Quality Provider Program: Frequently Asked Questions

General, All-Program FAQs

Q: How do the four Quality Provider Programs (QPPs) differ?
A: By specialty, region, and need of the organization. Different programs have specialty-related measures chosen to meet and improve HEDIS and Star ratings. Primary Care programs are available in Utah, Idaho, Nevada, and Colorado. See **Figure 1**.

Q: Is there a downside risk to participating?
A: No. The QPP payment is all upside benefit. Gaps not closed or metrics not met will result in no payment but also no penalty.

Q: When can we enroll in the program?
A: For a new clinic, enrollment starts at the beginning of the quarter after the contract is executed. For existing clinics, providers newly credentialed with Select Health can be added quarterly. When a new clinic expresses interest in participating, we schedule a program orientation/presentation.

Q: Do all of our providers qualify for the Select Health Quality Provider Program?
A: Providers participating on at least 1 Select Health provider network qualify for QPPs in their state and will be evaluated on a case-by-case basis. See **Figure 2** below for details.

Figure 1. Quality Provider Program Differences

Program Type	State(s) Available	Program Aim
Primary Care*	All States	Provide comprehensive, continuous medical care to members by focusing on preventive care for adult and pediatric patients.
Women's Health	Utah	Support for the mental and physical health of women to achieve the best possible outcomes for mom and baby.
Mental Health	Utah	Emphasize the importance of following up with a mental health provider after being admitted to a hospital or emergency department (ED) for a mental health illness, crisis, or other related issue.
Nephrology*	Utah	Preserve kidney health by emphasizing diabetes care, kidney health evaluation, and blood pressure control. Early diagnosis and management prevents or delays progression and complications, enhancing quality of care for our members.
Endocrinology*	Utah	Improve the outcomes in chronic endocrine conditions by achieving and maintaining glycemic control, increasing rates of annual eye exams and kidney screenings, improving medication adherence, and ensuring appropriate osteoporosis screening and treatment are completed.

Figure 2. Qualified Providers

Quality Provider Program	Qualified Providers Are Those In:
Primary Care	Pediatric, internal medicine, family practice, or geriatric specialties including physicians, nurse practitioners, and physician assistants.
Mental Health	Mental health and/or behavioral health specialties, including physicians, nurse practitioners, and physician assistants. See **Appendix**.
Nephrology	Nephrology specialties including physicians, nurse practitioners, and physician assistants.
Women's Health	Women's health specialties including physicians, CNMs, nurse practitioners, and physician assistants .
Endocrinology	Pilot program at Intermountain Health in Utah that includes physicians, nurse practitioners, and physician assistants.

* **QPP Plus (Quality + Risk). Similar to the Quality Provider Program, with additional support for addressing chronic conditions. Available for Primary Care, Nephrology, and Endocrinology programs.**

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Select Health

QPP Frequently Asked Questions, Continued

Q: Will the Quality Program structure include penalties in the future?
A: We do NOT anticipate adding penalties to the program. If there are changes to the program measures or payment structure/methodology, participating clinics will be re-contracted annually to continue the program. Prior to signing any new agreement, your clinic will have an opportunity to assess any changes to the program and decide if continued participation is desired.

Q: Will you expect us to complete additional forms or checklists?
A: Depending on the program type and National Council for Quality Assurance (NCQA) status, we may ask you to complete a Quality Improvement (QI) Project**, Transition of Care (ToC)***, and Social Drivers of Health*** form(s) once a year. For additional forms or checklists, Select Health will provide insight into your patient quality and coding gaps. Your clinic is not expected to fill out a report on each patient.

Q: Why do we need to complete a provider validation every quarter? How do we ensure that our provider roster is up to date throughout the year?
A: To ensure accurate and timely payment(s), participating clinics will be asked quarterly if there have been any changes to their provider rosters. Please let your Quality Provider team know of any changes to your provider roster as soon as you can. You do not have to wait for the quarterly update to inform your QPP team of any changes. Frequent provider updates will prevent problems related to payment, such as withholds and/or delays. Additionally, this will help ensure the accuracy of member attribution within program-specific measures.

Q: How do we receive payment?
A: Paid at the tax identification number (TIN) level, you should receive your quality payment 2 months after the quarter closes. For applicable clinics, the bonus payment will be paid in June of the year following the measurement year. Your Quality Provider team will keep you updated regarding payments.

Q: How do I know which patients qualify for the program?
A: All Select Health members can qualify for the program, but not all meet the criteria to be included in the measures. You will have access to a dashboard that will list the patients who qualify for the clinical measures. If you do not have access to the dashboard or reports, you can contact your Select Health Quality Provider team to view the information.

Q: How does Select Health know when a gap is closed?
A: Through the use of claims data, audits, and submissions of acceptable corrections, we can track gap closures. To reduce the number of corrections, Select Health can/will use a clinic's EMR to verify patient-specific information.

Q: How will we know how we are doing in the program?
A: Along with access to our dashboard, participating clinics have a dedicated Select Health Quality Provider team that meets with clinics regularly to:
- Review progress
- Train on how to view reports and use our corrections tool
- Assist team members in navigating the program

Q: If gap closure capture is claims based, why does Select Health need access to our EMR?
A: Select Health may use the EMR or set up a data transfer process to collect data not gathered through claims (e.g., when Select Health is listed as the patient's secondary payer), ensuring that the clinic receives credit and payment for all gaps closed. Benefits of this approach include:
- Reducing staff workload through submitting fewer corrections
- Supporting audits with full access to EMR information (manually submitting individual records for auditing also acceptable)
- Supporting specific programs that need access to a clinic's EMR to function. Clinics will be informed prior to contracting if this applies.

