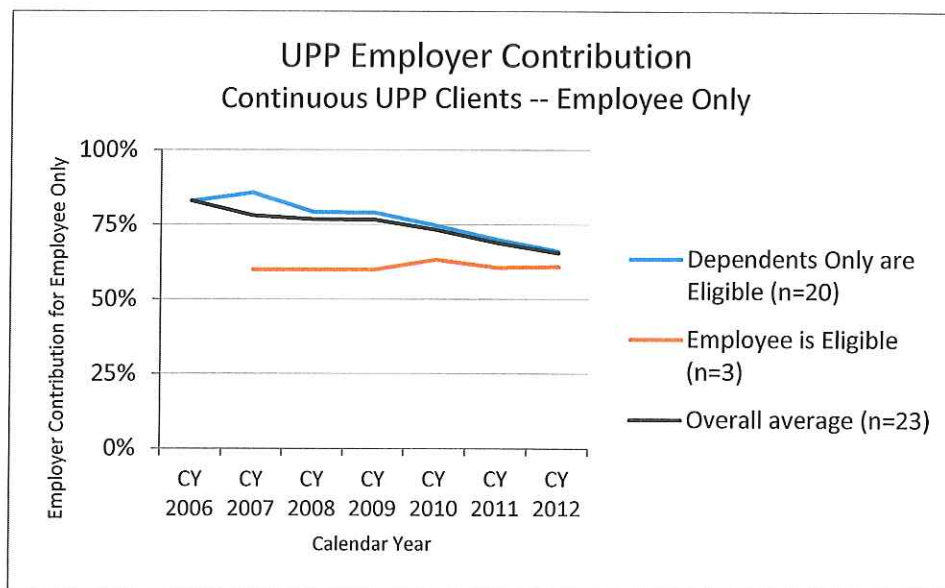
services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). Subsequently, enrollment in UPP in SFY 2012—919 participants—is approximately two-thirds of what it was at its peak.



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

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

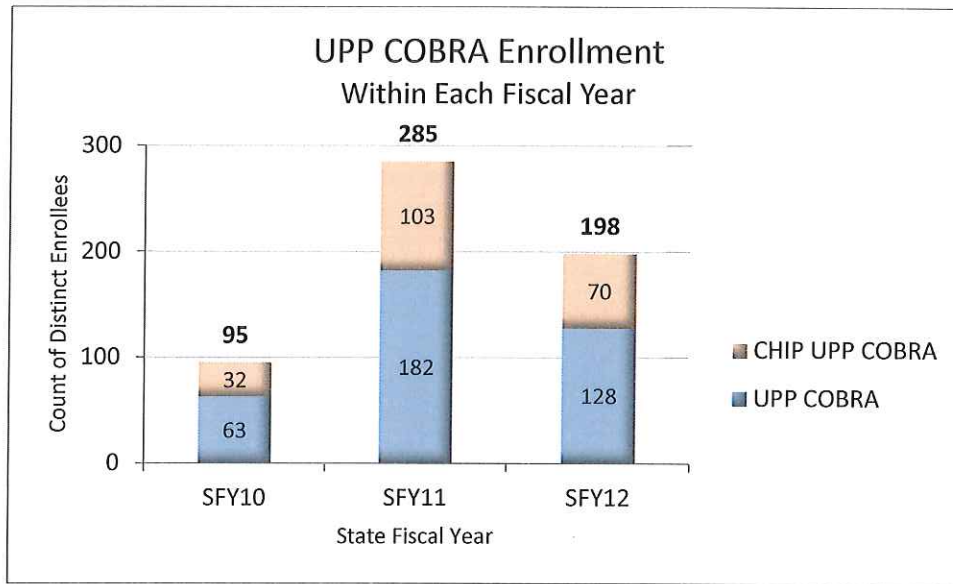
For individuals using UPP to assist with premiums for their dependents only, the employer contribution for their personal premium (not the premium of their dependents) has decreased from an average of 83 percent in 2006 to an average of 66 percent in 2012. However, UPP was not reimbursing this premium and is therefore not accountable for the decrease in the employer contribution. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.



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

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

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



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

Conclusion and Recommendations

Utah's 1115 Primary Care Network Demonstration Waiver has proved to provide a significant benefit to Utah residents who would otherwise have no health insurance coverage and would likely go without health care. Until such time, as the State of Utah determines how or if it will expand Medicaid coverage under the provisions of the federal Affordable Care Act, Utah's 1115 Primary Care Network Demonstration Waiver should continue. Without this waiver, thousands of Utahns would go without needed healthcare. The State will continue to gather additional data and will provide a formal analysis and recommendations when an application for a three year renewal is submitted to CMS in 2016.

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

**2013
Annual External Quality Review Report**

Report Issued December 2014

**Office of Health Care Statistics
Utah Department of Health**

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Appendix 4: Summary of Required Corrective Actions Identified in 2012

I. EXECUTIVE SUMMARY

A. Overview of External Quality Review Requirements and Process

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

In 2012, the year subject to external quality review (EQR) summarized in this report, the Division of Medicaid and Health Financing in the Utah Department of Health (UDOH) contracted with 13 managed care entities (MCEs) under 1915(b) waiver authority: three Physical Health Plans (PHPs) and 10 Prepaid Mental Health Plans (PMHPs). UDOH also contracted with the University of Utah's Health Outcomes Medical Excellence (HOME) program, under 1915(a) authority. (HOME is also considered a PHP in this report.) For the purposes of this report, the term MCE refers to both the PHPs and PMHPs. The majority of Utah's Medicaid population is enrolled in MCEs.

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

The Centers for Medicare and Medicaid Services (CMS) requires states to have an EQR of their MCEs. To fulfill this requirement, UDOH contracts with the Office of Health Care Statistics (OHCS), UDOH's external quality review organization, to conduct the required EQR.

OHCS's 2013 scope of work included EQR activities for the MCEs. This report includes:

- The results of OHCS's validation of Performance Improvement Project (PIP) activities underway during 2012 for two PHPs and ten PMHPs;
- The results of OHCS's validation of Performance Measures Performance for three PHPs and ten PMHPs; and
- The results of follow-up on contract compliance review corrective actions for the three PMHPs for which corrective action was required

This report also contains four appendices:

Appendix 1: Annual Report Format Crosswalk

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

Appendix 2: Sample HEDIS Measure

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

Appendix 3: Completion Status of Required Corrective Actions Identified in 2012

This appendix contains a summary of the corrective actions a previous vendor required of each MCE, based on its 2012 EQR, and the completion status of OHCS's 2013 follow-up reviews.

Appendix 4: Required Corrective Actions Identified in 2013

This appendix contains a summary of the required corrective actions for all EQR activities performed in 2012.

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

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

Performance Improvement Projects Performance

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

Three of the 10 PMHPs worked on projects intended to improve concurrent or collaborative documentation during client treatment sessions. Three other PMHPs chose topics that involved increasing the use of the Outcomes Questionnaire (OQ), which is described as "the measure of mental health signs" and helps clinicians track patients' progress over time. The projects vary, but they all involve making greater use of the OQ in order to better measure change over time and, ideally, result in better client outcomes. The four remaining projects involved assessing mental health clients' need for substance use disorder treatment, improving employment rates of clients, reducing unnecessary re-hospitalizations, and reducing no-show rates of intake appointments. All of these topics are timely and relevant to the client populations served by these PMHPs.

Based on OHCS's review of PIP activities performed in 2012, OHCS determined that overall the PMHPs met 99% of the applicable PIP criteria. PMHPs' scores ranged from 92.3% to 100%. Of the ten PMHPs, nine [Bear River Mental Health (BRMH), Central Utah Counseling Center (CUCC), Davis Behavioral Health (DBH), Four Corners Community Behavioral Health (FCCBH), Northeastern Counseling Center (NCC), Salt Lake County Division of Behavioral Health Services (SLCo DBHS), Southwest Behavioral Health Center (SBHC), Weber Human Services (WHS) and Wasatch Mental Health (WMH)] met 100% of the applicable criteria. Valley Mental Health (VMH) met 92% of the applicable criteria.

The Health Outcomes Medical Excellence (HOME) program chose as its PIP topic a study of a physical activity vital sign questionnaire and its impact on the BMI of adult enrollees. HOME met 97.5% of the applicable criteria and has completed its PIP. SelectHealth has a Medicaid and a CHIP program (SH Medicaid and SH CHIP). They are working on the same topic for both: improving HEDIS rates of well-child visits for 3-6 year old children. Both programs met 100% of the applicable criteria. SelectHealth has completed its Medicaid PIP halfway through Activity 7 and has completed its CHIP PIP. Neither Healthy U (HU) nor Molina Healthcare of Utah (MHU) submitted a PIP report; however, in 2014 they will each submit a report on two years of activities (CY2012 and CY2013).

Performance Measures Performance

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

OHCS obtained the report specifications defined by UDOH and the data files used by the PMHPs to create their annual performance measures reports. OHCS calculated the number of days between the initial contact and the first offered appointment time for urgent, non-urgent, and emergent contacts. OHCS calculated a percentage of compliance for each performance measure and an overall compliance rate based on the total number of initial contacts for each PMHP and in aggregate. Overall, OHCS validated that the PMHPs offered an appointment within the required timeframes to 92.3% of enrollees requesting an initial mental health appointment. This high level of compliance is evidence that the PMHPs provide timely access to care.

The PHPs are required to collect Healthcare Effectiveness Data and Information Set (HEDIS) measures, using National Committee for Quality Assurance (NCQA) methodology, and to have their data audited by an NCQA-certified vendor. MHU, HU and SH report the results of their HEDIS measures to OHCS and are required to provide a copy of the auditor's certification on an annual basis. OHCS prepares a written summary of the HEDIS findings and compares the PHP's results with the national averages. Overall, OHCS identified that in the aggregate, across all measures, MHU scored at or above¹ the national average on 75% of the 32 HEDIS measures included in this report. Healthy U scored at or above the national average on 37% of the measures.

¹ "At or above" means within 1% of the national average. For two measures, a lower value is better and these are included in the count of those measures that scored at or above if it is *below* the national average.

Compliance Reviews

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

Federal EQR regulations require a compliance review every three years. The MCEs are evaluated once every three years to establish their level of compliance with required standards. Subsequent to the compliance reviews, MCEs are required to take corrective action on each standard that is not in full compliance.

In 2011, UDOH's EQRO, HCE QualityQuest, conducted a full compliance review of the eleven MCEs that were contracted with UDOH at that time. At that time HU was contracted as a PAHP. Since UDOH's requirements for HU were very similar to UDOH's requirements for the other MCEs, UDOH elected to include HU in the compliance reviews.

In 2011, HCE QualityQuest determined that the PMHPs met 93% of the compliance standards. In the aggregate, HCE QualityQuest identified the need for 28 required corrective actions. The follow-up compliance reviews conducted in 2012 identified that 24 of the 28 (86%) required corrective actions were completed. Based on the follow-up reviews conducted in 2013, it was determined that the PMHPs had implemented their remaining corrective actions.

In 2011, HCE QualityQuest determined that the PHPs met 99% of the compliance standards in 2011. MHU met 100% of the standards and HU met 97% of the standards. HU was required to submit corrective action plans for two standards that were not fully met. The follow-up compliance review conducted in 2012 identified that additional corrective action was required for HU to complete its CAPs. Further review of HU's required corrective actions was not performed in 2013. Follow-up on these areas will occur during future contract compliance reviews.

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

Performance Improvement Projects

There is a great deal of diversity in the PIP projects currently underway at the PMHPs. The clinics each expressed an interest in doing projects that focused more on potential benefit to their clients than small-scale projects that had a better chance of statistically significant results. Four PMHPs (DBH, NCC, SLCBH, and SBHC) started new PIP projects in 2012 and have progressed through the planning stage and have identified study topics and project methodology.

The remaining PMHPs collected re-measurement data in 2012 that show the results of their projects over time. BRMH showed significant increases over time in the number of clients who indicate a need for substance abuse treatment. This increase has been sustained over three time periods. CUCC demonstrates consistent change in the time to

record therapy sessions over a two measurement periods. This change in elapsed time is statistically significant. The intervention has been shown to be effective in reducing the amount of time that therapists take to record sessions. FCCBH has demonstrated sustained improvement in the PIP over four total measurement periods in the percentage of sessions that are documented concurrently. VMH reports that it has shown sustained improvement over three measurement periods. While not all of the improvements reached statistical significance, there were no declines in concurrent documentation rates over the study period. WHS created an additional intervention to further improve no-show rates. The addition of a Friday walk-in clinic had a very small effect on the no-show rate, but couldn't be sustained because of staffing issues. No show rates remained relatively flat over the course of the study. WMH's data shows significant and sustained improvement over the study period. Increases observed in the first two measurement periods were not only maintained, but improved upon in the follow-up. Statistical analyses are valid for the data collected and show significant differences across the three study periods.

Performance Measures Performance

OHCS validated performance measures for nine PMHPs. One PMHP did not send in raw data so its measures could not be validated. Their report is included in the aggregate summary.

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

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

Compliance Reviews

In 2011, the PMHPs demonstrated very high levels of compliance with federal and state standards for managed care. In the aggregate the PMHPs met 93% of standards. For those PMHPs requiring corrective action, based on the 2012 and 2013 follow-up reviews, it was determined the PMHPs had successfully implemented required corrective actions.

In 2011, the PHPs demonstrated exceptionally high levels of compliance with federal and state requirements for managed care. MHU met 100% of the standards, and HU met 97% of the standards. HU was required to take correction action on two standards that were not fully met in 2011. In 2012, HU demonstrated progress toward completing its CAPs but the required actions were not completed. No other compliance activities occurred in 2013.

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

II. BACKGROUND

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

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

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

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

- Effective July 1, 2002, the MHU and HU contracts changed from risk-based to non-risk. HU's contracts fall under the federal definition of PIHP. MHU's contracts fell under the PIHP definition from July 1, 2002 through August 31, 2009;
- Effective October 1, 2002, Select Access became a Preferred Provider Network and a federally defined Primary Care Case Management (PCCM) system. Since the EQR regulations under 42 CFR 438 Subpart E (External Quality Review) apply to MCOs and PIHPs only, Select Access is not included in the EQR activities;
- Effective September 1, 2009, MHU's contracts are risk-based and now fall under the federal definition of a Managed Care Organization (MCO); and
- Effective February 1, 2010, HU's contracts are non-risk and fall under the federal definition of a PAHP.
- Effective January 1, 2013, all MCO contracts were changed to full risk and incorporated the administration of the pharmacy benefit in the MCO contracts. SelectHealth, Healthy U, Health Choice Utah, and Molina Healthcare of Utah all became full risk MCOs.

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

The Medicaid MCOs are risk-based contracts. Medicaid reimburses the MCOs an all-inclusive per-member-per-month premium payment. Both PHPs submit to Medicaid encounter records for all services provided to their enrollees.

