The State of Mississippi

Division of Medicaid

UnitedHealthcare Community Plan - Mississippi

2015 External Quality Review

NOVEMBER 23, 2015

The Carolinas Center *for* Medical Excellence

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Executive Summary

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The following report contains a description of the process and the results of the 2015 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid. The purpose of this review was to determine the level of performance demonstrated by UnitedHealthcare Community Plan – Mississippi (UHC) and to provide feedback for potential areas of further improvement.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review included a desk review of documents and files, a two-day onsite visit at the UnitedHealthcare Community Plan – Mississippi office, validation of performance improvement projects, validation of performance measures, validation of consumer and provider surveys, and a review of the health plan's Information System Capabilities Assessment.

Findings

The findings of the 2015 EQR indicate that UnitedHealthcare Community Plan – Mississippi improved their percentage of met scores in the areas of Provider Services and Utilization Management. Areas of concern included UHC's process for how credentialing and recredentialing decisions are made, members access to their PCP, and the non-HEDIS performance measure results reported to DOM.

Overall, UHC received a Met score for 83.78 percent of the standards for the 2015 External Quality Review.

STRENGTHS

Strengths of UnitedHealthcare's performance at the time of this review include the following:

- Policies and procedures show improvement from the previous EQR in addressing the MS contract requirements.
- Claims are processed timely.
- UHC's website and provider portal contain a wealth of resources for providers and their member population.
- Member Services call scripts ensure that consistent information is disseminated to members and providers.
- UHC has comprehensive member and community outreach programs, including community engagement activities and initiatives throughout the state of Mississippi.
- Topics for performance improvement projects were appropriate for the member population and met state contract requirements.
- In the asthma project, results are broken down by age, which is a good way to drill down to potential issues and apply appropriate interventions.

- The UM and appeals files confirmed that staff are following appropriate processes and timelines for review and notification of determinations.
- Case management processes and documentation has been updated to reflect the many new case management requirements. File review reflects consistent compliance with the new requirements.

WEAKNESSES

Weaknesses identified included the following:

- The Compliance Committee is not a voting committee and therefore members do not make decisions during meetings. Attendance by committee members was poor.
- UHC's Chief Medical Officer, Dr. Williams, does not chair or oversee the functions of the credentialing committee as required by the *DOM Contract, Section 1 (L).* Credentialing and recredentialing decisions are made at the national level without representation from any MS providers.
- The Provider Site Visit Tool contained an incorrect appointment timeframe for non-urgent (symptomatic) care.
- Member access to their PCP seems to be an issue for UHC as noted in several documents and study results.
- Discrepancies exist between the benefits listed in the Provider Administrative Guide and the Member Handbook.
- Several items that are required by the *DOM Contract* were missing in the Provider Administrative Guide and in the Provider Directory.
- The results of the provider satisfaction survey were unreliable due to a low response rate. The survey did not meet all of the CMS protocol requirements.
- There was inconsistent or missing information regarding member rights and responsibilities in the Member Handbook, Provider Administrative Guide, and in policies.
- Some of the required information in the Member Handbook was missing, incomplete, or incorrect.
- The member satisfaction survey failed to meet the validation requirements. The response rate fell below the rate targets.
- There was inadequate evidence that UHC reports the results of the member satisfaction survey to providers.
- Some inconsistencies and/or errors in documents regarding grievances were noted.
- The non-HEDIS® measures did not meet the validation requirements.
- Some of the deficiencies identified with the performance improvement projects include issues with the study question, interventions, statistically significant improvement, and inaccurate results.
- The issues identified in the Utilization Management area were predominantly related to errors in documentation in the UM Program Description, policies, procedures, the Member Handbook and the Provider Administrative Guide.
- The delegation oversight monitoring tools contained incorrect timeframes and/or did not address all of the Mississippi requirements.
- The corrections made for two of the deficiencies identified during the previous EQR were not implemented and found to be deficient during this review.

Comparative Data

A comparison review of the scored standards by review category for the previous EQR conducted by CCME in 2013 with the current review results is shown in the table that follows.

TABLE 1

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Administration					
2013	25	0	0	0	25
2015	28	1	0	0	29
Provider Services					
2013	46	3	20	0	69
2015	74	6	7	0	87
Member Services					
2013	30	6	1	0	37
2015	25	4	2	0	31
Quality Improvement					
2013	15	0	0	0	15
2015	12	3	0	0	15
Utilization Management					
2013	28	5	6	0	39
2015	42	10	1	0	53
Delegation					
2013	1	1	0	0	2
2015	1	0	1	0	2
State-Mandated Services					
2013	3	0	1	0	4
2015	4	0	1	0	5

Please note: the review tool used for the 2015 external quality review was updated based on changes in UHC's contract with the Division of Medicaid. The total number of standards for each category may have changed as a result of the updates.

Recommendations for Improvement

CCME made the following recommendations that UnitedHealthcare Community Plan – Mississippi should implement to improve their processes and comply with state and federal requirements.

- Change the format for the Compliance Committee so this committee is allowed to vote on actions that affect UHC, and identify a quorum of voting members needed for each meeting. Also, identify attendance standards for the voting committee members.
- Establish a local credentialing committee that is chaired by the Mississippi Medical Director or Chief Medical Officer and includes a variety of network providers as voting members of the committee.
- Update the UHC Provider Site Visit Tool to reflect the correct appointment criteria for routine sick visits.
- Implement interventions to address the member access issues.
- Update the Provider Administrative Guide and the Member Handbook to correct the member benefit discrepancies and address the contractually required information that was not found in the Provider Administrative Guide.
- Update the Provider Directory (paper and electronic) to include the providers' hours of operation as required by the *DOM Contract, Section 6 (E).*
- Implement interventions to increase the response rate in the member and provider satisfaction survey and improve survey documentation.
- Develop and implement a process to ensure that providers are notified of the member satisfaction survey results.
- Update all member rights and responsibilities in documents.
- Correct the errors in the Member Handbook, Provider Administrative Guide, and in policies and procedures regarding member rights and responsibilities.
- Revise the Member Handbook so that all information on second opinions is found in one location, rather than being separated by multiple pages.
- Revise the Member Handbook to inform members that they will be notified of changes to benefits and services. Include the timeframe and method of notification. Also, include additional information regarding advance directives, such as Member Services staff can provide more information about how to formulate an advance directive, etc.
- Update the Provider Administrative Guide, to clearly indicate that providers need the member's written consent to file a grievance on the member's behalf.
- Revise policy AG-01 to indicate that assistance is provided with filing grievances.
- Update the Member Handbook to include the timeframe for grievance acknowledgement.
- Remove the reference to the state-specified timeframe for expedited grievance resolution from policy AG-01.
- Update policy AG-01 to include all processes for handling expedited grievance requests, including requirements for extensions of resolution timeframes and notification of members when the grievance does not meet expedited grievance criteria and will be processed under the standard grievance resolution timeframe, etc.
- Include information on expedited grievance resolution and the possible extension in the Member Handbook and the Provider Administrative Guide.
- Provide the information on extensions of grievance resolution timeframes in the Provider Administrative Guide rather than referencing a federal regulation.
- Update the grievance acknowledgement letter to include information on extensions of grievance resolution timeframes.

- Update the grievance resolution letter to remove language related to appeals.
- Ensure that appropriate processes are followed for grievances, including written notification of resolution; investigation and notification of all issues related to each grievance; and timely acknowledgement of grievances.
- Include, in either an existing or a new policy, UHC's process for handling requests for PCP changes due to dissatisfaction.
- The Quality Improvement Program Description should include all committees on the Quality Improvement Program Structure and Organizational Chart and a description of each of those committees. All of the information in the Quality Improvement Program Description should be specific to Mississippi.
- Correct the coding issues with the numerators and denominators for all of the non-HEDIS® performance measures and re-run the results.
- Update the performance improvement project documents and correct the deficiencies identified.
- Correct policy UCSMM 06.16 to reflect an appropriate timeframe for notification of the proper procedure when a physician or consumer fails to follow the procedure for requesting a standard review. The updated timeframe should allow for compliance with contractually required determination timeframes.
- Revise the Member Handbook and Provider Administrative Guide to include standard and expedited authorization timeframes.
- Revise the MS Addendum of the UM Program Description to clearly reflect appeals rights and processes for both members and providers.
- Update policy USCMM 06.10 to include the correct IRR threshold and clear documentation of UHC's IRR process, including follow-up activities for scores below the established threshold (re-education, re-testing, etc.)
- Revise policy RX-012 to state that UHC uses the current version of Medicaid Program PDL.
- Update policy RX-012 to include the timeframe requirement for standard and expedited pharmacy authorization requests.
- Correct policy UCSMM 06.18 to state that members are notified of all decisions to deny, suspend, terminate, or reduce services. Ensure that UHC follows the correct process for adverse determinations of concurrent or retroactive reviews, even if the member is not at financial risk.
- Correct the timeframe for notification of adverse determinations in policy AG-01 and in the Provider Administrative Guide.
- Update policy AG-02 and the Provider Administrative Guide to indicate that a representative acting on the member's behalf may also file an appeal.
- Update the Member Handbook to indicate that expedited appeal requests do not require a written appeal to follow.
- Update the Provider Administrative Guide with information that the timeframe to file an appeal is within 30 calendar days from the date of receipt of the notice of action.
- Include information that members may present evidence or examine the case file/information used in the appeal process in policy AG-02, the Member Handbook, and the Provider Administrative Guide.
- Correct the timeframe for standard and expedited appeal resolutions in the "Appeals of Adverse Actions" policy for United Behavioral Health.
- Correct the timeframe for expedited appeal resolutions in policy MBR 13a.