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** The QI Project is a year-long process (applicable to all programs except Nephrology) that must be approved by Select Health. Work on the QI Project requirements will take place during scheduled meetings with your assigned Quality Team.
*** All clinics must have an established policy for determining Social Drivers of Health and Transitions of Care for their patients. Aside from the Women's Health program, NCQA-certified clinics are covered for these requirements.

Select Health

QPP Frequently Asked Questions, Continued

Q: What are the differences between the Quality Provider Program and the Quality Ribbon Transparency project?

A: The Quality Provider Program (QPP) is a Select Health program. It is an upside-only program designed to support clinics in the transition to a Patient-Centered Medical Home (PCMH). Participating clinics actively engage in quality improvement projects, with the support and collaboration of QPP representatives, to enhance the level of care, safety, and equity for patients. Additionally, providers strive to close patient healthcare gaps for specific NCQA, Stars, & HEDIS measures; many of which overlap with Quality Ribbon Transpararency (QRT) project.

As part of this model, Select Health provides clinics with robust, dynamic reporting of patients with gaps in care related to quality measures, summaries of success metrics over time for benchmarking and improvement, a consultant to support in maximizing program benefits, and the opportunity to earn quarterly performance payouts with an annual bonus structure.

Learn more: Visit the QPP Website and watch our **introductory video**.

The Quality Ribbon Transparency (QRT) project (also a Select Health program) gives providers peer-comparative information on obtaining high performance for national standards set by NCQA through the HEDIS audit process. QRT reports on 4 main categories:

1. Preventive screenings
2. Diabetes screenings
3. Medication adherence
4. Pediatric monitoring

To obtain an online badge for any of the categories mentioned, providers must have performance **above** national averages for the measurements in each category.

In the future, providers will receive emails with links to their individual reports where they can see more detail about their ratings. Download a **Quality Transparency Provider Report Example**.

Learn more: Access the **QRT area of our website** for more resources.

NOTE: Because this program is currently undergoing significant changes, referenced links/content will soon look different.

Q: What is the Risk Adjustment Program, and how does it apply to Quality Provider Program participants?

A: Our Risk Adjustment team (for Primary Care, Nephrology, and Endocrinology QPP programs) provides impactful insights and actionable data to help providers manage patients' chronic conditions.

Participants will need to attend a brief, online training during the first year of participation. The training covers the program, hierarchical condition categories, and the member journey. Learn more: Visit **Risk Adjustment Program**.

Select Health

Program-Specific FAQs

Quality Plus

Q: When can we enroll in the program?

A: New clinics are able to join the program quarterly on the 1st of January, April, July, or October). If a new clinic is interested in participating, a program orientation/presentation will be scheduled. For existing clinics, newly credentialed providers with Select Health can be added quarterly.

Q: How will I get information about which patients qualify for the Quality Plus Provider Program?

A: In addition to having access to a dashboard of patients who qualify for the clinical measures, chronic conditions will also be available via reports on the dashboard.

To find the gaps for which a patient may qualify, Select Health provides a tool through IllumiCare® that helps identify quality gaps and chronic conditions to be addressed.

Women's Health

Q: Will you expect us to complete additional forms or checklists?

A: As part of the program, we ask that you complete the following each year:

- **Quality Improvement (QI) Project.** The QI Project is a year-long process that must be approved by Select Health. Scheduled meetings with your assigned Quality Team will be used to work on the QI Project requirements.
- **Screening Processes.** Your clinic will be required to have an established screening process for pre- and postpartum depression as well as substance use.
- **Social Drivers of Health Forms.** Your clinic will need to have an established policy for determining social drivers of health.

Select Health will provide insight into your patient quality and coding gaps. Your clinic is not expected to fill out a report on each patient.

Q: If gap closure capture is all claims based, why does Select Health need access to our EMR?

A: We use the EMR to collect data not gathered through claims data. Note that:

- Global billing delays our ability to provide accurate gap closure data in real-time. We use audits to improve gap closure before pregnancy ends.
- This reduces the number of corrections the clinic needs to submit, thus reducing staff workload.
- It is necessary to have access to the full EMR to complete recurring audits.

Q: Why do we need to send over pregnancy lists?

A: Global billing delays Select Health's ability to identify new pregnancies. Waiting until a claim is submitted denies your clinic valuable data and time to close gaps and improve screening processes.

Q: Why are we required to use standardized screening tools and not a provider's diagnosis or assessment?

A: Standardized screening tools are scientifically proven to reliably predict individuals at risk for substance use and depression before and after pregnancy. This eliminates caregiver bias and promotes full disclosure by the patient.

Appendix: Mental Health Provider Definitions

- **An MD or doctor of osteopathy (DO)** who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or , if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a **psychologist** in his/her state of practice, if required by the state of practice.
- An individual who is certified in **clinical social work** by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- **A registered nurse (RN)** who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- **A nurse practitioner (NP)** or an **Advanced Practice Registered Nurse (APRN)** who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) who has a master of science (M.S) or doctor of philosophy (Ph.D.) degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- **An individual (normally with a master's or a doctoral degree in marital and family therapy** and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (**normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience**) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if a licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).
- **A physician assistant (PA)** who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.
- **A certified Community Mental Health Center (CMHC)**, or the comparable term (e.g., Mental health organization, mental health agency, Mental health agency) used within the state in which it is located, or a **Certified Community Mental Health Clinic (CCBHC)**.

  Only authorized CMHCs are considered mental health providers. **To be authorized as a CMHC**, an entity must be **either**:

  — Certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 41. CMS defines a CMNHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Services Act (PHS Act).; **or**

  — Licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.

  Only authorized CCBHCs are considered mental health providers. **To be authorized as a CCBHC**, an entity must meet be **either**:

  — Certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); **or**

  — Meets criteria within the State's Medicaid Plan to be considered a CCBHC.

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