For mental health services, UDOH has been managing a waiver program called the *Prepaid Mental Health Plan* (PMHP) since July 1, 1991, after receiving approval for a 1915(b) freedom-of-choice waiver in April 1990. Medicaid recipients are automatically enrolled with the PMHP contractor serving their county of residence. The major goals of the PMHP were to provide a coordinated single point-of-entry to allow enrollees access to a coordinated managed care approach to service delivery, to manage inpatient care, and to control inpatient hospital costs. The PMHP currently operates in 28 of Utah's 29 counties.

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

Table 1: Utah's Medicaid MCEs Undergoing EQR Activities

Physical Health Plans	Urban	Rural	Average Number Enrolled Per Month*
Healthy U (HU)	X		42,784
Health Outcomes Medical Excellence (HOME)	X		855
Molina Healthcare of Utah (MHU)	X	X	63,765
SelectHealth (SH)	X		77,631
Prepaid Mental Health Plans			
Bear River Mental Health (BRMH)		X	14,928
Central Utah Counseling Center (CUCC)		X	8,256
Davis Behavioral Health (DBH)	X		20,992
Four Corners Community Behavioral Health (FCCBH)		X	5,128
Northeastern Counseling Center (NCC)		X	6,654
Salt Lake County (SLCo)	X		101,761
Southwest Behavioral Health Center (SBHC)		X	23,807
Valley Mental Health (VMH)	X		6,939
Wasatch Mental Health (WMH)	X		43,344
Weber Human Services (WHS)	X		25,699

Note: The urban counties are Davis, Salt Lake, Utah, and Weber.

B. Ongoing State Quality Initiatives

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

Below are examples of ongoing State quality initiatives:

➤ Preferred Practice Guidelines for the Utah Public Mental Health System

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

➤ Recovery-Based Services

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

➤ National Outcomes Measures

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

➤ Outcomes Project

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

➤ Tobacco Cessation Initiative

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

➤ Utah Health Plan Partnership

The Utah Health Plan Partnership (HPP) is a collaborative effort, led by UDOH Bureau of Health Promotion, in partnership with Medicaid and commercial health plans throughout the state, and other community partners. The mission of the HPP is to improve health care performance and measures related to diabetes and cardiovascular health by sending unified, focused, and consistent information to providers and communities for the common goal of improving overall health.

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

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

➤ The Children's Healthcare Improvement Collaborative (CHIC)

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

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

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

➤ Chronic Disease Self-Management Program (CDSMP)

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

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

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

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

➤ Health Information Technology

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

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

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

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

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

➤ Restriction Unit Quality Improvement Initiative

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

- Implementation of a standardized referral process for the MCEs submitting client referrals for the Restriction and Care Management Program (Lock-in). This process/form enables an accurate and consistent means of assessing enrollment appropriateness and the efficient processing of lock-in within three working days.
- Implementation of standardized criteria for enrolling minors in the care of a legal guardian, into the Lock-in Program. Currently there is an increase in the number of Medicaid recipients who are minors (under the age of majority), that meet Lock-in criteria. Enrolling minors into the Lock-in (i.e., into care with one PCP and pharmacy), helps to minimize enrollees using the Emergency Department (ED), in place of care by a PCP. This also limits the ability of recipients under the age of majority to seek prescribed drugs of abuse and reduces overall costs to Medicaid. This process also supports quality of care for Medicaid recipients under the age of majority.
- Implementation of standardized tools for evaluation of claims with “non-emergent” diagnosis and assessing clients for appropriateness in the Lock-in program. Previously, only the first diagnosis listed in an emergency department claim triggered evaluation for enrollment in Lock-in.

The standardized tools developed by the MRU, take into consideration all “non-emergent” diagnoses for a client's emergency department claims and is a more

accurate and thorough means of assessing potential over-utilization. In addition, the additional information improves quality in case management.

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

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

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

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

➤ Chronic Disease Management Quality Improvement Initiative

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

The claims system generates a diabetes surveillance alert that is sent to the MRU staff. MRU staff use a standardized algorithm to perform an assessment for each member for whom an alert is generated. Staff evaluates the recipient's use of the ED for diabetes management that should be provided in a primary care setting. Staff also contacts recipients to encourage them to seek diabetes management through a PCP instead of the ED. Staff assist recipients to find a PCP if needed. When preliminary attempts to coordinate diabetes care through a PCP are unsuccessful, the recipient

may be enrolled in the Lock-in Program in an effort to curb overutilization of the ED for primary care and diabetes care management.

III. DESCRIPTION OF EXTERNAL QUALITY REVIEW ACTIVITIES

A. Overview of External Quality Review Requirements

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

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

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

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

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

This report is prepared in accordance with these regulations.

B. Performance Improvement Projects Performance

1. Description of Activity

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

2. Objectives

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

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

3. Methods

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

Activity 1—Appropriate Study Topic

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

Activity 2—Clearly Defined and Answerable Study Question

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

Activity 3—Clearly Defined Study Indicator(s)

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

Activity 4—Unambiguously Defined Study Population

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

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

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

Activity 6—Accurate and Complete Data Collection

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

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

Activity 7—Appropriate Performance Improvement Strategies

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

Activity 8—Analysis and Interpretation of Data

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

Activity 9—Real Performance Improvement Achieved

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

Activity 10—Real Performance Improvement Sustained

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

4. Data Obtained

UDOH's prior EQRO developed a PIP reporting and evaluation form that incorporates evaluation elements from the CMS protocol for validating PIPs and provides for a systematic assessment of each of the ten activities.

Each MCE was required to complete the form to document its progress on the ten PIP activities undertaken during 2012. Each MCE submitted the completed reporting form and supporting documentation directly to OHCS.

C. Performance Measures Performance

1. Description of Activity

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

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

The three PMHP access-to-care standards are as follows:

Table 2: Enrollee Initial Contact Classifications

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

UDOH contract requires the PMHPs to maintain an initial contact data system that allows for tracking, monitoring, calculating, and reporting adherence to performance standards for first face-to-face services when initial contacts are made during regular business hours.

The PMHPs are required to document the following:

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

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

- Access
 - Percentages by age groups of members with an MCO primary care physician visit
 - Percentages by age group of members with an ambulatory or preventive care visit
- Childhood Immunizations
 - Percentages of children receiving timely vaccinations
- Women's Health and Maternity Care
 - Percentages of women receiving cancer screenings
 - Percentages of women tested for Chlamydia
 - Percentages of women with postpartum visits receiving prenatal care
- Child and Adolescent Well-Care
 - Percentages of children and adolescents with well-care visits
 - Percentages of children and adolescents with pharyngitis receiving strep test and antibiotic
 - Percentage with an upper respiratory infection and no antibiotic prescription three dates after episode date
- Use of Medication
 - Percentage of members by two age groups with persistent asthma appropriately prescribed medication
- Care for People With Diabetes
 - Percentage of members who had a retinal exam

- Percentage of members with above- or below-specified HbA1c and LDL levels and screenings
- Percentage of members who had a kidney disease screening

➤ Health Care for Adults

- Percentage of members with acute low back pain but no imaging study

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

2. Objectives

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

3. Methods

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

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

In accordance with PHP contracts and OHCS' administrative rule, MCEs required to submit HEDIS, annually submit audited HEDIS data. OHCS analyzes the results for all MCEs reporting data and produces a performance report. Since the MCEs submitted audited HEDIS data, OHCS did not validate these findings.

MCEs collect the measures using an administrative (electronic records) or hybrid (medical record review and electronic records) methodology. The methodology used may vary based on the measure. Appendix 2, *Sample HEDIS Measure*, contains the information required to obtain the *Breast Cancer Screening* measure. It provides an example of the requirements for collecting one HEDIS measure.

4. Data Obtained

Data obtained for the PMHP performance measure validation included the initial contact data files provided by the PMHPs and the annual performance measures reports for the period ending December 2012.

D. Compliance Reviews

1. Description of Activity

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

Access Standards

42 CFR §438.206 through §438.210

- Availability of services
- Assurances of adequate capacity and services
- Coordination and continuity of care
- Coverage and authorization services

Structure and Operation Standards

42 CFR §438.214 through §438.230

- Provider selection, enrollee information, grievance systems
 - Sub contractual relationships and delegation
- 42 CFR §438.400 through §438.424 – Subpart F—Grievance System
- Statutory basis and definitions and general requirements
 - Notice of action and handling of grievances and appeals

Measurement and Improvement Standards

42 CFR §438.236 through §438.242

- Practice guidelines
- Quality assessment and performance improvement program
- Health information systems

Federal regulations require a compliance review every three years. HCE Quality Quest conducted a full compliance review of the MCEs in 2011. The MCEs were required to take corrective action on each standard that was not in full compliance. In 2012, UDOH conducted follow-up reviews to determine if the MCEs completed their CAPs and as necessary, follow-up was also performed in 2013 for those corrective actions that had not been fully implemented in 2012.

2. Objectives

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

3. Methods

In 2013, UDOH reviewed the PMHPs' responses and documentation and determined if the required corrective actions were completed.

E. Strategies for Using External Quality Review Findings

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

IV. DESCRIPTION OF FINDINGS

A. Prepaid Mental Health Plans

1. Performance Improvement Projects Performance

Introduction

In 2013 OHCS validated the PIP activities completed by each PMHP during calendar year 2012. OHCS validated the following PIPs:

- BRMH: Substance Abuse Assessment Study;
- CUCC: Rates of Real Time Treatment Documentation of Individual Therapy Sessions;
- DBH: Increasing the Use of the OQ to Increase Recovery Rates;
- FCCBH: Project to Increase Concurrent Documentation;
- NCC: OQ Analyst Administration and Clinical Use;
- SBHC: Improving Employment Rates at Southwest Behavioral Health Center;
- Salt Lake County Behavioral Health: Reducing Unnecessary Re-hospitalization for Inpatient Psychiatric Care;
- VMH: Improving Timeliness of Clinical Documentation;
- WHS: Reducing No-Show Rates of Initial Mental Health Evaluation Appointments; and
- WMH: Improving Youth and Adult Outcome Questionnaire (Y/OQ) Data Collection and Enhanced Use of the Outcome Data by Clinicians at WMH.

Findings

Overall, the PMHPs met 99% of the applicable PIP criteria in 2012. Nine PMHPs, BRMH, CUCC, DBH, FCCBH, NCC, SBHC, WHS, (SLCo and WMH met 100% of the applicable criteria. VMH met 92% of the applicable criteria.

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

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

Review Activity Description	BRMH	CUCC	DBH	FCCBH	NCC	SLCBH	SBHC	VMH	WMH	WHS	Aggregate PMHP-Wide Score
Study Topic	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Study Question	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Study Indicator(s)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Study Population	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sampling Techniques	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%
Data Collection	100%	100%	N/A	100%	100%	100%	N/A	100%	100%	100%	100%
Improvement Strategies	100%	100%	N/A	100%	N/A	100%	N/A	0%	100%	100%	86%
Analysis	100%	100%	N/A	100%	N/A	N/A	N/A	100	100%	100%	100%
Improvement Achieved	100%	100%	N/A	100%	N/A	N/A	N/A	100%	100%	100%	100%
Improvement Sustained	N/A	100%	N/A	100%	N/A	N/A	N/A	N/A	100%	100%	100%
OVERALL PMHP SCORE	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%	99%

Activity 1—Appropriate Study Topic

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

Activity 2—Clearly Defined and Answerable Study Question

The study question for each PMHP is as follows:

- BRMH: Does the implementation of a specific assessment instrument for identifying the need for substance abuse services (X) result in a greater rate of BRMH Medicaid clients being indicated as needing referral for further substance abuse assessment and/or treatment (Y)?
- CUCC: Does showing CUCC therapists the current average individual times it is taking to record individual therapy sessions decrease the average length of time taken for documentation of individual therapy sessions with all Medicaid enrollees receiving mental health treatment with CUCC?

- DBH: Does regular administration of the OQ result in an increased recovery rate and mental health functioning as evidenced by a lower OQ score over time, reduced hospitalization bed days, and/or shorter treatment durations?
- FCCBH: Will increasing concurrent documentation training for clinicians directly increase the rate of concurrent documentation compliance?
- NCC: Does electronic medical record monitoring, specific training and systematic feedback to providers and support staff, result in an increase of OQ administrations and incorporation of outcomes into individual treatment records of enrollees?
- SBHC: Does participation in and/or completion of IPS activities at SBHC increase the percent of adult mental health clients who are employed, participating in education or volunteering?
- VMH: Does providing feedback regarding time of documentation of adult outpatient services, compared to time of service, increase concurrent documentation?
- WMH: Does training support staff and clinicians on the importance of outcome data collection increase the number of outcome data protocols collected on average per client in outpatient clinics during a 12-month study period; and does training clinicians on the use and interpretation of the Y/OQ outcome data increase the number of reference data made in the client's clinical progress notes on average per client over a period of one year?
- WHS: Do interventions implemented by the WHS no-show committee result in a statistically significant decrease in client no-show rates to their mental health evaluation appointment?

All of the PMHPs met the criteria for a clear and answerable study question. All of the study questions were stated in clear and simple terms and all were answerable.

Activity 3—Clearly Defined Study Indicator(s)

All of the PMHPs met all seven of the criteria for selecting the study indicator(s). All PMHPs presented objective and measurable indicators based on current evidence-based practice guidelines, or pertinent peer-reviewed literature. All study indicators measure change in important aspects of care or service and all PMHPs report the data are readily available for outcomes analysis.

Activity 4—Unambiguously Defined Study Population

All of the PMHPs met the criteria for clearly identifying their study population. The study populations are complete and capture all enrollees to whom the study question applies.

Activity 5—Valid Sampling Techniques

This activity was not applicable for nine of the PMHPs. DBH will use sampling for their PIP and met all of the criteria for this activity. Their proposed methodology is clearly described and appropriate. It identifies inclusion and exclusion criteria and also specifies the acceptable margin for error. The sampling methodology will result

in a sample that is representative of the eligible population and the methodology is statistically sound.

Activity 6—Accurate and Complete Data Collection

Eight of the PMHPs met all of the criteria for this activity while the remaining two PMHPs have not reached this activity in their current PIP projects. All of the PMHPs clearly identified the data to be collected, the source of the data, whether the data are qualitative or quantitative, and reported that data will be collected on the entire population. Each described a data analysis plan that included the methodology to be used in its data analysis.

Activity 7—Appropriate Performance Improvement Strategies

The PMHPs are at various stages of implementing their intervention strategies. Six of the seven PMHPs who have reached this activity met all four of the criteria. Valley Mental Health did not meet any of the criteria having not responded to any of the corrective actions described in the 2012 plan report resulting in them receiving a *Not Met* score. The three remaining PMHPs have not yet reached this activity in their PIP projects.

Activity 8—Analysis and Interpretation of Data

Six of the PMHPs have collected some re-measurement data and analyzed and interpreted their results. All six of the PMHPs met all of the criteria and presented their findings in a clear and easily understood format. All of the analysis plans would allow generalization to the study population and identified factors that would threaten internal or external validity. All identified initial measurement and re-measurement periods and identified any factors that would affect comparisons across measurement periods. All interpretations indicated that the study interventions were successful.

Activity 9—Real Performance Improvement Achieved

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

Activity 10—Real Performance Improvement Sustained

Four PMHPs completed this activity. All four PMHPs are expected to start new PIPs in the 2013 calendar year.