- If policy UCSMM 07.11 is not used by UHC, the policy should be updated to refer the reader to the appropriate policies to obtain timeframes for appeal resolutions, or the policy should be retired.
- Update the timeframe for sending requests for extensions of expedited appeal timeframes to members in policy AG-02.
- Update the Member Handbook to include information that a request for an expedited appeal may be denied if expedited criteria are not met, and that if denied, UHC will transfer the appeal to the standard appeal timeframe, and notify the member verbally on the day of the decision to deny and in writing within two days.
- Correct the timeframe to file a request for a State Fair Hearing in the appeal upheld letter (UHC-041613) and policy MBR 13a.
- Remove the outdated reference to requesting a State Fair Hearing before exhausting the plan-level appeal process from policy MBR 13a.
- Revise policy AG-01, the United Behavioral Health policy titled “Appeals of Adverse Actions”, and the MS CAN Reduction in Service letter to contain correct information regarding the timeframe to request continuation of benefits pending an appeal. Refer to the *DOM Contract, Exhibit D, Section D*.
- Revise the Provider Administrative Guide to include information on continuation of benefits pending an appeal or State Fair Hearing.
- Remove from policy NCM 001 the reference to policy NCM 015 and the statement found in Section A (2) regarding stratification of members receiving LTSS. Alternatively, develop an addendum to this policy that contains Mississippi-specific information.
- Correct the timeframe for standard authorization turn-around times, and include the timeframe for expedited authorization turn-around times, on the Dental Program Monthly Report Card.
- Correct the timeframe for standard authorization turn-around times on the CareCore National Dashboard spreadsheet.
- Correct the Optum Behavioral Health 2015 CR Audit Report or implement another tool that clearly addresses all Mississippi-specific requirements for delegated credentialing. The tool should include query of the System for Award Management (SAM); a copy of CLIA certificate/waiver; and collection of the ownership disclosure form.
- Address the uncorrected deficiencies from the previous EQR. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which may include validation of encounter data, administration and validation of member and provider surveys, calculation of additional performance measures, and conduct performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; comparative information from previous reviews; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

Introduction

On January 1, 2011, the Mississippi Division of Medicaid (DOM) established the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Mississippi Medicaid beneficiaries. The goals of the program are to improve access to needed medical services, improve quality of care, and improve program efficiencies and cost effectiveness. The Mississippi Division of Medicaid has contracted with UnitedHealthcare Community Plan – Mississippi to provide services to individuals enrolled in the MississippiCAN Program.

DOM has contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all Coordinated Care Organizations (CCO) participating in the MississippiCAN Program. The purpose of this review was to determine the level of performance demonstrated by UnitedHealthcare Community Plan – Mississippi since the EQR was completed in 2013.

Goals of the review were:

1. To determine UnitedHealthcare's compliance with service delivery as mandated in the contract with DOM.

2. To evaluate the status of deficiencies identified during the 2013 annual review and any ongoing corrective action taken to remedy those deficiencies.

3. To provide feedback on potential areas for further improvement.

The overriding goal of the annual EQR process is to ensure that contracted health care services are actually being delivered and are of good quality.

Process

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On July 3, 2015, CCME sent notification to UnitedHealthcare Community Plan – Mississippi (UHC) that the annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow UnitedHealthcare to ask questions regarding the EQR process and the desk materials being requested.

The review consisted of two segments. The first was a desk review of materials and documents received from UnitedHealthcare on August 3, 2015 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization decisions, and appeal files.

The second segment was an onsite review conducted on October 12th and 13th at the UnitedHealthcare office located in Ridgeland, Mississippi. The onsite visit focused on areas not covered in the desk review or areas needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with UnitedHealthcare's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

Findings

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between UnitedHealthcare and DOM. Strengths and weaknesses are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), or the standard was not evaluated (Not Evaluated) and are recorded on the tabular spreadsheet. (*Attachment 4*)

I. ADMINISTRATION

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance, and confidentiality. Jocelyn Chisolm Carter serves as Chief Executive Officer (CEO) of UnitedHealthcare Community Plan of Mississippi. Dr. David Williams serves as the Chief Medical Officer. He is board certified in Internal Medicine, licensed and located in Mississippi. He provides clinical oversight for health plan staff and sits on the Quality Management Committee (QMC) and the National Credentialing Committee (NCC). Dr. Williams chairs the Healthcare Quality and Utilization Management Committee (HQUM) and the Provider Advisory Committee (PAC). The

organizational chart and onsite discussion confirm that key personnel and overall staffing appear to meet contract requirements.

A review of the policies and procedures shows improvements were made from the previous EQR. UHC Community Plan – Mississippi utilizes local policies and national policies that have been adopted by the plan. The national policies address Mississippi (MS) contract requirements through addendums or riders where applicable.

Terrence Christopher is the Compliance Officer and reports directly to the CEO. He chairs the Compliance Committee which meets on a monthly basis. The 2015 Mississippi Committee Matrix received for the Compliance Committee identified the voting members of the committee; however, the Compliance Officer indicated during onsite discussion that the Compliance Committee is not a voting committee. In addition, a review of committee minutes showed poor attendance by committee members.

CCME performed an evaluation of the Information System Capabilities Assessment (ISCA) and other associated documentation provided by UHC. The evaluation included a review of UHC's ability to handle and process claims appropriately and in a timely manner, meet the state guidelines for the delivery of health care services, collect health care data securely and accurately, and provide reports on those activities as required by DOM. Findings of the review showed UHC has a comprehensive system and processes in place and fully meets the requirements.

Results of the Administration section of the EQR showed UHC met 96.55 percent of the standards as shown in the chart below. The Partially Met score was due to issues identified with the Compliance Committee.

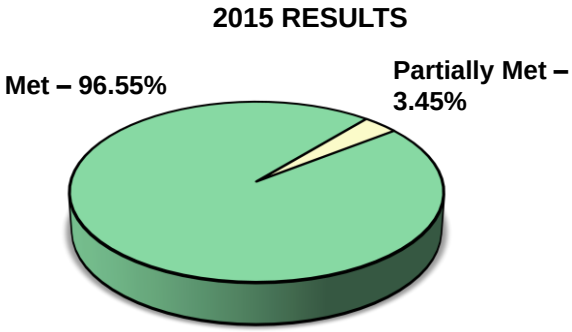


TABLE 1: ADMINISTRATION

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Organizational Chart / Staffing	Compliance Officer who will act as a primary point of contact for the Division and a compliance committee that are accountable to senior management and that have effective lines of communication with all the CCO's employees.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- UHC's policies and procedures show improvement from the previous EQR in addressing MS contract requirements.
- UHC processes 100 percent of clean claims well within the 30 day requirement of the contract and processes 100 percent of all claims within 90 days.

WEAKNESSES

- The 2015 Mississippi Committee Matrix received for the Compliance Committee identified voting members of the committee; however, the Compliance Officer indicated during onsite discussion that the Compliance Committee is not a voting committee. In addition, a review of committee minutes showed poor attendance by committee members.

II. PROVIDER SERVICES

A review of all policies and procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, practice guidelines, and the provider satisfaction survey was conducted for Provider Services. The Provider Advisor Committee (PAC) meets on a quarterly basis and is chaired by Dr. David Williams, Chief Medical Officer MS. The PAC performs peer review activities, including review of credentialing and review and disposition of concerns about quality of clinical care provided to members as requested by the Health Plan CMO. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network. The voting members of the 2015 committee include 10 network physicians with various specialties, and the CMO votes in case of a tie.

The UHC Credentialing Plan states that the National Credentialing Committee (NCC) will make credentialing decisions pursuant to the Credentialing Plan and will communicate those decisions to the Credentialing Entity. According to the credentialing plan, the committee will be comprised of participating practitioners from the various Credentialing Entities, Medical Directors, and a designated Chairperson unless a different committee composition is required by applicable Credentialing Authorities. The list of committee members did not include UHC's Chief Medical Officer; Dr. Williams or any Mississippi network providers. Onsite discussion confirmed that Dr. Williams sits on the committee even though the list of committee members did not include Dr. Williams and committee minutes did not list Dr. Williams as in attendance.

Decisions made by the NCC are reported to UHC's PAC Committee on a quarterly basis. The process UHC follows for credentialing and recredentialing of Mississippi providers is of concern. Credentialing and recredentialing decisions are not made by Mississippi providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *DOM Contract, Section 1 (L).*

PROVIDER ACCESS AND AVAILABILITY STUDY

As a part of the annual EQR process for UnitedHealthcare Community Plan, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by UHC, from which a population of 2,241 unique PCPs was found. A sample of 335 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

Calls were successfully answered 49 percent of the time by personnel at the correct practice, which estimates to between 47 and 52 percent for the entire population. When compared to last year's results of 54 percent, this year's result for successfully answered calls was lower than the previous study, but statistically it was unchanged. So in both actual terms and statistically, no improvement was seen.

For those calls not answered successfully, 19 percent of the time (estimates to 17 to 21 percent for the entire population) the caller was informed that the provider was not at that office or phone number called. Of the successful calls, 73 percent (70, 77) of the providers indicated they specifically accept UHC. Of those that indicated they accept the plan, 76 percent (72, 79) of the providers responded they are accepting new Medicaid patients.

When asked about any screening process for new patients, 40 percent (36, 44) indicated that an application or prescreen was necessary. Fifty percent (43, 57) of those with a prescreening process require an application before accepting the patient. When the office was asked about the next available routine appointment, 74 percent (71, 78) of the appointment answers met within contract requirements.

Overall, UHC has shown no improvement in provider access. There seems to be an issue with members being able to reach their provider by telephone which could result in an unnecessary visit to the emergency room. Provider access was also identified as an issue in the access study conducted by UHC, in the member satisfaction survey results, and identified as a barrier for not meeting some of the HEDIS measures.

PROVIDER SATISFACTION SURVEY VALIDATION

UnitedHealthcare performed a provider satisfaction survey administered by the Center for the Study of Services (CSS), a survey vendor. As a part of this EQR, this survey was validated using the EQR Protocol 5, Validation and Implementation of Surveys *(version 2.0, September 2012)*.

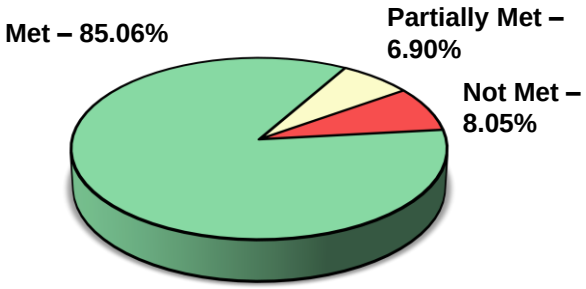
The survey did not meet the CMS protocol requirements. In the table that follows we have identified areas that should be corrected to improve the survey documents and process.

Section	Reasoning	Recommendation
3.4 Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	Detailed information regarding the selection of the sample size was not in the documentation. The documents received during the onsite indicated a non-statistical rationale for sample size which is not consistent with the CMS protocol.	Include in the survey documentation how the sample size was determined. Be sure to include the statistical assumptions such as acceptable margin of error and the level of certainty that was used in the sample size calculation.
4.1 Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	A response rate was documented in secondary documentation received at the onsite but no explanation of the calculation was provided. Only the number of complete surveys was documented in the main documentation.	Include in the main survey documentation the response rate and its calculation.
4.2 Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	A response rate was not calculated in the survey documentation. Only the number of complete surveys was documented. With only 95 completed surveys, the power of the results could be severely limited.	With such a small number of completed surveys it is assumed that the response rate was low. Seek different methods to administer the survey since the current method is not giving the response volume that most would expect from a survey.
6.3 Were all survey conclusions supported by the data and analysis?	While conclusions were made from the results of the survey, it is questionable how representative those results are of the provider population given the small number of responses received.	Look for new ways and approaches to deliver the survey to help increase the number of responses received.
7.2 Identify the technical weaknesses of the survey and its documentation.	Survey documentation was missing pieces of important documentation regarding survey development, sample size calculation and creation, and response rate calculation.	Include these items in the survey summary document to complete the documentation.
7.3 Do the survey findings have any limitations or problems with generalization of the results?	While conclusions were made from the results of the survey, it is questionable how representative those results are of the provider population given the small number of responses received.	Look for new ways and approaches to deliver the survey to help increase the number of responses completed.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report.

The chart below shows 85.06 percent of the standards in the Provider Services section were scored as Met. The Partially Met and Not Met scores were in the areas of Credentialing and Recredentialing, Practitioner Accessibility, Provider Education, and the Provider Satisfaction Survey.

2015 RESULTS



Percents may not total 100% due to rounding

TABLE 2: PROVIDER SERVICES

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Not Met	Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO	Met	Not Met
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Not Met	Met
	Current valid license to practice in each state where the practitioner will treat Members	Not Met	Met
	Valid DEA certificate and/or CDS certificate	Not Met	Met
	Professional education and training, or board certification if claimed by the applicant	Not Met	Met
	Malpractice claims history	Not Met	Met
	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Not Met	Met

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Credentialing and Recredentialing	Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Not Met	Met
	Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Not Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Partially Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Not Met	Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Not Met	Partially Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Not Met	Met
	Current valid license to practice in each state where the practitioner will treat Members	Not Met	Met
	Valid DEA certificate and/or CDS certificate	Not Met	Met
	Board certification if claimed by the applicant	Not Met	Met
	Malpractice claims since the previous credentialing event	Not Met	Met
	Practitioner attestation statement	Not Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Not Met	Met
	Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Not Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Not Met	Met
Adequacy of the Provider Network	The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Met	Partially Met
	Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- The provider portal on the website contains a wealth of resource information such as a cultural competency library, clinical practice guidelines, provider forms, claims information, communication bulletins and newsletters, the Provider Administrative Guide, etc.
- Through UnitedHealthcare Online, providers can take advantage of free instructor-led trainings, previously recorded on-demand sessions, slide presentations, and more. Topics covered include Website, HIPAA 5010 and ICD-10, Courses for CME Credit, and Additional Learning Opportunities.

WEAKNESSES

- The National Credentialing Committee is the credentialing/recredentialing decision-making committee. The list of committee members did not include UHC's Chief Medical Officer, Dr. Williams or any Mississippi network providers. Onsite discussion confirmed that Dr. Williams sits on the committee even though the list of committee members did not include Dr. Williams and committee minutes did not list Dr. Williams as in attendance. The process UHC follows for credentialing and recredentialing of Mississippi providers is of concern. Credentialing and recredentialing decisions are not made by Mississippi providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *DOM Contract, Section 1 (L).*
- The UHC Provider Site Visit Tool received in the desk materials showed an incorrect appointment timeframe for non-urgent (symptomatic) care. It stated within 14 days, when appointment criteria for a routine sick visit is seven calendar days. The correct appointment timeframe was found in other documents.
- Member access to providers continues to be an issue as follows:
    - Results of the telephonic Provider Access and Availability Study performed by CCME did not show improvement from the previous study.
    - UHC identified member access to their PCP or inability to schedule appointments as barriers for not meeting some of the HEDIS measures goals.
    - The member satisfaction survey results identified member access as an issue.
    - The Provider Appointment Availability and After-Hours survey demonstrated an overall issue with provider appointments and after hour availability.
- Discrepancies exist between the benefits listed in the Provider Administrative Guide (PAG) and the Member Handbook (MH). Some examples include:
    - For eye care the MH states prior authorization for children after the first pair per calendar year and the PAG states after the second pair per year. Also, the MH

mentions two eye exams per year for children and one eye exam per year for adults, and this is not mentioned in the PAG.
    - The MH states home health services for adults are limited to 25 visits per calendar year and the PAG states per fiscal year (July 1 – June 30).
    - The MH has prior authorization limits for hearing services that are not mentioned in the PAG.
    - The PAG lists limitations for coverages such as medical supplies and outpatient PT/OT/ST that are not mentioned in the MH.
- The following are issues identified in the Provider Administrative Guide as required by the *DOM Contract, Section 7 (H)*:
    - The EPSDT screening requirements and services could not be found in the Provider Administrative Guide.
    - Does not address the provider responsibility to follow-up with members who are non-compliant with EPSDT screenings and services.
    - Does not include the information regarding emergency supply of medication until authorization is complete.
    - Does not include instructions for the reassignment of a member to another PCP.
    - Does not include the process for communicating the provider's limitations on panel size to the CCO.
    - Does not include Information regarding available translation services and how to access those services.
    - Does not include a statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.
- The *DOM Contract, Section 6 (E),* states the Provider Directory shall include identification of hours of operation including identification of providers with non-traditional hours; however, the Provider Directory received in the desk materials does not include provider office hours. The website Provider Directory has a field for office hours but it appears that many of the providers listed indicate “Not Available”.
- The provider satisfaction survey did not meet the CMS protocol requirements.
- For the provider satisfaction survey, the low number of responses and low response rate could bias results and not provide reliable information on the underlying population.

III. MEMBER SERVICES

The review of Member Services included all policies and procedures, member rights, member training and educational materials, and UnitedHealthcare’s (UHC’s) processes for handling grievances, member satisfaction, and practitioner changes. UHC has policies and procedures in place to guide the Member Services functions.

The Member Handbook provides an overview of benefits and services as well as how to obtain more information if needed. The Member Handbook, overall, provides necessary information; however, revisions and/or corrections are needed for some information in the Member Handbook. UHC has robust member education processes in place, including the provision of a new member welcome packet, newsletters and other mailings, flyers and brochures, and welcome calls that provide information necessary for members to fully understand the Plan’s processes, programs, services, and requirements. Member materials are written at an appropriate reading level and are available in alternate formats, including alternate languages, large font, Braille, and audio versions.

Some inconsistencies and/or errors in documents regarding grievances were noted; however, review of the grievance files revealed only a few issues. The issues identified in the grievance files were not pervasive and appeared to be isolated occurrences.

MEMBER SATISFACTION SURVEY VALIDATION

A member satisfaction survey was performed on behalf of UnitedHealthcare by the Center for the Study of Services (CSS), an NCQA-certified vendor, using the CAHPS® 5.0H instrument. As a part of this EQR, the survey was validated using the CMS protocol for Administering or Validating Surveys (*Final Protocol Version 2.0, September 2012*).

Results of the validation found the member satisfaction survey did not meet the CMS protocol requirements. The response rate for the survey fell below the response rate targets. The table that follows provides an overview of the survey validation results and recommendations for correcting the issues identified.

Section	Reasoning	Recommendation
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	The results met the minimum number of responses considered by NCQA to be necessary for a valid survey (411 responses), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively). Alternative approaches may be needed to increase the response rates, especially for the Medicaid Child population, which suffered the lowest response rate. Response bias may be a large issue with the survey.	Focus on strategies that would help increase response rates for the Medicaid Child population. Solicit the help of the survey vendor.
Do the survey findings have any limitations or problems with generalization of the results?	The response rate for the Medicaid Child population suffered from a very low response rate. Response rate bias should be a concern.	Focus on strategies that promote higher response rates for the Medicaid Child population.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report.

The chart below shows that 80.65 percent of the standards in the Member Services section were scored as Met. All deficiencies are detailed in the Weaknesses section below. Partially Met scores were related to documentation of member rights and responsibilities, documentation of benefit information in the Member Handbook and Provider Administrative Guide, and grievances information. Two standards for the member satisfaction survey were scored as Not Met.