Follow-Up on Required Corrective Actions

In 2011, all of the PMHPs, with the exception of VMH, completed their required corrective actions. In 2012, VMH was required to revise its study question to clearly identify what is being studied and to submit a revised PIP Reporting and Evaluation Form. In addition, VMH was told to follow the PIP protocol and complete the PIP

Reporting and Evaluation Form for all Activity 8 criteria. The PIP Reporting and Evaluation Form that VMH submitted for review in 2012 included only two of the required corrective actions. VMH did not successfully complete the required corrective actions identified in 2012.

Appendix 3 provides a description of the corrective actions required and their completion status for each PMHP.

Strengths, Weaknesses, and Opportunities for Improvement

The PMHPs appreciate and have taken advantage of the opportunity to conduct PIPs that reflect the needs of their clientele. The PMHPs' PIPs are central to the mission of each individual PMHP.

Since so many of the PMHPs were in the initial planning stages, during site visits conducted in 2013, there was much opportunity to discuss these upcoming projects with staff and create a rigorous project that is likely to positively affect outcomes. OHCS staff lead, Keely Cofrin Allen, conducted site visits with each of the PMHPs in March/April of 2013 and offered input and technical guidance. Some of the PMHPs do not have a research analyst, which resulted in them requesting additional technical guidance to craft the methodological and analytical portions of their projects. The result is projects that are well-defined and methodologically sound.

Despite the focus on other topics, it is important that the PMHPs continue to ensure that they maintain the performance improvement gains they have made in other areas, such as concurrent documentation. Providing the best possible care for Medicaid enrollees and improving these clients' functional status should be of the utmost importance.

OHCS did not identify any significant weaknesses with PIP performance on an aggregated statewide level. The PMHPs in the aggregate, meet the requirements for conducting PIPs that have the potential to improve health outcomes and/or enrollee satisfaction.

2. Performance Measures Performance

Introduction

In 2013, OHCS validated three performance measures that each PMHP reported for calendar year 2012. OHCS obtained the report specifications defined by UDOH and the data files the PMHPs used to produce their individual annual performance measures reports.

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

Findings

Table 4 presents the findings reported by the PMHPs to UDOH for 2012 and the findings validated by OHCS. The reported and validated findings represent the percentage of compliance for each performance measure.

Table 4: PMHP Compliance with Access to Care Performance Measures

PMHPs	Initial Contacts							
	Emergency		Urgent		Non-Urgent		Overall	
	Reported	Validated	Reported	Validated	Reported	Validated	Reported	Validated
BRMH	100%	100%	100%	100%	97.5%	97.5%	97.5%	97.5%
CUCC	100%	100%	100%	100%	98.7%	99.7%	99.7%	99.7%
DBH	100%	100%	65.0%	65.0%	81.9%	81.9%	81.5%	81.5%
FCCBH	100%	100%	100%	100%	96.2%	96.2%	96.7%	96.7%
NCC	100%	100%	100%	100%	99.6%	99.6%	99.6%	99.6%
SBHC	100%	Not Validated	100%	Not Validated	96.8%	Not Validated	96.9%	Not Validated
SLCBH	Not Reported	100%	Not Reported	94.2%	Not Reported	78.3%	Not Reported	78.8%
VMH	100%	100%	80.0%	40.0%	98.3%	79.5%	97.5%	77.7%
WMH	100%	92.3%	100%	100%	100%	99.5%	100%	99.4%
WHS	100%	100%	100%	100%	99.8%	99.8%	99.8%	99.8%
Statewide	100%	99.1%	93.9%	88.8%	96.5%	92.4%	96.6%	92.3%

Nine of the PMHPs submitted data that could be validated. SBHC did not submit raw data due to technical problems. Statewide, the PMHPs reported 100% compliance with the emergency appointment standard, 93.9% compliance with the urgent appointment standard, and 96.5% compliance with the non-urgent appointment standard. Overall, the PMHPs, reported a compliance rate of 96.6% for offering an initial mental health appointment within the required timeframes.

OHCS validated 99.1% compliance with the emergency appointment standard, 88.8% compliance with the urgent appointment standard, and 92.4% compliance with the non-urgent appointment standard. Overall, OHCS validated a statewide compliance rate of 92.3% for offering an initial mental health appointment within the required timeframes. The following summarizes OHCS's findings by type of contact.

Emergency

Statewide, 99.1% of enrollees were provided an initial emergent service within the required time. Eight of the nine PMHPs who reported data (BRMH, CUCC, DBH, FCCBH, NCC, SLCBH, VMH, and WHS) met the emergent care standard 100% of the time. WMH met the standard 92.3% of the time.

Urgent

Statewide, 88.8% of clients seeking urgent care were offered an appointment within five working days. Six of the nine PMHPs who reported data (BRMH, CUCC, FCCBH, NCC, WMH, and WHS) met the standard 100% of the time; DBH met the standard 65.0% of the time; SLCBH met the standard 94.2% of the time; VHM met the standard 40.0% of the time.

Non-Urgent

In the aggregate, the PMHPs complied with the required non-urgent appointment standard 92.4% of the time. Six of the nine PMHPs that submitted data (BRMH, CUCC, FCCBH, NCC, WMH, and WHS) met the appointment standard 96% or more of the time. DBH met the appointment standard 82% of the time; SLCBH and VMH met the standard 78% and 79% of the time, respectively.

Strengths, Weaknesses and Opportunities for Improvement

Overall, the PMHPs reported a relatively high level (92.3%) of compliance with access to care standards. This level of compliance clearly demonstrates timely and accessible care. Two PMHPs (SLCBH and VMH) had significant problems with the raw data they submitted. After multiple submissions, OHCS validated the data that were received, but has low confidence that these data reflect actual clinical care. Both PMHPs are required to submit 2013 data for an additional validation. In addition, SBHC experienced a change in system's software which affected their ability to provide data. They will also be required to resubmit CY 2013 data for additional validation.

3. Follow-up Compliance Reviews

Introduction

In 2011, HCE QualityQuest conducted full compliance reviews to determine the PMHPs' compliance with standards as required by §438.204(g).

Overall, the PMHPs met 93% of the compliance standards in 2011.

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

Findings

Based on the 2011 reviews, all nine PMHPs were required to revise their member handbooks to include language on the amount, duration, and scope of covered benefits. All PMHPs modified their handbooks to include appropriate language and obtained approval from UDOH on their revisions. All nine PMHPs are now in compliance with the information requirements standard.

All nine PMPHs also were required to revise their corporate compliance plans to include the potential for enrollee fraud in their fraud and abuse program, and to develop a procedure to identify potential enrollee fraud. Based on the 2012 reviews, it was determined that seven of the nine PMHPs completed the required corrective actions. CUCC and VMH updated their corporate compliance plans to include the potential for enrollee fraud, however, a procedure for detecting and reporting enrollee fraud had not been included. Based on the 2013 reviews, it was determined that both PMHPs had completed the remaining corrective action. BRMH, as part of its 2011 compliance review, was required to revise its PIP study question. In 2012, HCE QualityQuest determined corrective action was still required. In 2013, as part of the PIP validation, OHCS determined that BRMH had implemented the corrective action and the study question was clear. All PMHPs have completed all required corrective actions related to the 2011 compliance reviews.

B. Physical Health Plans

1. Performance Improvement Projects Performance

Introduction

In 2013 OHCS validated the PIP activities completed by SelectHealth for their Medicaid and CHIP programs as well as the HOME program during calendar year 2012. OHCS validated the following PIPs:

- Improving HEDIS Well-Child Exam Rates for 3 to 6 Year Olds (SelectHealth CHIP)
- Improving HEDIS Well-Child Exam Rates for 3 to 6 Year Olds (SelectHealth Medicaid)
- Physical Activity Vital Sign Questionnaire and the Impact on BMI for Adults (HOME)

Findings

Healthy U and Molina did not submit PIP reports in 2013. They are being required to report on CY2012 and CY2013 activities in the PIP reports they submit in 2014, subject to penalties for non-compliance.

HOME is included in this section along with the physical health plans even though it provides both physical and mental health services. HOME did not submit a PIP report in 2012; however, its 2013 PIP reports on two years of activity. HOME has completed its PIP.

SelectHealth is doing the same PIP project for both its Medicaid and CHIP programs. SelectHealth CHIP has completed its PIP and SelectHealth Medicaid has progressed through Activity 7, Criterion 2. SelectHealth met 100% of the criteria for the activities completed in 2012 for both the Medicaid and CHIP projects.

Table 5 presents an overview of the validation scores by activity. A narrative summarizing the findings for each activity follows.

Table 5: PIP Validation Scores by Activity

Review Activity Number and Description	HOME	SH CHIP	SH Medicaid
1. Study Topic	100%	100%	100%
2. Study Question	100%	100%	100%
3. Study Indicator(s)	100%	100%	100%
4. Study Population	100%	100%	100%
5. Sampling Techniques	100%	100%	100%
6. Data Collection	100%	100%	100%
7. Improvement Strategies	100%	100%	100%
8. Analysis	100%	100%	N/A
9. Improvement Achieved	75%	100%	N/A
10. Improvement Sustained	100%	100%	N/A
Overall PHP Score	97.5%	100%	100%

Activity 1 – Appropriate Study Topic

SelectHealth selected well-child visits for children 3 to 6 years old after a review of their rates found them well below the mountain region average with little improvement over time. Furthermore, improvement in well exam rates allows for opportunities to impact health in many different ways. SelectHealth had also received feedback from physicians that getting this population in for well visits presented a challenge and an opportunity for improvement. While the study topic reflects a relatively small portion of both the Medicaid (21%) and CHIP (7%) clients, the impact is potentially very high as well-child visits can improve the health of a child over his or her entire lifetime.

HOME designed a physical activity vital sign (PAVS) questionnaire to increase the level of patient physical activity over a year for adults with a BMI or 25 or greater. Nearly 50% of HOME clients are overweight or obese and implementation of this survey was designed to provide regular measurements of how these clients were managing their weight. Higher BMI has been found to increase the risk of Type II Diabetes, coronary heart disease and a variety of other serious conditions. The PAVS questionnaire was developed by researchers at the University of Utah and has been validated with the general population.

Activity 2—Clearly Defined and Answerable Study Question

SelectHealth’s study question for both projects is “Does contacting the parents of CHIP members ages 3 through 6 years old via interactive voice response (IVR) calls and/or mailings reminding them of the importance of annual well-child visits, who have not had a Well Child Visit in the past 12 months, and distributing reports to

pediatricians reflecting SelectHealth patients in their practice who are overdue for a well exam, improve the percentage of those who will access this important care?”

HOME’s study question is “Does implementing the Physical Activity Vital Sign PAVS questionnaire increase the level of physical activity and/or impact BMI over the following 1 – 2 years?”

Activity 3—Clearly Defined Study Indicator(s)

The study indicator for both SelectHealth projects is the percentage of members 3 to 6 years of age who have had at least one well-child exam in the previous 12 months. The study indicator is a HEDIS measure for utilization and is objective and measurable. HEDIS measures are developed from evidence-based practice guidelines and are nationally recognized as the standard for measuring health care quality. HEDIS findings will be tracked over time to determine if interventions are effective. SelectHealth’s study indicator answers the study questions. SelectHealth is required to collect HEDIS data annually; therefore, the data are readily available for use as a study indicator.

HOME is using two study indicators for its project. The first is the percentage of adult enrollees with a BMI of 25 or greater who participated in the PAVS questionnaire. The second is the actual PAVS scores at each clinical visit. Both are measurable and will be extracted from the patients’ electronic medical records.

Activity 4—Unambiguously Defined Study Population

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

HOME’s study population is all adult enrollees who were enrolled in 2009 who had a BMI of 25 or greater and were willing and able to participate. The study population is well-defined and complete.

Activity 5—Valid Sampling Techniques

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

HOME is not using sampling to select its study population.

Activity 6—Accurate and Complete Data Collection

SelectHealth is using the NCQA methodology to collect and analyze the data for both projects. The HEDIS methodology clearly identifies and defines the data to be collected for this measure. SelectHealth identified the team members responsible for

collecting the data for its PIP. All are nurses experienced in Medicaid data extraction for HEDIS hybrid measures. SelectHealth compares its Medicaid and CHIP HEDIS performance to its commercial business and national Medicaid HEDIS benchmarks. HEDIS findings are audited by a vendor certified by NCQA on an annual basis.

HOME is using its electronic medical records to collect the information for the PIP project. Data will be collected at six month intervals and compared to the baseline and each subsequent measure. Analysts compared the average PAVS scores and BMI measures for the 218 members of the study population. Statistical tests of difference were used to determine to whether there is a significant difference between baseline and post measurements.

Activity 7—Implementing Intervention and Improvement Strategies

SelectHealth used feedback from primary care providers and their Quality Improvement Committee on why its well-child visits were below the national average. The intervention was chosen with an aim to maximize the effectiveness. The first measurement showed a 5% increase in well-child visits for 3 to 6 year olds during CY2012.

HOME developed its intervention in order to better monitor the BMI and activity level of their overweight patients in order to provide doctors with information they could use to better treat their patients. The first measurement period yielded mixed results with some people improving their BMI scores, but not always those people who indicated that they had increased their physical activity.

Activity 8—Review Data Analysis and Interpretation of Study Results

SelectHealth CHIP compared the HEDIS rates over the course of the study. Initially, there were three groups: mail reminder only, phone reminder only, and mail and phone reminders. The first measurement period showed very little improvement in the mail and phone only groups, so these were abandoned and all enrollees received both a mail and a phone reminder. That was the only change to the study protocol over time and a 9% increase in well-child visits over the course of the entire study. SelectHealth Medicaid has not yet progressed to this activity in its PIP project.

HOME followed the outlined data analysis plan and observed mixed results. The report identifies two factors that may account for this: the PAVS is self-report and thus collected data may not have been valid and the survey only captured the number of days of exercise and not exercise intensity. While the intervention overall was not a success there were subsets of the population who responded positively. The intervention also created an educational impetus for the entire patient population which included discussions about far reaching benefits of physical activity.

Activity 9—Plan for “Real” Improvement

SelectHealth CHIP has conducted baseline and six re-measurement periods. The percentage of 3 to 6 year old children who received a well-child visit in the

measurement year increased from 52% to 62% from July, 2010 to December, 2012. This longitudinal change is statistically significant.

HOME's data analysis did not find significant changes over the course of the study. However, other improvements were noted such as making the PAVS administration a part of the routine check-in process at each visit. The study intervention also changed the attitudes towards physical activity and increased motivation levels among the clinic population to become more active.

Activity 10—Achieving Sustained Improvement

SelectHealth CHIP demonstrated that the improvements in the rates of well-child visits have been sustained beyond the initial measurement period, or a period of nearly two years.

HOME's project did not demonstrate significant improvements over time but plans to continue to collect PAVS data and work toward increasing levels of physical activity of their patients with the goal of decreasing BMI and improving health.

Strengths, Weaknesses, and Opportunities for Improvement

SelectHealth's choice of the study topic to increase well-child visits for children 3 to 6 in both the Medicaid and CHIP populations is timely and relevant. The decision to utilize HEDIS methodology and its HEDIS data to monitor and track its progress is a wise use of resources. OHCS did not identify any weaknesses in the activities completed to date.

In the coming year, SelectHealth should focus on completing the initial measurement periods for the new CHIP study and continue to find ways to improve the rates for this measure.

HOME's choice of the study topic to increase the use of an activity measure and decrease BMI is likewise timely and relevant. Obesity is a common problem in this population of clients who take anti-psychotic medication and poses a serious risk to their physical health. Although HOME's study did not show significant improvement in this measurement cycle, the topic is worth modifying and continuing because of the dire need to reduce BMI in this vulnerable population.

2. Performance Measures Performance

Introduction

In 2013, OHCS, in collaboration with UDOH, prepared a summary of the results of the HEDIS measures reported by Healthy U and MHU based on 2012 data. This section of the report includes OHCS' findings based on the 2012 data. HOME does not collect HEDIS data. SelectHealth Medicaid will begin reporting HEDIS data in 2014.

Findings

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

Table 6: MHU HEDIS Scores Compared to National Average

HEDIS Measure	HU	MHU	National Average
The percentage of members 12 to 24 months who had a visit with an MCO primary care practitioner.	97.0%	96.9%	96.0%
The percentage of members 7 to 11 years who had a visit with an MCO primary care practitioner.	88.0%	89.5%	89.9%
The percentage of members 12 to 19 years who had a visit with an MCO primary care practitioner.	86.3%	89.4%	88.4%
The percentage of members 20 to 44 who had an ambulatory or preventive care visit.	82.7%	83.5%	80.4%
The percentage of members 45 to 64 who had an ambulatory or preventive care visit.	87.6%	88.5%	86.5%
The percentage of members 65 years and older who had an ambulatory or preventive care visit.	89.0%	89.2%	84.4%
The percentage of children who received four DTaP/DT vaccinations; three IPV vaccinations; one MMR vaccination; three HiB vaccinations; three hepatitis B vaccinations; and one VZV vaccination on or before the child's second birthday.	78.4%	80.1%	75.7%
The percentage of children who received an initial DTaP vaccination followed by at least three DTaP, DT or individual diphtheria and tetanus shots, with different dates of service on or before the child's second birthday.	82.7%	81.3%	81.0%
The percentage of children that received three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.	88.1%	91.0%	89.5%
The percentage of children that received three H influenza type B (HiB) vaccinations, with different dates of service on or before the child's second birthday.	93.4%	92.0%	92.0%
The percentage of children that received at least three polio vaccinations (IPV) with different dates of service on or before the child's second birthday.	90.8%	91.4%	91.6%
The percentage of children that received at least one measles, mumps, and rubella (MMR) vaccination, with a date of service falling on or before the child's second birthday.	92.7%	89.6%	91.6%
The percentage of children that received at least one chicken pox vaccination (VZV), with a date of service falling on or before the child's second birthday.	90.8%	89.6%	91.1%

HEDIS Measure	HU	MHU	National Average
The percentage of women who had a mammogram to screen for breast cancer.	45.1%	48.9%	51.8%
The percentage of women 21 to 64 years of age who received one or more Pap tests to screen for cervical cancer.	45.3%	63.8%	64.5%
The percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	21.2%	38.5%	57.1%
The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	48.6%	69.6%	63.0%
The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO.	18.4%	79.8%	82.9%
The percentage of members who were 12 to 21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	41.8%	41.7%	49.7%
The percentage of members who were three, four, five or six years of age who received one or more well-child visits with a primary care practitioner during the measurement year.	59.4%	63.2%	72.0%
The percentage of members who turned 15 months old during the measurement year and who had 5 well-child visits with a primary care practitioner during their first 15 months of life. <i>Lower value is better</i>	21.6%	17.6%	15.5%
The percentage of members who turned 15 months old during the measurement year and who had 6 or more well-child visits with a primary care practitioner during their first 15 months of life.	43.6%	60.9%	63.6%
The percentage of members 2 to 18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).	65.4%	72.4%	68.0%
The percentage of members age 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the Episode Date.	92.7%	90.1%	85.1%
The percentage of members 5 to 11 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	72.9%	89.8%	89.6%
The percentage of members 12 to 50 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	75.3%	84.8%	79.7%
HEDIS Measure	HU	MHU	National Average
Care for People with Diabetes			
The percentage of members who had an LDL level less than 100 mg/dl at their most recent test in the past two years.	34.9%	38.7%	41.4%
Percentage of members who had a retinal exam by an eye care professional.	52.3%	64.1%	53.2%
The percentage of members who had an HbA1c level above 8.0% during their last visit. <i>Lower numbers are better.</i>	40.3%	30.8%	44.6%
The percentage of members who had one or more HbA1c tests.	83.0%	89.7%	83.0%
The percentage of members who had a kidney disease (nephropathy) screening test.	67.3%	83.2%	78.4%

Health Care for Adults			
The percentage of members with acute low back pain for whom imaging studies did not occur.	74.1%	75.8%	75.6%

Strengths, Weaknesses, and Opportunities for Improvement

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

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

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

- The percentage of women that have had Chlamydia screenings;
- Adolescent well-care visits;
- The percentage of members who were three, four, five or six years of age who received one or more well-child visits with a primary care practitioner during the measurement year;
- Percentage of members who turned 15 months old and had 6 or more well-child visits with a primary care practitioner during their first 15 months of life;
- Percentage of women who received appropriate prenatal and post-partum care;
- Percentage of women who had a mammography to screen for breast cancer; and
- Percentage of women who received one or more Pap tests to screen for cervical cancer.

3. Follow-up Compliance Reviews

Introduction

In 2011, the HCE QualityQuest, conducted a full compliance review of MHU and HU to determine their compliance with federal managed care requirements in 42 CFR Part 438 and other additional contract requirements. In 2011, MHU met all of the required compliance standards. HU met 97% of the standards and was required to

submit corrective action plans for two standards that were not fully met. This report is limited to the follow-up on the two standards that were not fully met in 2011.

Findings

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

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

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

HU revised the language in the "What is Emergency Care" section of its Member Handbook. UDOH determined the language could be further simplified and provided suggested language for HU to use in its Member Handbook. HU revised its Provider Manual to include provider responsibilities related to culturally competent care, but did not revise its Cultural and Linguistically Appropriate Care Services Policy to include cultural and ethnic needs or considerations beyond the need for interpreter services. HU did not provide documentation describing how staff members are trained to provide culturally competent care and how HU monitors if care is provided in a culturally competent manner. HU did not fully implement and complete its CAPs. Additional corrective action is required to complete the CAPs. Follow-up with HU on these additional corrective actions was not conducted in 2013. During future compliance reviews, the EQRO will address these two items.

V. CONCLUSIONS, REQUIRED MCE CORRECTIVE ACTIONS AND UDOH RECOMMENDATIONS

A. Prepaid Mental Health Plans

1. Performance Improvement Projects Performance

Conclusions

In aggregate, the PMHPs met 99% of the applicable PIP criteria for the activities completed in 2012. Individual PMHP scores ranged from 92% to 100%. Nine of the ten PMHPs met 100% of the PIP criteria and one PMHP met 92%. The PMHPs have made improvements in mastering the activities and associated criteria for conducting a meaningful PIP and have PIPs that are relevant to their individual client needs and staff interests. These PIPs have the potential to impact clients' health and outcomes.

Required Corrective Actions

OHCS did not identify any statewide required corrective actions. The required corrective actions for the one PMHP with outstanding CAPs are identified in *Appendix 4*.

2. Performance Measures Performance

Conclusions

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

Required Corrective Actions

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

3. Compliance Reviews

Conclusions

Overall, the PMHPs demonstrated very high levels of compliance with Federal and State standards for managed care. In the aggregate, the PMHPs met 93% of the compliance standards in 2011. Based on the PMHPs' implementation of all required corrective actions, all PMHP have met the standards.

Required Corrective Actions

OHCS did not identify any statewide required corrective actions.

B. Physical Health Plans

1. Performance Improvement Projects Performance

Conclusions

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

Required Corrective Actions

OHCS did not identify any required corrective actions.

2. Performance Measures Performance

Conclusions

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

Required Corrective Actions

- MHU must develop and implement strategies to improve Chlamydia screening for women;
- MHU must develop and implement strategies to improve adolescent well-care visits; and
- MHU must develop and implement strategies to increase the rate of well-child visits for members three through six years of age.

3. Compliance Reviews

Conclusions

In 2011, the PHPs demonstrated exceptionally high levels of compliance with Federal and State requirements for managed care. MHU met 100% of the standards and HU met 97% of the standards. HU was required to take corrective action on two standards that were not fully met in 2011. In 2012, HU demonstrated progress toward

completing its corrective actions but the required actions were not complete. These areas will be subject to review during the 2014 compliance reviews.

Required Corrective Actions

OHCS did not identify any statewide required corrective actions.

HU is must complete the two following corrective actions.

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

C. UDOH Recommendations for all MCEs

1. Performance Improvement Projects Recommendations

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

2. Compliance Reviews Recommendations

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

Appendix 1

Annual Report Format Crosswalk

Appendix 1 – Annual Report Format Crosswalk

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

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

Appendix 2

Sample HEDIS Measures

Appendix 2 - Sample HEDIS Measures

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS 2011

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

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

Description

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

Eligible Population

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

Administrative Specification

Denominator The eligible population.

Appendix 2 - Sample HEDIS Measures

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

Table BCS-A: Codes to Identify Breast Cancer Screening

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

Current Procedural Terminology © 2010 American Medical Association. All rights reserved.

Exclusion (optional)

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

Table BCS-B: Codes to Identify Exclusions

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

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

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

Data Elements for Reporting

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

Appendix 2 - Sample HEDIS Measures

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

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

Appendix 3
Completion Status of Required Corrective Actions Identified in 2011

Bear River Mental Health (BRMH)

Performance Improvement Project Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
Activity 2 Criterion 1	The study question is stated in clear, simple terms.	BRMH must restate its study question in clear and simple terms.	Yes
Activity 3 Criterion 1	The study indicator(s) are well defined, objective, and measurable.	BRMH must define its study indicator so that it clearly and accurately describes what is to be measured	Yes
Activity 6 Criterion 4	The instrument(s) used for data collection are identified.	BRMH must carefully define the use of the term "study population." Some columns are subsets of others. The number of study population indicated for referral is not accurately labeled.	Yes
Activity 6 Criterion 9	Describe the data analysis plan and all pertinent methodological features.	BRMH must recalculate percentage data and present it in accordance with the study indicator definition or redefine and clarify the study indicator.	Yes
Activity 8 Criterion 1, 3, 4, 5, 6 and 7	Data analysis and interpretation	BRMH did not provide answers to Activity 8 Criteria 1, 3, 4, 5, 6, and 7 even though data analysis and interpretation occurred in 2011. BRMH must provide answers to these criteria.	Yes

Compliance Review Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
1.3 General Provisions	§438.10(f)(6) Information Requirements	BRMH must revise its PMHP member handbook to include language on the amount, duration, and scope of covered benefits and obtain approval from the state on the revisions.	Yes

Bear River Mental Health (BRMH) (continued)

Compliance Review Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
4.3 Quality Assessment and Performance Improvement— Measurement and Improvement Standards	§438.240(b), (d) Quality Assessment and Performance Improvement Program	BRMH must submit clarification of the study question within 30 calendar days of receipt of this required corrective action. The study question will be evaluated by UDOH prior to BRMH conducting further activity on its PIP. Once the study question is approved by UDOH, BRMH must submit to UDOH for validation a new PIP Reporting and Evaluation Form addressing the study question. The new PIP Reporting and Evaluation form must be submitted to UDOH within 90 calendar days of approval of the revised study question.	Yes

Central Utah Counseling Center (CUCC)

Performance Improvement Project Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
Activity 8 Criterion 4	Data analysis and interpretation are presented in a way that provides accurate, clear, and easily understood information.	In its 2013 submission of the PIP reporting tool, CUCC must label all columns and ensure that the data presented in its tables matches the data reported in the narrative.	Yes

Performance Measures Required Corrective Action

Activity	Requirement	Required Corrective Action	Completed? Yes or No
NA	NA	None	NA

Compliance Review Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with	CUCC must develop policies and procedures for detecting and reporting potential enrollee fraud or abuse. These policies and procedures may be contained in CUCC's Corporate Compliance Plan or in a separate document that is cross-referenced in the Corporate Compliance Plan.	Yes

Four Corners Community Behavioral Health (FCCBH)

Performance Improvement Project Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
Activity 8 Criterion 1	Data analysis and interpretation were conducted according to the data analysis plan.	FCCBH must describe in its submission of the PIP reporting tool in 2013 the statistical techniques it used, or plans to use, in its data analysis.	Yes
Activity 8 Criterion 7	Data analysis and interpretation identify initial measurement and re-measurement of study indicators.	FCCBH must describe in its submission of the PIP reporting tool in 2013 how it evaluated, or plans to evaluate the extent of the projects success. For example, what goal or benchmark, is or was, used as a measure of success	Yes
Activity 9 Criterion 4	There is statistical evidence that an observed improvement is real improvement.	FCCBH must describe in its submission of the PIP reporting tool in 2013 what statistical evidence it used, or plans to use, to identify real improvement.	Yes

Valley Mental Health (VMH)

Performance Improvement Project Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
Activity 7 Criterion 1	Intervention/improvement strategies undertaken are related to causes or barriers identified through data analysis and QI processes.	In its 2013 PIP submission VMH must provide information on how it implemented the strategies within its organization.	No
Activity 7 Criterion 2	Intervention/improvement strategies address whether they are likely to induce permanent change.	In its 2013 PIP submission VMH must provide information on what actions are taken by managers once the reports are received and address how the actions are likely to induce permanent change.	No
Activity 7 Criterion 3	Intervention strategies address whether they are revised if original interventions are unsuccessful.	In its 2013 PIP submission VMH must provide an analysis of why its intervention strategies are not successful and modify its strategies accordingly.	No

Valley Mental Health (VMH) (continued)

Compliance Review Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
3.8 Quality Assessment and Performance Improvement—Structure and Operation Standards	§438.214(b) Provider Selection	<p>VMH must implement processes to ensure compliance with its policy for credentialing and recredentialing subcontracted providers, and to ensure 100% of files are complete and current at all times. The following deficiencies were identified in the review sample:</p> <ul style="list-style-type: none"> ➢ 83% contained expired professional licenses. ➢ NPI verification was not included in any files. VMH policy, “Subcontractor Outpatient Services: Application to Become a Provider” states NPI verification will be documented in credentials files. ➢ Two provider applications were denied. The denial letters sent to the requesting providers did not include the reason VMH denied the application. VMH policy “Subcontractor Outpatient Services: Application to Become a Provider” states denial letters will include the reason for the denial. 	Yes
6.0 Certifications and Program Integrity	§438.214(d) Provider Selection; §438.608 Program Integrity Requirements; and §438.610 Prohibited Affiliations with Debarred Individuals	<p>VMH must update its compliance plan to include the potential for member or enrollee fraud in the fraud and abuse program.</p>	Yes

Wasatch Mental Health (WMH)

Performance Measures Required Corrective Actions

Activity	Requirement	Required Corrective Action	Completed? Yes or No
Item 4	Please explain the process you use to assure the data you are submitting to UDOH is complete and accurate (quality assurance processes).	The results of QQ's analysis of the data file submitted by WMH do not match the results WMH reported to UDOH. WMH must fully implement its quality assurance processes for tracking and monitoring to ensure it is accurately reporting data from its performance measures database to UDOH. WMH must document how it will ensure the data submitted for validation match the data reported to UDOH in annual reports.	Yes

Weber Human Services (WHS)

Performance Improvement Project Required Corrective Actions

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

Healthy U (HU)

Compliance Review Required Corrective Actions

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

Appendix 4
Summary of Required Corrective Actions Identified in 2013

Appendix 4 - Summary of Required Corrective Actions Identified in 2012 & 2013

Valley Mental Health (VMH)			
Performance Improvement Project Required Corrective Actions for 2012			
Activity	Requirement	Required Corrective Action	Completed YES or No
Activity 7 Criterion 1	Intervention/improvement strategies undertaken are related to causes or barriers identified through data analysis and QI processes.	In its 2013 PIP submission VMH must provide information on how it implemented the strategies within its organization.	NO
Activity 7 Criterion 2	Intervention/improvement strategies address whether they are likely to induce permanent change.	In its 2013 PIP submission VMH must provide information on what actions are taken by managers once the reports are received and address how the actions are likely to induce permanent change.	NO
Activity 7 Criterion 3	Intervention strategies address whether they are revised if original interventions are unsuccessful.	In its 2013 PIP submission VMH must provide an analysis of why its intervention strategies are not successful and modify its strategies accordingly.	NO

VHM failed to complete its corrective action in its 2013 submission. All three corrective actions continue. VMH will be required to address this issue in its 2014 submission of CY 2013 PIP activities.