2015 RESULTS

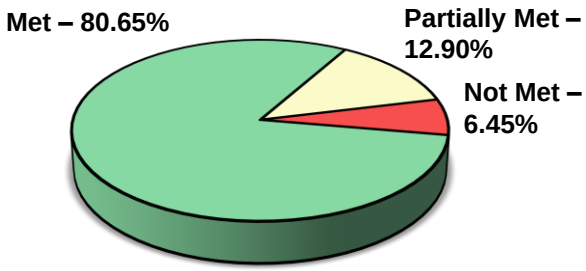


TABLE 3: MEMBER SERVICES

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Member Rights and Responsibilities	All Member rights included	Met	Partially Met
Member CCO Program Education	Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled	Not Met	Partially Met
	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Partially Met	Met
Member Disenrollment	Member disenrollment is conducted in a manner consistent with contract requirements	Partially Met	Met
Member Satisfaction Survey	The CCO conducts a formal annual assessment of Member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Not Met
	The CCO reports the results of the Member satisfaction survey to providers	Met	Not Met
Complaints/ Grievances	Definition of a complaint/grievance and who may file a complaint/grievance	Partially Met	Met
	Notification to the Member of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- Member Services call scripts ensure that consistent information is disseminated to members and providers.
- UHC has comprehensive member and community outreach programs, including community engagement activities and initiatives throughout the state of Mississippi. These include initiatives to promote and encourage healthy living and participation in health screenings. Of note, the KidsHealth Online Resource Center is an online resource containing over 200 videos and over 10,000 written articles ranging from condition-specific information to wellness information to meet member needs by age, language, and learning style.

WEAKNESSES

- The right to receive services that are not denied or reduced solely because of diagnosis, type of illness, or medical condition is not addressed in policy NQM-051, Member Rights and Responsibilities (or the corresponding Rider or Attachment A), the Member Handbook, and the Provider Administrative Guide.
- The right to oral interpretation services free of charge is not found in policy NQM-051, Member Rights and Responsibilities (or the corresponding Rider or Attachment A), or the Provider Administrative Guide. The Member Handbook contains information regarding interpreter services, but there is no indication that interpreter services are free for members.
- Policy NQM-051, Member Rights and Responsibilities (along with the corresponding Rider and Attachment A), and the Provider Administrative Guide do not address the member responsibility to inform the plan of changes in family size, address, or other health care coverage. The Member Handbook, page 46, does inform members of this responsibility.
- The Member Handbook addresses second opinions; however, the information is broken into two sections. Part of the information is found on page 21 and the remainder of the information is found on page 27.
- There is no information in the Member Handbook that informs members they will be notified of changes to benefits/services. Refer to the *DOM Contract, Section 4 (D) (8) (g)*.
- Page 48 of the Member Handbook defines the purpose of an advance directive and informs members they have the right to formulate an advance directive. However, it does not provide any additional information, such as that Member Services staff can provide more information about how to formulate an advance directive, etc.
- The member satisfaction survey failed to meet the validation requirements. The response rate fell below the rate targets.
- Inadequate evidence that UHC reports the results of the member satisfaction survey to providers. Information provided was not Mississippi specific and did not offer actual results.
- The Provider Administrative Guide, page 43, states, “A member or his/her authorized representative as designated in writing or a provider, may file a grievance…” This does not clearly indicate that a provider must also have the member’s written consent to file a grievance on the member’s behalf.
- Policy AG-01, Complaint, Grievance, and Appeal Procedures, does not state UHC provides assistance (other than language assistance) with the grievance filing process.
- The Member Handbook informs that grievances will be acknowledged, but does not provide the timeframe.

- Policy AG-01, Complaint, Grievance, and Appeal Procedures, states standard grievances are resolved within 30 calendar days of receipt, and expedited grievances are resolved within state specified timeframes not to exceed 72 hours from receipt. Issues with the timeframes for grievance resolution include:
    - There is no state-specified timeframe for resolution of expedited grievances; therefore, the reference to the state-specified timeframe should be removed from the policy.
    - Policy AG-01 does not address the processes followed for expedited grievances, including extensions of expedited grievance resolution timeframes and requirements for notification of members when the grievance does not meet expedited grievance criteria and will be processed under the standard grievance resolution timeframe.
    - Expedited grievances are not addressed in the Member Handbook or the Provider Administrative Guide.
- Issues related to extensions of grievance resolution timeframes were noted, as follows:
    - The Member Handbook does not address extensions of grievance resolution timeframes.
    - The Provider Administrative Guide states UHC may extend timeframes by up to 14 calendar days in accordance with *42 C.F.R. § 438.408(c)*. Rather than listing a federal regulation, this should specify that the timeframe may be extended by up to 14 calendar days if the member requests the extension or if UHC determines there is a need for additional information and the extension is in the member's best interest. Also, information that if UHC requests the extension, the member will be notified within two business days of the reason for the extension should be included.
    - The grievance acknowledgement letter does not address extensions of grievance resolution timeframes.
- The Grievance Resolution Letter template contains the following statements, which are related to appeals and are not applicable to grievances:
    - "You have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your APPEAL, GRIEVANCE, or COMPLAINT, as well as copies of any internal rule, guideline or protocol that we relied on to make this payment decision."
    - "You also have the right to receive, upon request and free of charge, an explanation of the scientific or clinical judgment that we relied on in making this benefit decision as well as the diagnosis or treatment codes, and their corresponding meaning."
    - "Please understand that your request for information will not change the time you have to file any subsequent appeals."
- Review of grievance files revealed the following issues:
    - Two files revealed that members were not sent resolution letters.
    - One file contained evidence that not all issues identified in the grievance were investigated and included in the grievance resolution. Information received via email after the onsite visit confirmed that "the protocol was not followed in this case which lead to only partial resolution for the member".
    - An appeal acknowledgement letter was sent instead of a grievance acknowledgement letter for one file. The mistake was realized and a grievance acknowledgement letter was sent on day 18.
- Onsite discussion confirmed that requests for PCP changes related to dissatisfaction are tracked and monitored. Information related to this process was not noted in a policy.

IV. QUALITY IMPROVEMENT

UnitedHealthcare has a Quality Improvement (QI) program in place that actively involves the entire organization in the responsibility of improving the quality of care and services the health plan delivers to its providers and members. The 2015 Quality Improvement Program Description contains the program's goals, objectives, structure, and scope. The program description contained the committee structure and a description for each committee. The committee chart was incomplete and did not contain all of UHC's committees and/or a description for some committees was not included in the program description.

The Quality Management Committee is responsible for all quality improvement activities. Membership for this committee includes UnitedHealthcare senior level staff members and representatives from program areas. Network primary care and subspecialty physicians serve on the Provider Advisory Committee. The Provider Advisory Committee is responsible for evaluating and monitoring quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the health plan's network. Both committees meet at least quarterly and the discussions and decisions made by both committees are well documented in committee minutes.

PERFORMANCE MEASURE VALIDATION

As part of the EQR for United, CCME conducted a validation review of the HEDIS® and non-HEDIS® performance measures following the protocols developed by CMS. UHC was found to be fully compliant and met all the requirements for the HEDIS® measures.

The validation of the non-HEDIS® measures required a review of the following for each measure:

- General documentation for the performance measure.
- Denominator data quality.
- Validity of denominator calculation.
- Numerator data quality.
- Validity of numerator calculation.
- Data collection procedures (if applicable).
- Sampling methodology (if applicable).
- Measure reporting accuracy.

This process assesses the production of these measures by the plan to ensure that what is submitted to the Division of Medicaid (DOM) complies with the measure specifications, as defined by DOM. The table that follows gives an overview of the validation score for each measure.

PERFORMANCE MEASURE VALIDATION SCORES

Measures	Current Review Decision
ASTHMA RELATED ER VISITS	35 / 55 = 64% NOT VALID
ASTHMA RELATED RE-ADMISSIONS	35 / 55 = 64% NOT VALID
CONGESTIVE HEART FAILURE RE-HOSPITALIZATION	35 / 55 = 64% NOT VALID
PRE AND POST NATAL COMPLICATIONS	40 / 55 = 73% SUBSTANTIALLY COMPLIANT

The non-HEDIS® measures did not meet the validation requirements. One measure was found to be *Substantially Compliant* and three of the measures were *Not Valid*. Issues with the way the numerators and denominators were calculated were of concern. The table that follows provides an overview of the deficiencies identified for the non-HEDIS Performance Measures.

ASTHMA RELATED ER VISITS		
Section	**Reasoning**	**Recommendation**
D2. Denominator	The source code provided appears to be counting members and not member months. The scaling factor for the denominator is only 100 instead of the required 1000.	Correct the source code to align with the measure specifications.
N2. Numerator	The source code being used includes any diagnosis that starts with 493 instead of diagnosis codes 493.0-2 and 493.9 as required by the specifications. The results may be selecting codes that should not be included. The measure specifications for CPT codes only include 99282, 99283, and 99285. The source code provided is looking at codes 99281-99285, and so including additional codes into the calculation.	Correct the source code to align with the measure specifications.
R1. Reporting	The reported results could be incorrect due to issues with the numerator and denominator.	Correct the issues with the denominator and the numerator and recalculate the measure.
ASTHMA RELATED RE-ADMISSIONS		
Section	**Reasoning**	**Recommendation**
D2. Denominator	The source code provided appears to be counting members and not member months. The scaling factor for the denominator is only 100 instead of the required 1000.	Correct the source code to align with the measure specifications.
N2. Numerator	The source code includes all diagnoses codes starting with 493 instead of 493.0-493.2 and 493.9 as required by the specifications. Codes may have been included in the numerator that should not have been included. Also, the inpatient specific codes (99221, 99222, etc.) do not appear to have been included in the provided source code.	Correct the source codes used for calculating the numerator.

R1. Reporting	The reported results could be incorrect due to issues with the numerator and denominator.	Correct the issues with the denominator and the numerator and recalculate the measure.
CONGESTIVE HEART FAILURE RE-HOSPITALIZATION		
Section	**Reasoning**	**Recommendation**
D2. Denominator	The source code provided appears to be counting members and not member months. The scaling factor for the denominator is only 100 instead of the required 1000.	Correct the source code issue.
N2. Numerator	The specific codes (99221, 99222, etc.) do not appear to be included in the source code as required by the state specifications.	Include all of the diagnosis codes required by the state specifications.
R1. Reporting	The reported results could be incorrect due to issues with the numerator and denominator	Correct coding for the denominator and numerator and recalculate the measure.
PRE AND POST NATAL COMPLICATIONS		
Section	**Reasoning**	**Recommendation**
N2. Numerator	The prenatal complication codes being used were incorrect. The prenatal complications codes should only be in the range of 640-649, with only the .01 and .03 fifth digits. (For example 640.01, 640.03, 640.81, 640.83, 640.91, 640.93, 641.01, 641.03 etc.…).	Correct the prenatal complication codes where more specific ranges of codes are required by the specification (ie not just the first three digits of the code).
R1. Reporting	The reported results could be incorrect due to issues with the numerator and denominator.	Correct the issues with the denominator and the numerator and recalculate the measure.