MEDICAL CARE ADVISORY COMMITTEE

A G E N D A

July 16th, 2015

CANNON HEALTH BUILDING

288 NORTH 1460 WEST

ROOM 125

1:30 p.m. – 3:30 p.m.

- | | | |
|---|-------------------|------------|
| 1. Welcome | Andrew Riggle | 10 Minutes |
| - Nominations to Fill Committee Vacancies (Business Community and Long-Term Care Providers) | | |
| - Introduction of Jonathan George to the MCAC (Representing Pharmacy Providers) | | |
| - Resignation of RyLee Curtis Following August's Meeting (Consumer Advocacy Groups) | | |
| - **Approve Minutes of June 18 th , 2015 Meeting** | | |
| 2. **Committee Voting on Funding Priorities** | Committee Members | 15 Minutes |
| 3. New Rulemakings - *Information* | Craig Devashrayee | 10 Minutes |
| 4. Budget Update | Janica Gines | 10 Minutes |
| 5. Update on ACO Transitions in New Managed Care Counties | Emma Chacon | 10 minutes |
| 6. AUCH/CHC Funding Presentation | Alan Pruhs | 20 minutes |
| 7. PRISM Updates | Jason Stewart | 15 minutes |
| 8. HCBS Waiver Updates | Tonya Hales | 15 minutes |
| 9. Director's Report | Emma Chacon | 10 minutes |
| - Dr. Patton's Resignation & Process to Find a New Department Director | | |
| - Medicaid Expansion Updates | | |
| - PCN Open Enrollment Period | | |
| - CMS Request to Extend 1115 Waiver (PCN Program) | | |
| 10. Voting Results | Josip Ambrenac | 5 minutes |

* Informational handout in the packet sent to Committee members

** Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)

*** Please send meeting topics or other correspondence to Josip Ambrenac (jambrena@utah.gov)

**** If unable to attend in person, the Bridge Phone# is 877-820-7831 participant code 988316#****

NEXT MCAC MEETING:

August 20th, 2015

CANNON HEALTH BUILDING

288 NORTH 1460 WEST

ROOM 125

1:30 p.m. – 3:30 p.m.

**Health
Health Care Financing, Coverage and Reimbursement Policy**

Notice for December 2015 Primary Care Network (PCN) Waiver Extension Request and Notice of Public Hearing

The Utah Department of Health, Division of Medicaid and Health Financing will hold a public hearing to discuss a request to extend the 1115 Primary Care Network Medicaid Waiver through December 31, 2016. This will allow the Division to continue operating the Primary Care Network (PCN), Non-Traditional Medicaid, and Utah's Premium Partnership Program through December 31, 2016. The proposed extension is subject to Centers for Medicare and Medicaid Services (CMS) approval.

The public hearing will be held Thursday, October 22, 2015, from 3:30 p.m. to 5:30 p.m., in Room 129 of the Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah. You may also participate by phone at 1-877-820-7831 CODE 196690#.

Individuals needing special accommodations to participate in this meeting should contact Jennifer Meyer Smart at 801-538-6338 or jmeyersmart@utah.gov by October 19, 2015.

**Health
Health Care Financing, Coverage and Reimbursement Policy**

Notice for November 2015 Medicaid Rate Changes

Effective November 1, 2015, Utah Medicaid will adjust its rates consistent with approved methodologies. Rate adjustments include new codes priced consistent with approved Medicaid methodologies as well as potential adjustments to existing codes. All rate changes are posted to the web and can be viewed at: <http://health.utah.gov/medicaid/stplan/bcrp.htm>

End of the Special Notices Section

Public Hearing on 1115 PCN Waiver Extension

Minutes of Public Hearing October 22, 2015

Participants

UDOH Staff

Emma Chacon, Jennifer Meyer-Smart, Nate Checketts, Jeff Nelson, Karen Larson

Visitors

None

Welcome

Emma Chacon, Hearing Officer, called the hearing to order at 3:31 pm.

Opening Remarks

Emma: This is the official opening of the public hearing regarding the request for a one year extension for the Primary Care Network demonstration waiver. At this point we will wait for anyone from the public to provide any input or ask any questions.

Public Comments

None

Conclusion

After no comments were given from the public, Emma Chacon concluded the hearing at 5:31 pm.

Utah Indian Health Advisory Board

Minutes of Meeting September 11, 2015

Participants

Committee Members Present

Donna Singer, *Consultant, Utah Navajo Health Services, Inc., UIHAB Chairperson*

Michael Jensen, *CEO, Utah Navajo Health Systems*

Allen Pitts, *Health Director, Paiute Indian Tribe of Utah (via phone)*

Rozanna Padilla, *Ute Tribe Health Educator (via phone)*

James Toledo, *Utah Division of Indian Affairs*

LeAnna Van Keuren, *Health Director, Urban Indian Center of Salt Lake*

David Ward, *Ute Mountain Ute Health Center Director (via phone)*

Committee Members Excused

Joan Perank, *Ute Indian Tribe Health Board*

Hunter Timbimboo, *Tribal Health Director, Northwestern Band of Shoshone, UIHAB Vice Chairperson*

Committee Members Absent

Kristen Bear Stewart, *Skull Valley Band of Goshute*

Carol Chicharello, *Deputy Director OSD, PAO HIS*

Erna Granbois, *CEO, U & O IHS Service*

Michele Lefebvre, *Health Program Director, Paiute Indian Tribe of Utah*

Malcom Lehi, *Tribal Council, White Mesa, Ute Mountain Ute Tribe*

Christine Steele, *Acting Health Director, Confederate Tribes of Goshute Indians*

John Trocheck, *Tribal Health Director, Ute Mountain Ute Tribe*

Guests

Jake Fitisemanu, *Health Program Specialist III FHP, Utah Department of Health*

Jacoy Richens, *Eligibility Specialist, Utah Department of Work Force Services, American Indian Team*

Craig Devashrayee, *Technical Specialist, UDOH Bureau of Coverage and Reimbursement Policy*

Greg Bateman, *Health Program Manager II HSI, Utah Department of Health*

Ying Yang, *University of Utah Biometrics Student & Intern for AI/AN Health Affairs for SIM grant*

Jeff Nelson, *Bureau Director, UDOH Bureau of Eligibility Policy*

Sam Lee, *Research Consultant, UDOH Bureau of Child Development*

Teresa Whiting, *Bureau Director, UDOH Bureau of Child Development*

Teresa Roark, *Health Program Coordinator, Utah Department of Health*

Kelly Robinson, *Health Program Coordinator, Utah Department of Health*

Tracy Altman, *Manager of Governmental Programs for the University of Utah Health Programs*

Nate Gladwell, *Director of TeleHealth and TeleMedicine at the University of Utah*

Franci Taylor, *President's Liaison to Utah Leaders, University of Utah*

Dr. Ana Maria Lopez, *Associate Vice President for Health Equity and Inclusion, University of Utah Health Sciences Center*

Deb LaMarsh, *Utah TeleHealth Network*

Ed Napia, *Urban Indian Center of Salt Lake, Health Promotion Programs*

Kevin McCulley, *Health Program Manager II HIS, Utah Department of Health*

Wei Hou, *Epidemiologist, Utah Department of Health*

Mindy Colling, *Health Program Specialist III FHP, Utah Department of Health*

Welcome and Introductions

Donna Singer called the meeting to order at 9:10 am.

Approval of minutes

Michael motioned to approve the July and August minutes, with one typo correction to the August minutes. Leanna seconded, and the motion was passed.

Committee Updates and Discussion

UDOH Office of Health Disparities (data tool) – Jake F. had one handout

Jake reviewed the demographic profile pages on their website and asked the group for input on the information. De-emphasized the “history”. Talked more about the tribes. Left raw data at the bottom, with links to details from the sources of that information. Added socio-demographic information as far as languages spoken. Added “Urban” and “Reservation” language. They want the website to be a snapshot and a transition to the people who work more closely with the information.

LeAnna asked a question about the background paragraph – she thought the distinction between tribes and sovereign governments might be a bit confusing to someone who is not familiar with the terms. Melissa suggested adding the word “Historically” at the beginning of the paragraph.

LeAnna also asked about the socio-demographic information. Again, Jake indicated that additional information could be provided through links on this web page.

Allen asked Jake to clarify that this web page would be a basic overview of the information, with more detailed information coming from this office. Also thought it would be good to have a link to each specific tribal page. Melissa noted that those links already exist on the Indian Health web page.

Donna spoke about the Navajo nation. She suggested that the web page should specify the Utah Portion of the Navajo Nation. Melissa suggested adding another sentence about tribes that share boundaries with other states.

The group agreed to make the above changes and have Jake move ahead.

Medicaid State Plan Amendments (SPA) & Rules

Craig Devashrayee and Greg Bateman presented.

R414-71C Alternative Remedies for Nursing Facilities. No substance change, just movement in oversight from Medicaid to DFHP. This is for Medicaid only certified nursing homes. For nursing facilities, if there are findings on a survey of concern, there are statutorily required penalties that should be imposed. Now the DFHP will be able to impose those penalties directly without input from Medicaid. Most of the facilities are along the Wasatch Front.

Craig reviewed Rule R414-307. Updated the age requirement for Autism Waiver eligibility. Will go into effect on 11/1/15.

Donna asked if autism in patients is increasing. Craig said he would need to defer that questions to Tonya Hales.

DWS Medicaid Eligibility Operations

Care About Child Care Program and Children’s Services Society. Individuals are eligible if they are recently unemployed, and not eligible for other State child care. May be eligible for the program if the child is 12 or under, or over 13 if they have a special need. Contact Tina at 801-326-4399 or go to CSS.

LeAnna suggested having Tina attend an upcoming meeting to explain more.

UT Medicaid Eligibility Policy

Jeff Nelson presented a follow up to the discussion about the new application.

On Medicaid only side, they were able to incorporate all the suggested changes from this Board with a few minor edits.

Melissa asked Mike if his people had a chance to review the application. They have not. Darlene Eddy would need to do this. Mike will forward a copy of the application to Darlene for her review.

Melissa asked the group to get responses back to Jeff by 9/18.

A draft application will be sent to CMS. We will be able to make changes up through this review time.

Melissa asked Jacoy to verify that consultation is occurring. Jacoy said she is waiting to hear from Nate McDonald. Melissa will start including Nate on meeting invites and ask him to attend an upcoming meeting. Melissa will also send information to Nate regarding the purpose of this group and the policies and bylaws.

New tool – On the back of Medicaid cards, there is a website that allows a person to get information on their Medicaid coverage. Individuals are able to use this on a smart phone or computer. More formal information will be coming around January.

Melissa asked how expansion is going. Meetings are happening. Most of the discussion is about tax levies and how to pay for coverage. It looks like progress is occurring.

Federal and State Health Policy Impacting I/T/U

Melissa presented an update.

Lots of things coming out from CMS regarding trainings and updates. Today there is a call with CMS about the Affordable Care Act (ACA). Melissa included in the packet information on a call that will be happening on 9/29.

The National Indian Health Board Consumer Conference is coming up. Go to the website to get information ([NIHB 2015 National Consumer Conference](#)). Melissa said she would like to aim to participate in the conference next year.

Melissa is still trying to get more information on the population that receives coverage under the Affordable Care Act.

LeAnna talked about a recent article she read from the Kaiser Foundation about how Native Americans are leery of using health care. Melissa suggested holding some sessions for the public to educate them. LeAnna will write a letter to the Tribal Leaders to offer support.

Paiute – Allen said Laurel Yellowhorse is the contact (Laurel.Yellowhorse@ihs.gov). Allen will check with Laurel about the population that is eligible for the ACA.

Mike said they do not have much enrollment in the ACA, but they are very active in enrolling in other programs. Medicaid expansion would be very helpful in this area.

MCAC

The meeting last month was cancelled. Will update next month.

CHIP Advisory Committee

The meeting last month was cancelled. Will report in November.

I/T/U Updates

UNHS

Mike Jensen reported.

They are performing site to site inspections to make sure things are ready for surveys.

Navajo Nation still does not have their pumps on, water is still being hauled. Operationally they are fine. Melissa is not sure what the next steps should be. She will try to get in touch with Craig Deitrich about this.

Mike said there is a concern about recent suicide attempts over the last month. Rick Hendy has been reaching out to Kim from the State for support. Tribal of Indian Issues Committee will be meeting next week and might be able to offer some support.

Paiute

Allen Pitts reported.

HRSA and grants have been taking a lot of time.

There is a Health Care seminar on 10/10.

A lot of wellness programs are stepping up (weight loss, etc.). Paiute Rock contest – the idea is to get people out walking. Several walking programs are continuing. Many nutrition classes are happening. Several clinics are prescribing nutrition and exercise. Focusing more on the holistic approach to wellness.

Northwestern Band of Shoshone

No report

Confederate Tribes of Goshute Indians

No report

Ute Indian Tribe

Donna Singer reported.

The Ute Tribe is in the middle of negotiations which has been very challenging. Needs to be completed by 9/17, with implementation on 10/1.

Melissa asked if Joan has gotten the Medicaid packet up and going. Donna will check with Joan. Need official documentation from IHS that they have implemented 638 Status.

Urban Indian Center

LeAnna VanKeuren reported.

NOMI Navigator grant is for the next three years. Push in the Uintah Basin. Christine has been a great help.