Complete details of the validation process results are explained in the *CCME EQR Validation Worksheets, Attachment 3,* of this report.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

The validation of the performance improvement projects submitted by UHC was done in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Topics for the projects included asthma, monitoring patients on ACE/ARB inhibitors, diabetes, and obesity. The results of the validation are summarized in the table that follows.

PERFORMANCE IMPROVEMENT PROJECTS

PROJECT	VALIDATION SCORE
Use of Appropriate Medications for People with Asthma	105 / 106 = 99% HIGH CONFIDENCE
Annual Monitoring for Patients on ACE/ARB Inhibitors	95 / 111 = 86% CONFIDENCE
Comprehensive Diabetes Care	111 / 116 = 96% HIGH CONFIDENCE
Reducing Adult, Adolescent and Childhood Obesity	126 / 136 = 93% HIGH CONFIDENCE

Three of the projects scored within the *High Confidence* range and one in the *Confidence* range. In the table that follows we have listed the specific errors by project and included our recommendations to correct the errors.

Use of Appropriate Medications for People with Asthma		
Section	**Reasoning**	**Recommendation**
Is there any statistical evidence that any observed performance improvement is true improvement?	Improvement from previous measurement was not statistically significant.	Continue to improve interventions to help boost rates.
Annual Monitoring for Patients on ACE/ARB Inhibitors		
Section	**Reasoning**	**Recommendation**
Was/were the study question(s) stated clearly in writing?	There are two study questions present in the documentation for the project. Although they are similar, one has a more narrow focus. Also, the project seems to focus on those with CHF, but the indicator is anyone on an ACE inhibitor or ARB.	Be sure the study question is clear.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Reasonable interventions are described in the documentation, but there are others included that seem to pertain to other projects. There are co-branded calls made that are aimed at improving asthma treatment.	Be sure that interventions performed will actually impact this project.
Is there any statistical evidence that any observed performance improvement is true improvement?	Improvement from previous measurement was not statistically significant.	Continue to improve interventions to help boost rates.
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	The HEDIS 2013 and 2014 results showed continued improvement, but the latest result did not. Although the result is above the baseline, it is below the previous measurement and not meeting the goal.	Continue to improve interventions to help boost rates.
Comprehensive Diabetes Care		
Section	**Reasoning**	**Recommendation**
Did the MCO/PIHP present numerical PIP results and findings accurately and	The Comparison Goal (3% annually from previous rate) is not calculated consistently.	Review all reported results for accuracy and consistency.

clearly?	For HEDIS 2013, it is 3 percentage points over the previous rate, but for the remainder of the years it is 3% of the previous rate. The DOM Goal is not always documented consistently. The DOM goal for Measure #3 is documented as 83.24% and also as 55.01% and for Measure #4 it is documented as 66.29% and 66.59%.	
Reducing Adult, Adolescent and Childhood Obesity		
Section	**Reasoning**	**Recommendation**
Did the study use objective, clearly defined, measurable indicators?	The denominator for Measure #2 is the number of members 3-17 years, but the measure is based on those members 3-17 with an outpatient visit.	Be sure all measures are clearly defined.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The same quarter is not always used in the comparison rates included in the interim analysis of HEDIS 2016. For example, for Measure #1, 5.85% is the documented rate for the previous year. This is the July 2014 rate, not the June 2014 rate. A similar issue is seen with Measure #2.	Review all reported results for accuracy and consistency.

Complete details of the validation of the performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3.*

The chart below shows that 80 percent of the scored standards for the Quality Improvement section of this EQR received a Met score. The Partially Met scores are related to deficiencies noted in the Quality Improvement Program Description, the performance measures, and the performance improvement projects.

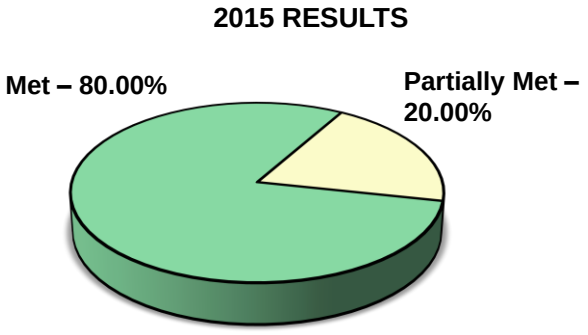


TABLE 4: QUALITY IMPROVEMENT

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
The Quality Improvement (QI) Program	The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to Members	Met	Partially Met
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Partially Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- Topics for performance improvement projects were appropriate for UHC's member population and met state contract requirements.
- In the asthma project, results are broken down by age, which is a good way to drill down to potential issues and apply appropriate interventions.

WEAKNESSES

- The following issues were identified in the 2015 Quality Improvement Program description:
    - Page nine discusses the Quality Improvement Program Structure and Organizational Chart and provides a description of the organization's committees. A description for the Compliance Committee was not included nor was this committee included in the Organizational Chart.
    - A description for the National Integrated Behavioral Health Steering Committee was not included.
    - A description of the following committees was included in the QI program description but not included in the chart on page nine: National Peer Review Committee, National Provider Sanctions Committee, and the Regional Peer Review Committee.
    - Page 24 includes a section regarding Ambulatory Medical Record Review. This section states "UHC conducts Ambulatory Medical Record Review for its plans when required by state contract." This section should be Mississippi specific.
- The non-HEDIS® measures did not meet the validation requirements. One measure was found to be *Substantially Compliant* and three of the measures were *Not Valid*. Issues with the way the numerators and denominators were calculated were of concern.
- Three of the projects scored within the *High Confidence* range and one in the *Confidence* range. Some of the deficiencies identified with the projects included:
    - The study question for the ACE/ARB project focuses on members with CHF but the indicator is anyone on an ACE inhibitor or ARB.
    - Some interventions underway for one project actually pertained to other projects.

- Improvements were not statistically significant.
- Reported results were not always accurate.

V. UTILIZATION MANAGEMENT

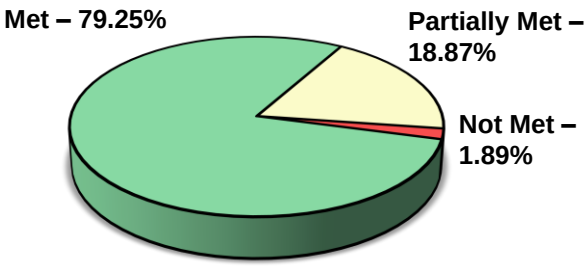
The Utilization Management (UM) review included a review of policies, the program description, and approval, denial, appeal, and case management files. UnitedHealthcare's UM Program is guided by the 2015 UM Program Description and its Mississippi Addendum along with departmental policies and procedures. Overall, there was improvement in UM and appeals policies and procedures; however, issues were identified that need to be corrected and/or clarified. The noted issues should be easily correctable.

Utilization management approval and denial files reviewed for this EQR confirmed that UHC staff appropriately process authorization requests. Determinations were made within the required timeframes, appropriate criteria were used for reviews, information was requested when necessary, and appropriate referrals for second-level review were made. Appeals files reviewed confirmed appropriate acknowledgements, appropriate MD reviewers, timely determinations, and timely notification of determinations. UM denial and appeal resolution letters contained clear documentation of the denial rationale.

Many new requirements for case management are in place in the *DOM Contract* that became effective July 1, 2014. UHC has adapted their processes and documentation to include all the new requirements. Case management files reflected that the new contractual requirements are consistently met.

UnitedHealthcare achieved a Met score of 79.25 percent of the standards for UM. Scores of Partially Met were predominantly related to errors in documentation in the UM Program Description and its Mississippi Addendum, policies and procedures, the Member Handbook, and the Provider Administrative Guide. One standard related to the written notice of appeal resolutions was scored as Not Met due to an uncorrected deficiency from the previous EQR. All issues are detailed in the Weaknesses section below.

2015 RESULTS



Percents may not total 100% due to rounding

TABLE 5: UTILIZATION MANAGEMENT

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
The Utilization Management (UM) Program	The CCO formulates and acts within policies and procedures that describe its utilization management program	Not Met	Met
	Guidelines/standards to be used in making utilization management decisions	Not Met	Met
	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Not Met	Partially Met
	The appeal process, including a mechanism for expedited appeal	Not Met	Partially Met
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all Members across all reviewers	Met	Partially Met
	Initial utilization decisions are made promptly after all necessary information is received	Not Met	Met
Appeals	The procedure for filing an appeal	Met	Partially Met
	A mechanism for expedited appeal where the life or health of the Member would be jeopardized by delay	Partially Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Not Met	Partially Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- Minutes of the Provider Advisory Committee confirm review of clinical practice guidelines and criteria. There are seven external providers on this committee, and overall attendance is good. One member with very poor attendance was replaced.
- The UM and appeals files confirmed that staff are following appropriate processes and timelines for review and notification of determinations.
- UHC has updated its case management processes and documentation to reflect the many new case management requirements. File review reflects consistent compliance with the new requirements.

WEAKNESSES

- Policy UCSMM 06.16, Initial Review Timeframes, documents timeframes for standard and expedited authorization determinations. However, page two, item four, states that if the physician or consumer fails to follow the procedure for requesting a review, they must be notified of the proper procedure within five calendar days for standard review requests. This five-day timeframe will cause UHC to be out of compliance with the three calendar day/two business day timeframe for a standard authorization determination required by the *DOM Contract, Section 5 (J) (4)*.
- Timeframes for utilization decisions for standard and expedited authorizations are not included in the Member Handbook or Provider Administrative Guide.
- The MS Addendum to the UM Program Description, pages 15 through 19, seems to address provider appeals, with only an occasional mention of members. This section should be revised to reflect that the appeals process is available to members, per requirements of the *DOM Contract, Exhibit D*, and *Federal Regulation § 438.400-410*.
- Policy UCSMM 06.10, Clinical Review Criteria, page nine, states reviewers must exceed a score of 90 percent on inter-rater reliability (IRR) testing. Onsite discussion confirmed that the threshold for IRR testing is 100 percent. Also, this policy does not clearly define the processes used for IRR testing and there is no information on the follow-up actions for scores below the established threshold.
- Policy RX-012, Pharmacy Coverage Reviews, page one, states UHC provides a prescription drug list (PDL); however, the policy does not indicate that UHC must use the current version of the Medicaid Program PDL, as required by the *DOM Contract, Section 5 (F)*.
- Policy RX-012, Pharmacy Coverage Reviews, does not include the timeframe requirement for pharmacy authorization reviews.
- Review of policies pertaining to the notice of action requirements contained the following issues:
    - Policy UCSMM 06.18, Initial Adverse Determination Notices, page two, item seven (i), states that if an urgent request results in an adverse determination and the review is either concurrent or retroactive, and the member is not at financial risk, only the provider must be notified of the determination. This is incorrect—members are to be notified of any decision to deny, suspend, terminate, or reduce services. Refer to the *DOM Contract, Section 5 (J) (4),* and *Federal Regulation § 438.210 (b) (3) (c)*.
    - Policy AG-01, page eight, states the notice of action shall be mailed within 14 days of the date of the action for newly requested services. The *DOM Contract, Section 5 (J) (4)*, states, “The Contractor must make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days.”
    - The Provider Administrative Guide, page 42, states for standard service authorization decisions that deny services, the notice of action will be sent no later than 14 calendar days of receipt of the request.
- Policy AG-02, Expedited Review Process, and the Provider Administrative Guide do not include that in addition to the member and provider, a representative acting on the member’s behalf may file an appeal.
- Per the *DOM Contract, Exhibit D, Section D*, appeals may be filed orally or in writing within 30 calendar days of the receipt of the notice of action, and follow-up with a written appeal request is needed only for standard appeals. Issues noted with the procedure for filing an appeal include:

    - The Member Handbook, page 53, states that an oral request for an appeal must be followed by a written request; however, it does not include this applies only to standard appeal requests.
    - The Provider Administrative Guide, page 42, incorrectly states the timeframe to file an appeal is within 30 calendar days from the date of the notice of action.
- The *DOM Contract, Exhibit D, Section D*, requires the Plan to provide the member or the member's representative the opportunity to present evidence of the facts or law, and the opportunity to examine the case file, including medical/clinical records and any other documents/records considered during the appeals process. This information is not documented in the following:
    - Policy AG-02, Expedited Review Process
    - The Provider Administrative Guide
    - The Member Handbook
- Policy AG-01, Complaint, Grievance and Appeal Procedures, states the standard appeal determination timeframe is within 30 calendar days of receipt of the appeal. A discrepancy is noted in the United Behavioral Health policy titled "Appeals of Adverse Actions", page seven, which states standard (non-urgent) pre-service appeal resolutions are determined within 15 calendar days.
- Policy AG-02, Expedited Review Process, states the expedited appeal resolution timeframe is within 72 hours from request. Issues with resolution timeframes for expedited appeals include:
    - The "Appeals of Adverse Actions" policy for United Behavioral Health, page seven, states the expedited appeal resolution timeframe is three working days.
    - Policy MBR 13a, Plan Members are Informed about Complaint and Grievance Procedure, page five, states that the expedited appeal resolution timeframe is three working days.
- Policy USCMM 07.11, Appeal Review Timeframes, lists state and federal requirements in a table in the policy addendum, but does not state what timeframes UHC adheres to for standard and expedited appeal resolutions. Onsite discussion revealed that UHC does not use this policy.
- Regarding extensions of appeal resolution timeframes, policy AG-02, Expedited Review Process, page six, states UHC sends a request for an extension letter to the member within three business days of determining the need for an extension. This will place UHC out of compliance with the expedited appeal resolution timeframe, which must be determined within 72 hours of the request. If an extension of an expedited appeal is requested by UHC, the member must be notified within 72 hours of the request.
- Regarding the denial of an expedited appeal, the Member Handbook does not inform members a request for an expedited appeal may be denied if expedited criteria are not met, and that if denied, UHC will transfer the appeal to the standard appeal timeframe, and notify the member verbally on the day of the decision to deny and in writing within two days.
- The *DOM Contract, Exhibit D, Section F*, states a member may request a State Fair Hearing within 30 days of the final decision by the contractor, and must exhaust all plan-levels of appeals prior to requesting a State Fair Hearing. Issues noted with information on filing a State Fair Hearing include:
    - The appeal upheld letter (UHC-041613), page one, states members must file a request for a State Fair Hearing within 30 days from the original notice of denial from UHC. This was an issue in the previous EQR and has not been corrected.

    - Policy MBR 13a, Plan Members are Informed about Complaint and Grievance Procedure, page five, states the filing timeframe for a State Fair Hearing is within 30 calendar days from receipt of UHC's notice of action.
    - Policy MBR 13a, page five, also contains a statement that, "a member who chooses to seek a State Fair Hearing without pursuing the UnitedHealthcare's process must do so within 30 calendar days of receipt of the UnitedHealthcare's notice of Action." This is outdated information. Members must exhaust all Plan-level appeals before requesting a State Fair Hearing.
- Per the *DOM Contract, Exhibit D*, the timeframe to request continuation of benefits pending a plan-level appeal is within 10 days of the notice of action. Regarding requests for continuation of benefits, the following issues were noted:
    - The timeframe is not specified in policy AG-01, Complaint, Grievance and Appeal Procedures, page 11, and the United Behavioral Health policy titled "Appeals of Adverse Actions", page 10. These documents state UHC shall continue the member's benefits if the member or service provider files a timely appeal of an action.
    - The MS CAN Reduction in Service letter, page four, states, "But you must appeal within 10 receiving the notice of contractor's action." (Incomplete)
    - The Provider Administrative Guide does not address continuation of benefits pending an appeal or State Fair Hearing.
- Policy NCM 001, Identification of High Risk Members for Case Management, Section A, Item 2, states members identified as high risk are stratified into two groups, those receiving long term services and support (LTSS) and those not receiving LTSS. Members identified as high risk and receiving LTSS (community or facility based) will be referred for Case Management as outlined in Policy NCM 015, Care Coordination for Members Receiving LTSS. Policy NCM 015 was requested during the onsite visit, and UHC's written response was, "United Healthcare Community and State of MS does not have LTSS as a benefit for our MS membership."

VI. DELEGATION

UnitedHealthcare has delegated contracts with Optum Behavioral Solutions (UBH), Vision Service Providers (VSP), Medical Transportation Management, Inc., CareCore National, Dental Benefit Providers, MHG and Physician Corporation, Hattiesburg Clinic, Mississippi Health Partners, River Region, HubHealth, and University Physicians.

Documentation of annual oversight activities was reviewed and several issues were identified that are discussed in the Weaknesses section below.

Fifty percent of the standards for the Delegation review were scored as Met. One standard received a score of Not Met due to failure to include all Mississippi-required elements on delegated credentialing audit tools. This was noted as an issue on the previous EQR and has not been corrected.

2015 RESULTS

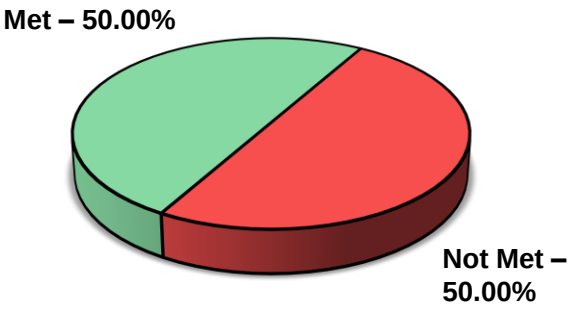


TABLE 6: DELEGATION

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Delegation	The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions	Partially Met	Not Met

WEAKNESSES

- The following issues were noted in delegation oversight documentation:
  - The Dental Program Monthly Report Card 2015 contains an incorrect timeframe for standard authorization turn-around times, and does not include the timeframe for expedited authorization turn-around times.
  - The CareCore National Dashboard spreadsheet contains an incorrect timeframe for standard authorization turn-around times.
  - The Optum Behavioral Health 2015 CR Audit Report tab titled “Audit Tool” does not address all Mississippi-specific requirements. Items missing are:
    - Query of the System for Award Management (SAM);
    - Copy of CLIA certificate/waiver; and
    - Collection of the ownership disclosure form.

VII. STATE-MANDATED

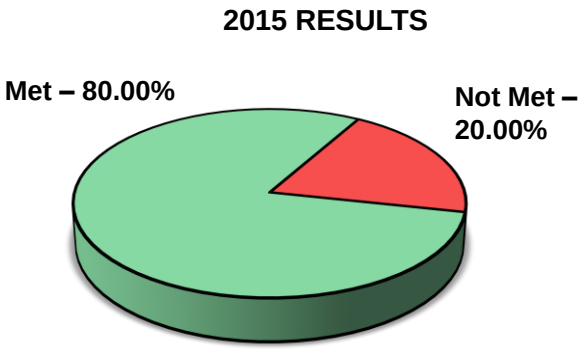
UnitedHealthcare provides to members all of the benefits specified in the in the *DOM Contract*. PCP utilization and quality profiles summarize utilization history and provider compliance on five utilization and nine quality indicators, including visits by age range. Additionally, initial visits for newborns are monitored via medical record documentation reviews.

UHC monitors for EPSDT service utilization and conducts outreach to members and practitioners as part of its EPSDT program. This outreach includes written education related to the components of

EPSDT comprehensive screening exams and the periodicity schedule. Additionally, UHC reports to practitioners on assigned members in need of services.