SAMSA grant for suicide prevention. Focus on treatment and operational changes with the education system, juvenile system and foster family program. NOMI is sponsoring a walk on 9/12 at Liberty Park for Suicide Prevention.

Started a Zumba class two nights a week at their center. A lot of interest in this, they might add another class. May add step Zumba and light weights. A lot of the people in the community have lost weight; some have gone off of insulin and their A1Cs have dropped.

UDOH updates

Melissa Zito reported.

Medicaid data for July and August is in the packet. In July there is a significant decrease in enrollment. Melissa is reviewing the data to see if she can determine a reason for the drop.

Student from University of Utah, Ying Yon, who is majoring in Biostatistics. We got money from CMS to look at diabetes, substance abuse, obesity, mental health. Ying will be reviewing databases to see if information is being captured for the Indian Nations. Jill Jim, a former student who worked with this Board, will be at an upcoming meeting to talk about her work with diabetes.

Melissa went to a diabetes seminar training. She participated at the policy level to make sure needs of the tribes were being covered. She was also able to meet two people from the CDC.

Melissa and Christine will be going out to sites starting next week to talk about emergency preparedness. There is a Utah Prepare Conference and Expo on 9/12. Melissa said there would be table top presentations in the near future.

UIHAB Priorities for 2015

Community Health Assessments/Data Collections and Sharing

Melissa Zito presented.

ITCAs data agreement has been signed.

Melissa will keep updated on how implementation is going and on the SIM grant progress

Strengthening Families (EPICC program funding)

Gestational Diabetes

Teresa Roark and Kelly Robinson presented.

Focus on working with health care systems to improve health care. Melissa suggested to Teresa that she look at gestational diabetes and the special diabetes program by focusing on prevention. Over the next two years will follow those people who have been identified as having gestational diabetes. Grant money will focus on DP13-1305 and DP14-1422. 1305 is focused on hypertension and diabetes management. 1422 will focus on prevention. Melissa thought linking to the 1422 would be a better fit because they are already working on prevention. Donna said this collaboration would be a good idea because people are already involved and it will be a spark to start the fire going again. LeAnna said they are providing competency training at the community health centers. Kelly said it might be interesting to look at data for people who "fall off the radar". How would this be operationalized? Identify the people and see if there is follow up (an action item would be to identify them when they bring in their babies for wellness checks after birth). LeAnna said that many people are part of Molina Health Care and often do not go in for post-partum follow up checks. Melissa will ask Ying to work with Maryann at Molina and possibly Tracy Altman from the University of Utah to get this data. It will be interesting to see if there are improvements with the incentives that are currently being offered. Need to develop a timeline when there has been policy intervention. There is funding to support time for Kelly and for the UIHAB staff to be reimbursed. Teresa said the next step most likely would be to follow up with each tribal representative to map things out. Melissa asked if the funding would pay for printing materials like the "Baby Your Baby – Protect the Circle" booklet if it is categorized as training material; Teresa thought it would. Melissa thinks they can use the booklet to incentivize the moms to follow up the best that they can. Suggested adding a piece to the booklet about gestational diabetes (is already in there; would need to add information on blood testing and what it is for). Donna suggested adding in a couple of pages about mom's health post-partum. Get buy-in from medical staff to figure out who plays which role in giving out and helping to complete the booklet with the mom. Would SDPI money be able to cover incentives to moms? Mike said yes for the Navajo Nation; Allen felt that money from the Paiute Tribe would be tight right now because it's being used for other programs, but he felt there could be money found from other sources. Teresa asked for a list of the best people to follow up with at the community health clinics – Melissa will send this to Teresa.

Side note – Teresa asked Mike who would be the best person to contact at UNHS to talk about CDC accredited programs. This would be Andy Bayliss.

Medicaid/Medicaid Expansion (PCN Waiver Extension)

Melissa Zito presented on behalf of Nate Checketts.

As Emma Chacon points out, the waiver extension needs to be submitted to CMS and is still seeking approval from the UIHAB. Melissa received approval from all parties and will pass this on to Emma.

UDOH Updates

TeleHealth

Presenting were: Tracy Altman (Manager of Gov. programs for the University of Utah Health Programs) and Nate Gladwell (Director of TeleHealth and TeleMedicine at the University of Utah), Franci Taylor (President's Liaison to Utah Leaders), Dr. Ana Maria Lopez (Associate Vice President for Health Equity and Inclusion, University of Utah Health Sciences Center), Deb LaMarsh (Utah TeleHealth Network).

The timeline for assessing connectivity should be taking place between now and the end of October. During this time we will be assessing equipment, need and people (contacts). Melissa wants to know who the point person is. Nate suggested that person should be Tracy because of her experience. Tracy said she is planning to submit a whitepaper to give an overview of things that have been happening.

Donna commended Deb LaMarsh for her work over the last 20 years to get TeleHealth to very remote areas.

Next step would be for the group to establish points of contact in the tribes for the TeleHealth group to connect with. Do this by 9/18/15. Deb suggested having two points of contact – one for facilities or technical questions, and the other for the clinical needs. LeAnna also suggested creating a contact list of “tribal experts” for historical purposes. Melissa will work with Tracy to get the TeleHealth group up to speed and to develop a plan for implementation and services.

Deb is looking to capture needs or challenges to developing a TeleHealth program to create historical data.

Donna asked if the University of Utah has plans to expand services to the Vernal area.

Melissa proposed having a draft of the analysis completed in time to present to the Utah Tribal Leaders' Meeting on 11/5/. Tracy proposed presenting in February. This would be an overview of the needs and capabilities of each tribe to have TeleHealth.

PHEP Planning

Melissa needs a consensus so she can sign a letter stating that the Board approves moving the grant forward. Not enough people here today, so Melissa will send an email asking for support.

CMS UT training

Cindy Smith from Denver Division 8 would like to come for training. It looks like the training will be sometime in March.

MCH

Side note

Melissa expressed concern about Board members who do not consistently participate in the meetings. It is difficult to get items passed and move things forward. Not sure how to remedy this. Donna and Melissa will try to contact people. Melissa asked Donna to go with her to the next Utah Tribal Leaders' meeting to speak about why participation is important for policy development and implementation.

Office of Home Visiting Grant; Family Spirit Project

Sam Lee and Teresa Whiting presented.

Teresa and Sam reviewed the grant document. Suzanne Lianelli gave a presentation earlier about the Family Spirit model. A grant was not received, but the DWS approved an application from another funding source (TAMA funding) with which they will contract with tribes. Two requirements: Tribe would have to meet the Family Spirit requirements and 2) Would have to report on program outcomes to the legislature. Outcome areas would be: Increase parenting knowledge and skills around substance abuse prevention, suicide and depression prevention, HIV prevention, nutrition promotion, diabetes prevention and youth development. Would need to develop data points around these outcomes. Sam and Teresa are asking that any tribes interested in participating would need to work with Melissa to develop a

paragraph about why they are interested in participating. This would be presented to DWS. The reporting would be aggregate information, not personal information. There is also a mechanism for each tribe to put in information regarding what the visit is about, who they are seeing, etc. and have the ability for each tribe to generate reports of their own. LeAnna asked how the funding would be given to the tribes. Teresa said this would be in the form of a three year grant (\$1M for each year). Some of the money would go to the Central Utah Health Department to support the clinics. Melissa suggested having a public health nurse be the hub for coordinating the CHRs. Consensus from all tribes to move forward with the program. Melissa will have everything written up and given to Teresa by the end of September. Teresa left copies of the overview of the Family Spirit Program.

PHEP (Public Health Emergency Preparedness) Grant; New Cycle & Deliverables

Kevin McCulley presented.

Process will be similar for ensuring contact information and interest in the program.

Continuing to move forward with base preparedness work.

Executive summary in the packet is in the overview; Nate will send a summary of the actual work items.

Questions about the expectations of the grant: Donna said the biggest challenge is getting the program coordinated as it pertains to each area, and also with maintaining the program after it is established (doing practice exercises so everyone can practice their roles). Kevin said they put an emphasis on quarterly training for core staff of incident command. Biggest benefit is to have the key people ensure that they know what to do. Look at continuity of services being core to operations.

Melissa would like to have a meeting of people at the tribal level to talk about expectations of the program.

Ed expressed concern about someone who needs to be treated for a radiation injury and how to handle those situations.

Melissa and Christine will be heading out to all the tribes in the next few months to do preparedness training and table top exercises.

Infectious Disease Emergency Response (IDER) – Wei Hou and Mindy Colling

Wei Hou and Mindy Colling gave an update.

LeAnna said American Indian tribes need to be specifically mentioned in the forefront (Melissa reiterated this as well). On the flow chart, "Incident Manager" was mentioned, but it was referred to as the "Incident Commander" throughout the remainder of the document. Need to better spell out how the tribes will work with the plan.

Rosanna – will talk with Eldora Prank to see if she has any recommendations.

Mindy said this focuses on infectious diseases, but would overarch into emergency preparedness plans.

Inclusion of the Tribal Indian Organization needs to flow throughout the plan.

Kevin asked about San Juan County starting as its own district – will this present new challenges that need to be navigated?

LeAnna said we need to make implicit throughout the document that the tribes have the opportunity to work directly with the UIHAB if they choose. Mindy asked the group to help with the proper language to put in the document.

Wei will send a copy of the most recent version to Melissa who will send this to the rest of the group.

Ed said it is important to clarify who has fiscal responsibility. Also said it's important to determine which media to include. Kevin said this might be an opportunity to revisit the pandemic flu plan.

Ed said the role/communications between tribes and counties needs to be laid out regarding what resources will be funneled to them in the case of an emergency.

Mindy said the template is available to use if tribes want to develop their own plan.

Wei said if there are additional comments, she would like those forwarded to her by the end of the month.

Adjourn

With no further business to consider, the meeting adjourned at 1:15 pm.

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SPECIAL NOTICES

Health

Health Care Financing, Coverage and Reimbursement Policy

Notice for Primary Care Network (PCN) Waiver Extension Request

The Utah Department of Health, Division of Medicaid and Health Financing will submit a request to extend the 1115 Primary Care Network Medicaid Waiver for one year. This will allow the Department to continue operating PCN, Non-Traditional Medicaid, and Utah's Premium Partnership Program through December 31, 2016. A copy of the Department's Request for Extension can be viewed at: <http://www.health.utah.gov/pcn/>.

The public may comment on this request until January 1, 2016, by submitting comments to echacon@utah.gov.

End of the Special Notices Section

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

Medicaid Eligibility Group	SFY 2001 Per Member Per Month (PMPM) (Base Year)	Trend Rate	Member Months						Total	Effective FMAP	Budget Neutrality Limit DY 1 (TF)	Budget Neutrality Limit DY 1 (FF)
			Q1 12/02	Q2 12/02	Q3 3/03	Q4 6/03	Q5 9/03	Q6 12/03				
Current eligibles 1902(r)(2) - PCN	\$333.55	1.08	\$338.05					223,729	70.93%	\$61,739,157.29		
	n/a	1.08	\$34.00					62,978	70.93%	\$2,412,195.95		
								Total BN Limit	70.93%	\$64,151,353.24		
Current eligibles 1902(r)(2) - PCN		1.08	\$420.18					257,558	71.60%	\$75,680,390.97		
		1.08	\$39.92					115,212	71.60%	\$4,810,921.31		
								Total BN Limit	71.60%	\$80,491,312.28	25%	
Current eligibles 1902(r)(2) - PCN		1.08	\$453.75					269,541	72.04%	\$88,115,945.64		
		1.08	\$62.98					138,562	72.04%	\$6,287,226.67		
								Total BN Limit	72.04%	\$94,403,172.32	17%	
Current eligibles 1902(r)(2) - PCN		1.08	\$490.09					264,052	71.10%	\$92,010,795.28		
		1.08	\$68.02					116,364	71.10%	\$5,627,989.37		
								Total BN Limit	71.10%	\$97,638,784.65	3%	
Current eligibles 1902(r)(2) - PCN		1.08	\$29.99					214,792	70.30%	\$79,923,943.63		
		1.06%	\$73.47					133,813	70.30%	\$6,911,024.21		
								Total BN Limit	70.30%	\$86,834,967.84	-11%	
Current eligibles 1902(r)(2) - HIFA		1.066	\$564.24					194,914	71.26%	\$78,369,943.69		
		1.066	\$73.32					148,028	71.26%	\$8,261,058.09		
								Total BN Limit	71.26%	\$86,631,001.78	0%	

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

	DY #7				Total	Neutrality Limit DY 7 (TF)	Effective FMAP	Neutrality Limit DY 7 (FF)
	PM/PM	QE 9/08	QE 12/08	QE 6/09				
Current eligibles	1,066	\$601.48			231,636	\$189,823,367	70.94%	\$88,835,992.59
1902(r)(2) - PCN	1,066	\$83.48			143,979	\$12,079,947	70.94%	\$8,526,946.30
1902(r)(2) - HIFA	1,066	\$170.45			2,875	\$490,054	70.94%	\$347,643.97
					Total BN Limit	\$157,833,356	70.94%	\$107,710,582.86
								24%
	DY #8				Total	Neutrality Limit DY 8 (TF)	Effective FMAP	Neutrality Limit DY 8 (FF)
	PM/PM	QE 9/09	QE 12/09	QE 6/10				
Current eligibles	1,066	\$641.17			278,979	\$175,873,747	71.44%	\$127,787,405.04
1902(r)(2) - PCN	1,066	\$88.99			124,731	\$11,100,302	71.44%	\$7,930,055.85
1902(r)(2) - HIFA	1,066	\$181.70			3,290	\$597,804	71.44%	\$427,071.13
					Total BN Limit	\$199,571,853	71.44%	\$136,144,532.02
								26%
	DY #9				Total	Neutrality Limit DY 9 (TF)	Effective FMAP	Neutrality Limit DY 9 (FF)
	PM/PM	QE 9/10	QE 12/10	QE 6/11				
Current eligibles	1,063	\$681.57			321,691	\$219,259,970	71.27%	\$156,262,232.97
1902(r)(2) - PCN	1,063	\$94.60			128,540	\$12,159,955	71.27%	\$8,666,399.69
1902(r)(2) - HIFA	1,063	\$133.15			3,079	\$694,711	71.27%	\$423,850.39
					Total BN Limit	\$232,008,535	71.27%	\$165,352,483.05
								21%
	DY #10				Total	Neutrality Limit DY 10 (TF)	Effective FMAP	Neutrality Limit DY 10 (FF)
	PM/PM	QE 9/11	QE 12/11	QE 6/12				
Current eligibles	1,063	\$724.57			382,634	\$277,220,396	71.02%	\$196,881,924.92
1902(r)(2) - PCN	1,063	\$100.56			101,403	\$10,197,135	71.02%	\$7,241,997.93
1902(r)(2) - HIFA	1,063	\$205.32			2,460	\$603,062	71.02%	\$357,253.22
					Total BN Limit	\$287,920,552	71.02%	\$204,481,176.08
								24%
	DY #11				Total	Neutrality Limit DY 11 (TF)	Effective FMAP	Neutrality Limit DY 11 (FF)
	PM/PM	QE 9/12	QE 12/12	QE 6/13				
Current eligibles	1,063	\$770.15			394,625	\$303,920,140	69.96%	\$212,622,529.87
1902(r)(2) - PCN	1,063	\$106.90			83,304	\$8,904,838	69.96%	\$6,229,824.98
1902(r)(2) - HIFA	1,063	\$218.25			1,854	\$400,278	69.96%	\$280,034.67
					Total BN Limit	\$313,225,257	69.96%	\$219,132,389.51
								7%
	DY #12				Total	Neutrality Limit DY 12 (TF)	Effective FMAP	Neutrality Limit DY 12 (FF)
	PM/PM	QE 9/13	QE 12/13	QE 6/14				
Current eligibles	1,0554	\$812.82	97,748	96,616	101,397	99,491	70.16%	\$225,400,892.79
1902(r)(2) - PCN	1,0554	\$112.82	22,892	20,571	17,852	14,201	70.16%	\$5,977,310.79
					Total BN Limit	\$321,266,952	70.16%	\$252,623,011
								\$2,562,623.01
								\$79,451,089.24
								\$2,320,773.11
								\$82,417,052.99
								\$80,867,826.65
								\$2,014,021.76
								\$1,602,124.30

BN Ceiling Calculation

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

1902(r)(2) - HIFA	DY #13		Member Months				Total	Budget Neutrality Limit DY 13 (TF)	Effective FMAP	Federal Funds	Budget Neutrality Limit DY 13 (FF)	Total funds 1st qtr ending 9/30/13	Total funds 2nd qtr ending 12/31/13	Total funds 3rd qtr ending 3/31/14	Total Funds 4th qtr ending 6/30/14
	PM/PM	QE 9/14	QE 12/14	QE 3/15	QE 6/15	QE 9/15									
1.0554	\$230.35	540	527	504	528	2,059	\$463,495	70.16%	\$339,220.25	\$124,386.58	\$121,392.09	\$116,094.14	\$121,622.43		
							\$230,269,998	70.16%	\$231,717,423.84	\$82,158,098.83	\$80,973,147.29	\$84,547,168.88	\$82,591,573.37		
										\$57,642,122.14	\$56,810,760.14	\$59,318,293.89	\$57,946,247.88		

1902(r)(2) - PCN	DY #13		Member Months				Total	Federal Funds	Effective FMAP	Federal Funds	Budget Neutrality Limit DY 13 (FF)	Total funds 1st qtr ending 9/30/13	Total funds 2nd qtr ending 12/31/13	Total funds 3rd qtr ending 3/31/14	Total Funds 4th qtr ending 6/30/14
	PM/PM	QE 9/14	QE 12/14	QE 3/15	QE 6/15	QE 9/15									
1.05	\$853.46	95,284	91,358	93,841	97,315	377,798	\$322,434,073	70.50%	\$227,316,021.28	\$81,320,727.44	\$77,970,058.12	\$80,089,190.04	\$83,054,097.13		
1.05	\$118.46	20,080	26,504	24,108	17,915	88,607	\$13,496,264	70.50%	\$7,399,863.63	\$2,378,648.59	\$3,139,626.61	\$2,855,799.81	\$2,122,185.73		
1.05	\$241.86	670	851	1,176	1,252	3,949	\$955,116	70.50%	\$673,356.89	\$162,048.07	\$205,825.23	\$284,430.64	\$302,812.21		
							\$335,885,450	70.50%	\$235,389,241.99	\$83,861,424.10	\$81,315,509.86	\$83,229,420.50	\$85,479,095.08		
										\$59,122,303.99	\$57,327,434.52	\$58,676,741.45	\$60,262,762.03		

1902(r)(2) - HIFA	DY #14		Member Months				Total	Federal Funds	Effective FMAP	Federal Funds	Budget Neutrality Limit DY 14 (FF)	Total funds 1st qtr ending 9/30/13	Total funds 2nd qtr ending 12/31/13	Total funds 3rd qtr ending 3/31/14	Total Funds 4th qtr ending 6/30/14
	PM/PM	QE 9/15	QE 12/15	QE 3/16	QE 6/16	QE 9/16									
1.05	\$896.13	88,607	88,607	88,607	88,607	377,798	\$339,555,776	70.45%	\$238,512,544.45	\$77,764,346.48	\$77,764,346.48	\$77,764,346.48	\$77,764,346.48		
1.05	\$124.98	88,607	88,607	88,607	88,607	377,798	\$11,021,074	70.45%	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48		
1.05	\$253.96	3,949	3,949	3,949	3,949	3,949	\$1,002,872	70.45%	\$706,523.30	\$706,523.30	\$706,523.30	\$706,523.30	\$706,523.30		
							\$350,579,722	70.45%	\$246,983,414.23	\$246,983,414.23	\$246,983,414.23	\$246,983,414.23	\$246,983,414.23		

1902(r)(2) - PCN	DY #14		Member Months				Total	Federal Funds	Effective FMAP	Federal Funds	Budget Neutrality Limit DY 14 (FF)	Total funds 1st qtr ending 9/30/13	Total funds 2nd qtr ending 12/31/13	Total funds 3rd qtr ending 3/31/14	Total Funds 4th qtr ending 6/30/14
	PM/PM	QE 9/15	QE 12/15	QE 3/16	QE 6/16	QE 9/16									
1.05	\$940.94	377,798	377,798	377,798	377,798	377,798	\$355,483,565	70.45%	\$250,438,171.68	\$8,152,563.81	\$8,152,563.81	\$8,152,563.81	\$8,152,563.81		
1.05	\$130.60	88,607	88,607	88,607	88,607	377,798	\$11,572,137	70.45%	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48		
1.05	\$256.66	3,949	3,949	3,949	3,949	3,949	\$1,053,016	70.45%	\$741,849.46	\$741,849.46	\$741,849.46	\$741,849.46	\$741,849.46		
							\$366,108,708	70.45%	\$259,332,584.94	\$259,332,584.94	\$259,332,584.94	\$259,332,584.94	\$259,332,584.94		

1902(r)(2) - HIFA	DY #15		Member Months				Total	Federal Funds	Effective FMAP	Federal Funds	Budget Neutrality Limit DY 15 (FF)	Total funds 1st qtr ending 9/30/13	Total funds 2nd qtr ending 12/31/13	Total funds 3rd qtr ending 3/31/14	Total Funds 4th qtr ending 6/30/14
	PM/PM	QE 9/16	QE 12/16	QE 3/17	QE 6/17	QE 9/17									
1.05	\$940.94	377,798	377,798	377,798	377,798	377,798	\$355,483,565	70.45%	\$250,438,171.68	\$8,152,563.81	\$8,152,563.81	\$8,152,563.81	\$8,152,563.81		
1.05	\$130.60	88,607	88,607	88,607	88,607	377,798	\$11,572,137	70.45%	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48	\$7,764,346.48		
1.05	\$256.66	3,949	3,949	3,949	3,949	3,949	\$1,053,016	70.45%	\$741,849.46	\$741,849.46	\$741,849.46	\$741,849.46	\$741,849.46		
							\$366,108,708	70.45%	\$259,332,584.94	\$259,332,584.94	\$259,332,584.94	\$259,332,584.94	\$259,332,584.94		

* Enrollment in HIFA amendment began in December 2006
 = Neutrality Limit without waiver ceiling
 = Actual Member Months
 = Estimated Member Months **
 = Inflation percentage submitted in HIFA Amendment

** Membership Assumptions:
 Current Eligibles' climbed steadily since SFY2008 and then leveled off in SFY13-14
 PCN average enrollment per month has declined from a peak in SFY2008 of 19,000 to 13,500 in SFY2013-14
 UPP averages about 170 members per month of which 90% are adults with children

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds

Get numbers from Bradley: Information only tab when FFY 2014 is complete; CMS occasionally asks for this information

	DY #3	DY #4	DY #5	DY #6	DY #7	DY #8	DY #9	DY #10	DY #11	DY #12	DY #13
	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011	FFY 2012	FFY 2013	FFY 2014	FFY 2015
State's Allotment	\$31,699,161	\$32,207,704	\$40,485,868	\$41,291,966	\$65,264,100	\$69,925,931	\$63,915,866	\$67,820,283	\$	\$	\$
Funds Carried Over From Prior Year(s)	\$48,784,806	\$51,794,787	\$38,752,157	\$40,381,700	\$51,420,653	\$41,070,648	\$51,486,312	\$63,915,866	\$74,933,993	\$	\$
SUBTOTAL (Allotment + Funds Carried Over)	\$80,483,967	\$84,002,491	\$79,238,025	\$81,673,666	\$116,684,753	\$110,996,579	\$115,402,178	\$131,736,149	\$74,933,993	\$	\$
Reallocated Funds (Redistributed or Retained that are Currently Available)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
TOTAL (Subtotal + Reallocated funds)	\$80,483,967	\$84,002,491	\$79,238,025	\$81,673,666	\$116,684,753	\$110,996,579	\$115,402,178	\$131,736,149	\$74,933,993	\$	\$
State's Enhanced FMAP Rate	80.50%	79.53%	79.10%	80.14%	79.50%	80.18%	79.79%	79.69%	78.73%	79.71%	78.97%
State's Blended SFY FMAP Rate	80.42%	79.77%	79.21%	79.88%	79.66%	80.01%	79.89%	79.71%	79.71%	79.71%	78.97%

COST PROJECTIONS OF APPROVED SCHIP PLAN

	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Benefit Costs	\$38,157,940	\$48,249,026	\$50,334,412	\$53,933,024	\$66,815,360	\$69,956,815	\$69,147,471	\$69,782,580	\$65,423,195
Managed care	28,579	35,186	31,895	32,021	38,019	41,641	38,506	37,372	35,446
Estimated Average Number in Direct Coverage	\$111.26	\$114.27	\$131.51	\$140.36	\$146.45	\$140.00	\$149.65	\$155.60	\$153.81
Per Member/Per Month Rate	\$38,157,940	\$48,249,026	\$50,334,412	\$53,933,024	\$66,815,360	\$69,956,815	\$69,147,471	\$69,782,580	\$65,423,195
Total Benefit Costs	\$ (663,617)	\$ (789,861)	\$ (824,391)	\$ (1,520,033)	\$ (1,900,000)	\$ (1,986,060)	\$ (1,418,355)	\$ (1,886,821)	\$ (2,399,936)
(Offsetting beneficiary cost sharing payments)	\$37,494,323	\$47,459,165	\$49,510,021	\$52,412,991	\$64,915,360	\$67,970,755	\$67,729,116	\$67,896,059	\$63,023,259
Net Benefit Costs	\$	\$	\$	\$	\$	\$	\$	\$	\$

Administration Costs

Personnel	\$430,170	\$519,094	\$900,533	\$922,816	\$867,544	\$1,009,954	\$826,238	\$1,132,659	\$569,928
General administration	\$18,332	\$51,760	\$274,300	\$168,167	\$28,039	\$41,341	\$95,458	\$179,192	\$14,300
Contractors/Brokers (e.g., enrollment contractors)	\$1,924,878	\$2,754,711	\$2,668,693	\$2,510,813	\$1,934,210	\$3,740,617	\$5,555,409	\$1,569,292	\$2,209,706
Outreach/marketing costs/Other	\$304,738	\$272,691	\$40,474	\$1,368,519	\$2,413,215	\$4,252,822	\$	\$20,198	\$1,382,271
Total Administration Costs	\$2,678,118	\$3,598,456	\$3,884,000	\$4,970,315	\$5,243,008	\$9,044,734	\$6,477,105	\$2,901,341	\$4,176,205
10% Administrative Cap	\$4,166,036	\$5,273,241	\$5,501,113	\$5,823,666	\$7,212,818	\$7,552,306	\$7,525,457	\$7,544,007	\$7,002,584
Federal Title XXI Share	\$32,306,677	\$40,730,451	\$42,291,535	\$45,837,785	\$55,888,156	\$61,620,093	\$59,283,350	\$56,432,608	\$53,067,417
State Share	\$7,865,764	\$10,327,170	\$11,102,486	\$11,545,521	\$14,270,212	\$15,395,396	\$14,922,871	\$14,364,792	\$14,132,047
TOTAL COSTS OF APPROVED SCHIP PLAN	\$40,172,441	\$51,057,621	\$53,394,021	\$57,383,306	\$70,158,568	\$77,015,489	\$74,206,221	\$70,797,400	\$67,199,464

CHIP Member Months

Estimated Inflation	342,948	422,226	382,742	384,250	456,225	499,693	462,070	448,465	425,355
Managed Care PMPM	\$111.26	\$114.27	\$131.51	\$140.36	\$146.45	\$140.00	\$149.65	\$155.60	\$153.81
Administration PMPM	\$7.81	\$8.52	\$10.15	\$12.94	\$11.49	\$18.10	\$14.02	\$6.47	\$9.82
	\$119.07	\$122.80	\$141.66	\$153.29	\$157.94	\$158.10	\$163.66	\$162.07	\$163.63

COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL

Benefit Costs for Demonstration Population #1 (e.g., children)

	Pop. 1	Pop. 2	Pop. 3	Pop. 4	Pop. 5	Pop. 6	Pop. 7	Pop. 8	Pop. 9	Pop. 10
Estimated Average Number Enrolled in HIFA	73	235	352	407	331	310	310	310	310	310
Per Member/Per Month Rate	\$94.90	\$115.60	\$74.61	\$122.77	\$133.40	\$112.84	\$112.84	\$112.84	\$112.84	\$112.84
Total Benefit Costs for Waiver Population #1	\$83,133	\$25,985	\$315,164	\$599,624	\$529,855	\$420,121	\$420,121	\$420,121	\$420,100	\$420,100
(Offsetting beneficiary cost sharing payments)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Net Benefit Costs	\$83,133	\$25,985	\$315,164	\$599,624	\$529,855	\$420,121	\$420,121	\$420,121	\$420,100	\$420,100

Administration Costs

Personnel	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
General administration	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Contractors/Brokers (e.g., enrollment contractors)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Outreach/marketing costs	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Total Administration Costs	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
10% Administrative Cap	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

IX. Member Month Reporting

Enter the member months for each of the eligibility groups for the quarter

A. For Use in Budget Neutrality Calculations Eligibility Group

	Month 1 Jul 2014	Month 2 Aug 2014	Month 3 Sep 2014	Month 4 Oct 2014	Month 5 Nov 2014	Month 6 Dec 2014	Month 7 Jan 2015	Month 8 Feb 2015	Month 9 Mar 2015	Month 10 Apr 2015	Month 11 May 2015	Month 12 Jun 2015	Total for Quarter Ending 06/15
Current Eligibles	32,346	31,720	31,218	30,641	30,289	30,428	30,793	31,105	31,943	32,856	32,537	32,422	377,798
PCN Demonstration Population (DP) #1 (PC1 & PC2)	15,111	17,666	19,882	20,078	19,820	19,552	18,703	17,610	16,215	15,228	14,220	12,898	206,983
High Risk Pregnancy DP #2	0	0	0	0	0	0	0	0	0	0	0	0	0
HIFA DP #3	207	223	250	273	275	304	370	397	413	409	423	432	3,976
HIFA COBRA DP #5	5	5	5	9	9	8	8	8	8	8	7	6	86