The findings of this EQR indicate that two deficiencies from the previous EQR have not been corrected. Details of the uncorrected deficiencies are provided in the Weaknesses section below.

UHC received Met scores for 80 percent of the standards in the State-Mandated section of the review. Uncorrected deficiencies from the previous EQR account for the score of Not Met for one standard.



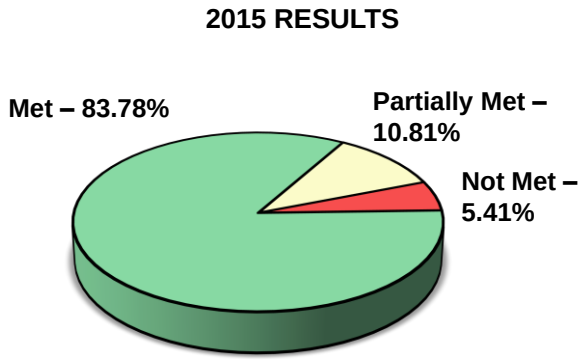
WEAKNESSES

- The following issues were noted in the previous EQR and have not been corrected:
    - The appeal upheld letter (UHC-041613), page one, states members must file a request for a State Fair Hearing within 30 days from the original notice of denial from UHC.
    - The Optum Behavioral Health 2015 CR Audit Report/Audit Tool does not address all Mississippi-specific requirements.

Summary and Recommendations

The findings of the 2015 EQR indicate that UnitedHealthcare Community Plan – Mississippi improved their percentage of met scores in the areas of Provider Services and Utilization Management. Areas of concern included UHC's process for how credentialing and recredentialing decisions are made, members access to their PCP, and the non-HEDIS performance measure results reported to DOM.

Overall, UHC received a Met score for 83.78 percent of the standards for the 2015 External Quality Review.



CCME recommends that UnitedHealthcare implement the following recommendations to improve their processes and comply with all Federal Regulations and DOM Contract requirements.

1. Change the format for the Compliance Committee so this committee is allowed to vote on actions that affect UHC and identify a quorum of voting members needed for each meeting. Also, identify attendance standards for the voting committee members.
2. UHC should establish a local credentialing committee that is chaired by the Mississippi Medical Director or Chief Medical Officer and includes a variety of network providers as voting members of the committee.
3. Update the UHC Provider Site Visit Tool to reflect the correct appointment criteria for routine sick visit.
4. Implement interventions to address the member access issues.
5. Update the Provider Administrative Guide and the Member Handbook to correct the member benefit discrepancies and address the contractually required information that was not found in the Provider Administrative Guide.
6. Update the Provider Directory (paper and electronic) to include the providers' hours of operation as required by the *DOM Contract, Section 6 (E).*
7. Implement interventions to increase the response rate in the provider satisfaction survey and improve survey documentation.
8. Include the right to receive services that are not denied or reduced solely because of diagnosis, type of illness, or medical condition in policy NQM-051 (or its Rider or Attachment), the Member Handbook, and the Provider Administrative Guide.

9. Update policy NQM-051 (or the corresponding Rider or Attachment), the Member Handbook, and the Provider Administrative Guide to include the member right to oral interpretation services free of charge.
10. Update policy NQM-051 (or the corresponding Rider or Attachment) and the Provider Administrative Guide to include the member's responsibility to inform the plan of changes in family size, address changes, or other health care coverage.
11. Revise the Member Handbook so that all information on second opinions is found in one location, rather than being separated by multiple pages.
12. Revise the Member Handbook to inform members that they will be notified of changes to benefits and services. Include the timeframe and method of notification.
13. Include additional information in the Member Handbook regarding advance directives, such as Member Services staff can provide more information about how to formulate an advance directive, etc.
14. Focus on strategies that would help increase response rates for the Medicaid Child population for the member satisfaction survey.
15. Develop and implement a process to ensure that providers are notified of the member satisfaction survey results.
16. Update the Provider Administrative Guide, page 43, to clearly indicate that providers need the member's written consent to file a grievance on the member's behalf.
17. Revise policy AG-01 to indicate that assistance is provided with filing grievances.
18. Update the Member Handbook to include the timeframe for grievance acknowledgement.
19. Remove the reference to the state-specified timeframe for expedited grievance resolution from policy AG-01.
20. Update policy AG-01 to include all processes for handling expedited grievance requests, including requirements extensions of resolution timeframes and notification of members when the grievance does not meet expedited grievance criteria and will be processed under the standard grievance resolution timeframe, etc.
21. Include information on expedited grievance resolution in the Member Handbook and the Provider Administrative Guide.
22. Update the Member Handbook to include information on extensions of grievance resolution timeframes.
23. Provide the information on extensions of grievance resolution timeframes in the Provider Administrative Guide rather than referencing a federal regulation.
24. Update the grievance acknowledgement letter to include information on extensions of grievance resolution timeframes.
25. Update the grievance resolution letter to remove language related to appeals.
26. Ensure that appropriate processes are followed for grievances, including written notification of resolution; investigation and notification of all issues related to each grievance; and timely acknowledgement of grievances.
27. Include, in either an existing or a new policy, UHC's process for handling requests for PCP changes due to dissatisfaction.
28. The Quality Improvement Program Description should include all committees on the Quality Improvement Program Structure and Organizational chart and a description of each of those committees.
29. All of the information in the Quality Improvement Program Description should be specific to Mississippi.
30. Correct the coding issues with the numerators and denominators for all of the non-HEDIS® performance measures and re-run the results.

31. Update the performance improvement project documents and correct the deficiencies identified.
32. Correct policy UCSMM 06.16 to reflect an appropriate timeframe for notification of the proper procedure when a physician or consumer fails to follow the procedure for requesting a standard review. The updated timeframe should allow for compliance with contractually required determination timeframes.
33. Revise the Member Handbook and Provider Administrative Guide to include standard and expedited authorization timeframes.
34. Revise the MS Addendum of the UM Program Description, pages 15-19, to clearly reflect appeals rights and processes for both members and providers.
35. Update policy USCMM 06.10 to include the correct IRR threshold and clear documentation of UHC's IRR process, including follow-up activities for scores below the established threshold (re-education, re-testing, etc.)
36. Revise policy RX-012 to state that UHC uses the current version of Medicaid Program PDL.
37. Update policy RX-012 to include the timeframe requirement for standard and expedited pharmacy authorization requests.
38. Correct policy UCSMM 06.18, page two, item seven (i), to state that members are notified of all decisions to deny, suspend, terminate, or reduce services. Ensure that UHC follows the correct process for adverse determinations of concurrent or retroactive reviews, even if the member is not at financial risk.
39. Correct the timeframe for notification of adverse determinations in policy AG-01, page eight, and in the Provider Administrative Guide, page 42.
40. Update policy AG-02 and the Provider Administrative Guide to indicate that a representative acting on the member's behalf may also file an appeal.
41. Update the Member Handbook to indicate that expedited appeal requests do not require a written appeal to follow.
42. Update the Provider Administrative Guide, page 42, with information that the timeframe to file an appeal is within 30 calendar days from the date of receipt of the notice of action.
43. Include information that members may present evidence or examine the case file/information used in the appeal process in policy AG-02, the Member Handbook, and the Provider Administrative Guide.
44. Correct the timeframe for standard and expedited appeal resolutions in the "Appeals of Adverse Actions" policy for United Behavioral Health, page seven.
45. Correct the timeframe for expedited appeal resolutions in policy MBR 13a.
46. If policy UCSMM 07.11 is not used by UHC, the policy should be updated to refer the reader to the appropriate policies to obtain timeframes for appeal resolutions, or the policy should be retired.
47. Update the timeframe for sending requests for extensions of expedited appeal timeframes to members in policy AG-02.
48. Update the Member Handbook to include information that a request for an expedited appeal may be denied if expedited criteria are not met, and that if denied, UHC will transfer the appeal to the standard appeal timeframe, and notify the member verbally on the day of the decision to deny and in writing within two days.
49. Correct the timeframe to file a request for a State Fair Hearing in the appeal upheld letter (UHC-041613) and policy MBR 13a.
50. Remove the outdated reference to requesting a State Fair Hearing before exhausting the plan-level appeal process from policy MBR 13a.

51. Revise policy AG-01, the United Behavioral Health policy titled “Appeals of Adverse Actions”, and the MS CAN Reduction in Service letter to contain correct information regarding the timeframe to request continuation of benefits pending an appeal. Refer to the *DOM Contract, Exhibit D, Section D*.
52. Revise the Provider Administrative Guide to include information on continuation of benefits pending an appeal or State Fair Hearing.
53. Remove from policy NCM 001 the reference to policy NCM 015 and the statement found in Section A (2) regarding stratification of members receiving LTSS. Alternatively, develop an addendum to this policy that contains Mississippi-specific information.
54. Correct the timeframe for standard authorization turn-around times, and include the timeframe for expedited authorization turn-around times, on the Dental Program Monthly Report Card.
55. Correct the timeframe for standard authorization turn-around times on the CareCore National Dashboard spreadsheet.
56. Correct the Optum Behavioral Health 2015 CR Audit Report or implement another tool that clearly addresses all Mississippi-specific requirements for delegated credentialing. The tool should include query of the System for Award Management (SAM); a copy of CLIA certificate/waiver; and collection of the ownership disclosure form.
57. Address the uncorrected deficiencies from the previous EQR. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

UnitedHealthcare Community Plan - Mississippi

External Quality Review

Attachment 1

Initial Notice

The Carolinas Center *for* Medical Excellence
100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

July 2, 2015

Jocelyn Chisolm Carter, Esq., Plan President
UnitedHealthcare Community Plan- Mississippi
795 Woodland Parkway, Suite 301
Ridgeland, MS 39157

Dear Ms. Carter:

This letter serves as your notification that the 2015 external quality review of UnitedHealthcare Community Plan is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with the Mississippi Division of Medicaid (DOM). The annual EQR is being initiated at this time at the request of DOM. It will include both a desk review at CCME and a multi-day onsite review at UnitedHealthcare Community Plan's office in Ridgeland, and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Please note that CCME's review methodology will include the protocols required by the Centers for Medicare and Medicaid Services for the external quality review of Medicaid Managed Care Organizations.