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B. Not Used in Budget Neutrality Calculations Eligibility Group

	Month 1 Jul 2014	Month 2 Aug 2014	Month 3 Sep 2014	Month 4 Oct 2013	Month 5 Nov 2013	Month 6 Dec 2013	Month 7 Jan 2014	Month 8 Feb 2014	Month 9 Mar 2014	Month 10 Apr 2014	Month 11 May 2014	Month 12 Jun 2014	Total for Quarter Ending 06/15
CHIP Current Eligibles (C1-C13)	15,377	15,506	15,675	15,852	14,966	15,045	15,460	15,834	16,149	16,274	16,223	16,171	189,532
CHIP HIFA COBRA DP #6 (C14-C19)	280	273	291	297	290	298	345	376	401	403	409	433	4,096

Federal Title XXI Share	\$	125,459	\$	397,392	\$	288,567	\$	500,147	\$	469,930	\$	369,548	\$	366,105
State Share	\$	32,936	\$	100,094	\$	68,575	\$	124,958	\$	118,291	\$	94,068	\$	97,495
TOTAL COSTS FOR DEMONSTRATION	\$	158,395	\$	497,486	\$	337,142	\$	625,105	\$	588,222	\$	463,616	\$	463,600
TOTAL PROGRAM COSTS (State Plan + Demonstration)	\$53,552,416	\$57,880,792	\$70,495,510	\$77,840,594	\$74,794,443	\$71,261,016	\$67,663,064							
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$79,238,025	\$81,673,666	\$96,694,753	\$110,996,579	\$115,402,178	\$131,736,149	\$74,933,993							
Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$42,416,994	\$46,235,177	\$56,156,723	\$62,120,239	\$69,763,280	\$68,802,156	\$53,433,522							
Unused Title XXI Funds Expiring (Allotment or Reallocated)	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$36,821,031	\$35,438,489	\$40,528,030	\$48,876,340	\$55,648,898	\$74,933,993	\$21,500,471							
Source of Funds: Tobacco Settlement Funds	\$40,836,058	\$51,847,482	\$54,376,807	\$59,400,825	\$72,395,510	\$76,212,798	\$70,063,000							

= Actual Costs
 = Estimated Costs

III. SUMMARY BY DEMONSTRATION YEAR AND CUMULATIVELY (Federal Funds)

	Budget Neutrality Limit	Waiver Costs on CMS-64	Annual Variance	Variance As % of Annual BN Limit	Cumulative Budget Neutrality Limit	Cumulative Waiver Costs on CMS-64	Cumulative Variance	Variance As % of Cumulative BN Limit
DY #1 (SFY 2003)	\$64,151,353	\$68,519,660	-\$4,368,307	-6.81%	\$64,151,353	\$68,519,660	-\$4,368,307	-6.81%
DY #2 (SFY 2004)	\$80,491,312	\$77,006,658	\$3,484,654	4.33%	\$144,642,666	\$145,526,318	-\$883,652	-0.61%
DY #3 (SFY 2005)	\$94,403,172	\$90,341,017	\$4,062,155	4.30%	\$239,045,838	\$235,867,335	\$3,178,503	1.33%
DY #4 (SFY 2006)	\$97,638,785	\$87,381,267	\$10,257,518	10.51%	\$336,684,622	\$323,248,602	\$13,436,020	3.99%
DY #5 (SFY 2007)	\$86,958,239	\$85,043,241	\$1,914,998	2.20%	\$423,642,861	\$408,291,843	\$15,351,018	3.62%
DY #6 (SFY 2008)	\$86,915,636	\$83,042,595	\$3,873,041	4.46%	\$510,558,497	\$491,334,438	\$19,224,059	3.77%
DY #7 (SFY 2009)	\$107,710,583	\$98,021,370	\$9,689,213	9.00%	\$618,269,080	\$589,355,808	\$28,913,272	4.68%
DY #8 (SFY 2010)	\$136,144,532	\$118,491,483	\$17,653,049	12.97%	\$754,413,612	\$707,847,291	\$46,566,321	6.17%
DY #9 (SFY 2011)	\$165,352,483	\$113,974,083	\$51,378,400	31.07%	\$919,766,095	\$821,821,374	\$97,944,721	10.65%
DY #10 (SFY 2012)	\$204,481,176	\$103,738,251	\$100,742,925	49.27%	\$1,124,247,271	\$925,559,625	\$198,687,646	17.67%
DY #11 (SFY 2013)	\$219,132,390	\$122,359,381	\$96,773,009	44.16%	\$1,343,379,661	\$1,047,919,006	\$295,460,655	21.99%
DY #12 (SFY 2014)	\$231,717,424	\$126,974,320	\$104,743,104	45.20%	\$1,575,097,084	\$1,174,893,326	\$400,203,758	25.41%
DY #13 (SFY 2015)	\$235,389,242	\$134,454,146	\$100,935,096	42.88%	\$1,810,486,326	\$1,309,347,472	\$501,138,854	27.68%
DY #14 (SFY 2016)	\$246,983,414	\$141,178,000	\$105,805,414	42.84%	\$2,057,469,741	\$1,450,525,472	\$606,944,269	29.50%
DY #15 (SFY 2017)								
Only two quarters estimated. Waiver extension ends 12/31/2016.	\$129,666,292	\$74,118,450	\$55,547,842	42.84%	\$2,187,136,033	\$1,524,643,922	\$662,492,111	30.29%

Legend

- = Estimated Figures
- = Neutrality Limit without waiver ceiling QTD Amount
- = Actual Expenditures 1115 Waivers QTD Amount

Row #	B	C	D	E	F	G	H	I	J	K	
	II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)										
	EXPENDITURES (Federal Funds)										
	Current Eligibles	Demo Population I - PCN Childless Adults (Section 1902(r)(2) PCN Adults in Demo Population I = 1115	Demo Population II (High-Risk Pregnant Women = 1115	Demo Population III - HIFA Childless Adults (HIFA Adults in Demo Population III = 1115	Adults	State Plan Eligibles	Expansion Group	State Plan Eligibles	Expansion Group	TOTAL	VARIANCE
State Fiscal Year (SFY)- Demonstration Year (DY)											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											

Legend

- = Estimated Figures
- = Neutrality Limit without waiver ceiling
- = Actual Expenditures from MBES/CBES reports including prior period adjustments

Row #	B	C	D	E	F	G	H	I	J	K	
II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)											
EXPENDITURES (Federal Funds)											
State Fiscal Year (SFY)- Demonstration Year (DY)	Budget Neutrality Limit (FF)	Current Eligibles (Sections 1925 and 1931 Adults and Medically Needy)	Adults	State Plan Eligibles	Expansion Group	Adults w/Children (Section 1902(f)(2) Adults; also Known as Hypothetical)	Childless Adults (PCN) Adults in Demo Population I = 1115	Adults w/Children (Section 1902(f)(2) Adults; also Known as Hypothetical)	Childless Adults (HIFA) Adults in Demo Population III = 1115	Total	Variance
SFY14-DY12	\$231,717,423.84	\$117,401,623	\$2,805,566	\$5,712,481	\$846,706	\$196,273	\$11,671	\$126,974,320	\$104,743,104		
QE 9/13	\$30,520,807	\$808,907	\$1,413,888	\$370,570	\$50,241	\$2,088	\$33,166,501				
QE 12/13	\$28,785,389	\$719,994	\$1,529,438	\$336,585	\$47,608	\$3,843	\$31,422,857				
QE 3/14	\$27,956,030	\$750,936	\$1,513,147	\$152,256	\$49,361	\$3,504	\$30,425,234				
QE 6/14	\$32,146,166	\$620,106	\$1,496,500	\$24,242	\$50,315	\$2,447	\$34,339,776				
SFY15-DY13	\$235,389,241.99	\$121,303,682	\$3,696,542	\$9,081,566	\$17,994	\$344,314	\$10,048	\$134,454,146	\$100,935,096		
QE 9/14	\$28,420,265	\$757,709	\$2,117,542	\$13,523	\$86,794	\$2,315	\$31,370,148				
QE 12/14	\$32,199,953	\$1,035,542	\$2,615,201	\$4,226	\$73,983	\$2,295	\$35,931,200				
QE 3/15	\$28,594,171	\$1,153,257	\$2,481,997	\$165	\$100,649	\$2,499	\$32,332,758				
QE 6/15	\$32,089,293	\$750,094	\$1,866,826	\$60	\$110,888	\$2,939	\$34,820,040				
TOTAL	\$1,810,478,997	\$1,309,347,472	\$501,131,525	\$501,131,525	\$501,131,525	\$501,131,525	\$501,131,525	\$501,131,525	\$501,131,525	\$501,131,525	
QE 9/15											
QE 12/15											
QE 3/16											
QE 6/16											
SFY16-DY14	\$246,983,414.23	\$127,369,000	\$3,881,000	\$9,536,000	\$19,000	\$362,000	\$11,000	\$141,178,000	\$105,805,414.23		
TOTAL	\$2,057,462,412	\$1,450,525,472	\$606,936,940	\$606,936,940	\$606,936,940	\$606,936,940	\$606,936,940	\$606,936,940	\$606,936,940	\$606,936,940	
QE 9/16	\$33,434,363	\$1,018,753	\$2,503,200	\$4,988	\$95,025	\$2,888	\$37,059,225				
QE 12/16	\$33,434,363	\$1,018,753	\$2,503,200	\$4,988	\$95,025	\$2,888	\$37,059,225				
End of Waiver Extension											
SFY17-DY15	\$129,566,292.47	\$66,868,725	\$2,037,525	\$5,006,400	\$9,975	\$190,050	\$5,775	\$74,118,450	\$55,547,842.47		
TOTAL	\$2,187,128,704	\$1,524,643,922	\$662,484,782	\$662,484,782	\$662,484,782	\$662,484,782	\$662,484,782	\$662,484,782	\$662,484,782	\$662,484,782	

Row #	B	C	D	E	F	G	H	I	J	K
2	II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)									
3	EXPENDITURES (Federal Funds)									
4			Current Eligibles	Demo Population I - PCN	Demo Population II	Demo Population III - HIFA				
5			(Sections 1925 and 1931 Adults and Medically Needy)	Childless Adults (PCN)	(High-Risk Pregnant Women = 1115)	Childless Adults (HIFA)				
6				Adults in Demo Population I = 1115	Adults w/Children (Section 1902(r)(2) Adults; also Known as Hypothetical	Adults in Demo Population III = 1115				
7				State Plan Eligibles	Expansion Group)	Expansion Group)	Expansion Group)			
8				\$28,929,148	\$1,170,194	\$419,020	\$43,026	\$835		
9										
10										
11										
12										
56										
57										

Row#	B	C	D	E	F	G	H	I	J	K
II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)										
EXPENDITURES (Federal Funds)										
State Fiscal Year (SFY)- Demonstration Year (DY)	BUDGET NEUTRALITY LIMIT (FF)	Current Eligibles (Sections 1925 and 1931 Adults and Medically Needy Adults)	Demo Population I - PCN (Section 1902(r)(2) Adults; also Known as Hypothetical Population I = 1115)	Demo Population II (High-Risk Pregnant Women = 1115)	Demo Population III - HIFA (Section 1902(r)(2) Childless Adults (HIFA) Adults in Demo Population III = 1115)	Expansion Group	State Plan Eligibles	Expansion Group	TOTAL	VARIANCE
SFY03-DY1	\$84,151,353	\$61,595,233	\$2,809,194	\$4,115,233					\$68,519,660	-\$4,368,307
SFY04-DY2	\$80,491,312	\$64,047,444	\$5,102,354	\$7,856,860					\$77,006,658	\$3,484,654
SFY05-DY3	\$84,403,172	\$75,766,088	\$5,025,695	\$8,945,075	\$604,159				\$90,341,017	\$4,062,155
SFY06-DY4	\$97,638,785	\$73,867,437	\$5,003,894	\$7,830,419	\$679,517				\$87,381,267	\$10,257,518
SFY07-DY5	\$86,938,233	\$69,226,888	\$6,689,112	\$8,423,719	\$640,957	\$4,406			\$85,043,241	\$1,914,998
SFY08-DY6	\$86,915,636	\$64,034,372	\$7,816,087	\$10,288,425	\$695,696	\$22,970			\$83,042,595	\$3,873,041
SFY09-DY7	\$107,710,583	\$80,057,050	\$7,678,231	\$9,135,522	\$908,465	\$10,444			\$88,021,370	\$9,689,213
SFY10-DY8	\$136,144,532	\$88,953,823	\$7,113,145	\$10,884,573	\$1,216,540	\$19,733			\$118,491,483	\$17,653,049
QE 9/09		\$25,404,224	\$2,089,905	\$3,213,039	\$232,319	\$3,732			\$31,021,018	
QE 12/09		\$24,615,745	\$1,874,409	\$3,044,399	\$347,954	\$4,565			\$29,963,790	
QE 3/10		\$24,962,162	\$1,689,854	\$2,599,851	\$267,213	\$6,686			\$29,611,262	
QE 6/10		\$24,021,210	\$1,461,277	\$2,038,639	\$392,409	\$4,829			\$27,988,661	
SFY11-DY9	\$165,352,483	\$97,505,075	\$6,667,985	\$7,558,191	\$2,065,494	\$4,491			\$113,974,083	\$51,378,400
QE 9/10		\$23,642,606	\$1,593,935	\$1,378,275	\$470,913	\$3,671			\$27,149,949	
QE 12/10		\$21,985,218	\$1,448,113	\$1,409,797	\$568,743	\$2,444			\$25,470,411	
QE 3/11		\$26,748,422	\$2,022,504	\$2,547,211	\$519,788	\$1,247			\$31,896,585	
QE 6/11		\$25,483,124	\$1,609,947	\$2,252,914	\$508,848	\$1,193			\$29,912,746	
SFY12-DY10	\$204,481,176	\$92,082,713	\$4,062,659	\$5,229,714	\$2,178,598	\$4,404			\$103,738,251	\$100,742,925
QE 9/11		\$21,287,271	\$907,793	\$1,421,012	\$489,245	\$896			\$24,158,284	
QE 12/11		\$24,518,095	\$871,277	\$1,252,389	\$562,692	\$1,270			\$27,255,049	
QE 3/12		\$24,001,563	\$1,065,431	\$1,072,774	\$478,982	\$1,255			\$26,661,940	
QE 6/12		\$25,124,250	\$1,271,595	\$1,751,893	\$660,865	\$963			\$28,846,411	
SFY13-DY11	\$219,125,060,336	\$113,323,744	\$2,995,349	\$3,582,897	\$2,310,740	\$3,335			\$122,359,381	\$96,765,679
QE 9/12		\$24,949,124	\$1,018,742	\$1,563,872	\$519,334	\$1,116			\$28,083,161	
QE 12/12		\$27,674,525	\$864,079	\$1,479,990	\$867,999	\$940			\$30,921,732	
QE 3/13		\$32,399,012	\$493,117	\$824,297	\$515,655	\$731			\$34,271,956	