In preparation for the desk review, the items on the enclosed list are due at CCME no later than **August 3, 2015**. To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME through the website. The file transfer site can be found at:

https://www.thecarolinascenter.org/EQRFileTransfer/Default.aspx

This site allows you to create an account and download a container file that you will use while gathering your materials. When all the materials have been saved to the container file, log back in and upload your materials. We will be happy to provide you with additional information or help in using the file transfer website.

The CCME EQR team plans to conduct the onsite visit at UnitedHealthcare Community Plan on **October 12th** through **October 13th**. To prepare your organization for the upcoming review, we would like to offer to schedule a conference call with your management staff, in conjunction with DOM, to describe our process and answer any questions you may have. If you would like to have a conference call, please contact me at 800-682-2650, ext. 5588 or 919-461-5588 with dates your staff will be available for the call.

Sincerely,

Karen Smith
Project Manager

Enclosure
cc: DOM

The Carolinas Center *for* Medical Excellence

UnitedHealthcare Community Plan - Mississippi

2015 External Quality Review

Attachment 1

Materials Requested for Desk Review

External Quality Review 2015

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, member demographic studies, population needs assessments) that support the adequacy of the provider base. Please include any provider identified limitations on panel size considered in the network assessment.

5. A complete list of network providers for the MississippiCAN members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization.

6. The total number of unique specialty providers as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2014 and 2015.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Care Management programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.

b. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction, and
    - 15 sample records from those abstracted charts.
c. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP, and
    - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

13. Minutes of all committee meetings in the past year for all committees reviewing or taking action on MississippiCAN-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the Care Management program from July 1, 2014 through June 30, 2015. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool, and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials, and/or other mailings.

23. A copy of the Grievance, Complaint, and Appeal logs for the months of July 1, 2014 through June 30, 2015.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment access monitoring.

26. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. Sample provider contracts.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A description of the data security policy with respect to email and PHI.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All performance measures calculated and required to be reported to the state. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen, and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member

months/years calculation, other specified parameters);

d. if non HEDIS, programming specifications that include data sources such as files/databases and fields with definitions, programming logic, and computer source codes;
e. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
f. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.

    c. Forty medical necessity denial files made in the months of July 1, 2014 through June 30, 2015. Include any medical information and physician review documentation used in making the denial determination. Please include four behavioral health files. Also, include 10 additional pharmacy medical necessity denial files with five being antipsychotic medication.

    d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of July 1, 2014 through June 30, 2015, including any medical information and approval criteria used in the decision.

        Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at** https://www.thecarolinascenter.org/EQRFileTransfer/Default.aspx
- **should be submitted in the categories listed.**

The Carolinas Center *for* Medical Excellence

UnitedHealthcare Community Plan - Mississippi

2015 External Quality Review

Attachment 2

Materials Requested for Onsite Review

External Quality Review 2015

MATERIALS REQUESTED FOR ONSITE REVIEW

Items with an * should be provided as copies that can be retained by CCME. If possible, please provide these copies on a CD/flash drive.

1. *Copies of all committee minutes for committees that have met since the desk materials were copied.

2. *Please provide the following documents that were not received as part of the Credentialing Files:
    a. Copies of office site evaluations for PCP and OB/GYN initial credentialing files
    b. Felton Combest, MD – Valid DEA certificate and/or CDS certificate
    c. Sarah Moore, NP – Name of supervising physician, Verification of specialty and hospital admittance plan
    d. Douglas Turner, MD – work history (5 years) and justifications for gaps (only 1 year work history was provided)

3. *Please provide the following documents that were not received as part of the Recredentialing Files:
    a. Timothy Estes, MD – Ownership disclosure Form
    b. Christopher Miller, MD – CLIA certificate or waiver of a certificate of registration alone with CLIA identification number
    c. Jay Pinkerton, MD – Board/specialty certification, proof of query for the System for Aware Management (SAM)
    d. John Dodd, OD – Hospital admitting privileges and/or attestation that another physician or group will admit members on PCP's behalf

4. * Please provide the following document that was not received as part of the Organizational Provider Recredentialing Files:

    a. OS Surgical & Endoscopy Center – proof of accreditation by a nationally recognized body

5. *Please provide the list of committee members for the National Credentialing Committee with their roll or specialty, voting status, and state represented.

6. *Please provide minutes for the National Credentialing Committee for unclean MS providers that were presented to the committee for review. Please provide at least 6 meeting minutes that meet this criteria.

7. *Committee minutes for the Regional Peer Review Committee for September 2014 – September 2015.

8. *MS CAN Resource Guide

9. *Copy of the 2014 Optum Quality Management and Improvement Program Evaluation.

10. *The 2014 and 2015 Optum work plan.

11. *2015 Optum Behavioral Quality Management and Improvement Program Description.

12. *List of providers where credentialing/recredentialing has been delegated. Include proof of annual delegation oversight with copy of the delegation oversight tool.

13. *Copy of annual oversight for Optum credentialing/recredentialing delegation. Include copy of oversight tool.

The Carolinas Center *for* Medical Excellence

UnitedHealthcare Community Plan - Mississippi

2015 External Quality Review

Attachment 3

EQR Validation Worksheets

Attachment 3

EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PIP/FS	**USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA (ASM)**
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY			
STEP 1: Review the Selected Study Topic(s)			
	Component / Standard (Total Points)	**Score**	**Comments**
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Asthma was on the state approved topic list for PIPs.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3	Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used a HEDIS measure for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Collection was through HEDIS certified software.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in their documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. The measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of successes and the barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Some improvement has been seen in the indicator.

9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Improvement from previous measurement was not statistically significant. ***RECOMMENDATION*** *Continue to improve interventions to help boost rates.*
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not able to judge. Too early in project cycle.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	0	NA
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	**105**
Project Possible Score	**106**
Validation Findings	**99%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PIP/FS	**ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS**
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY			
STEP 1: Review the Selected Study Topic(s)			
	Component / Standard (Total Points)	**Score**	**Comments**
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	CVD is leading cause of death in Mississippi. Appropriate use of ACE/ARB Inhibitors should help reduce this threat.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3	Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**PARTIALLY MET**	There are two study questions present in the documentation for the project. Although they are similar, one has a more narrow focus. Also, the project seems to focus on those with CHF, but the indicator is anyone on an ACE inhibitor or ARB. ***RECOMMENDATION*** *Be sure the study question is clear.*
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used a HEDIS measure for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was performed for this study.

STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Collection was through HEDIS certified software.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**PARTIALLY MET**	Reasonable interventions are described in the documentation, but there are others included that seem to pertain to other projects. There are co-branded calls made that are aimed at improving asthma treatment. ***RECOMMENDATION*** *Be sure that interventions performed will actually impact this project.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in the documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. The measures have a goal of 3% increase each year.

8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of successes and the barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Some improvement has been seen in the indicator.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Improvement from previous measurement was not statistically significant. ***RECOMMENDATION*** *Continue to improve interventions to help boost rates.*
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NOT MET**	The HEDIS 2013 and 2014 results showed continued improvement, but the latest result did not. Although it is above the baseline, it is below the previous measurement and not meeting the goal. ***RECOMMENDATION*** *Continue to improve interventions to help boost rates.*

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	5
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	0	NA
Step 7		
7.1	10	5
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	5	0
Activity 2		
Verify Findings	20	20

Project Score	**95**
Project Possible Score	**111**
Validation Findings	**86%**

CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PIP/FS	**COMPREHENSIVE DIABETES CARE**
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used HEDIS measures for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid Methodology
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.

6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	The Comparison Goal (3% annually from previous rate) is not calculated consistently. For HEDIS 2013, it is 3 percentage points over the previous rate, but for the remainder of the years it is 3% of the previous rate. The DOM Goal is not always documented consistently. The DOM goal for Measure #3 is documented as 83.24% and also as 55.01% and for Measure #4 it is documented as 66.29% and 66.59%. ***RECOMMENDATION*** *Review all reported results for accuracy and consistency.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The baseline was reestablished when the hybrid method was introduced. The same methodology has been used since.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Some improvement has been seen in the indicators.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Measure #4 and Measure #6 have seen statistically significant improvement from previous measurement.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Sustained improvement has been demonstrated.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	5
Activity 2		
Verify Findings	20	20

Project Score	**111**
Project Possible Score	**116**
Validation Findings	**96%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PIP/FS	**REDUCING ADULT, ADOLESCENT AND CHILDHOOD OBESITY**
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY			
STEP 1: Review the Selected Study Topic(s)			
	Component / Standard (Total Points)	**Score**	**Comments**
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi community.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3	Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**PARTIALLY MET**	The denominator for Measure #2 is the number of members 3-17 years, but the measure is based on those members 3-17 with an outpatient visit. ***RECOMMENDATION*** *Be sure all measures are clearly defined.*
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid Methodology
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.

STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	The same quarter is not always used in the comparison rates included in the interim analysis of HEDIS 2016. For example, for Measure #1, 5.85% is the documented rate for the previous year. This is the July 2014 rate, not the June 2014 rate. A similar issue is seen with Measure #2. ***RECOMMENDATION*** *Review all reported results for accuracy and consistency.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of successes and the barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	The baseline was reestablished when the hybrid method was introduced. The same methodology has been used since.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement has been seen in the indicators.

9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Measure #1 and Measure #2a have seen statistically significant improvement from previous measurement.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**MET**	Sustained improvement has been demonstrated.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	5
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	5
Activity 2		
Verify Findings	20	20

Project Score	**126**
Project Possible Score	**136**
Validation Findings	**93%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

Attachment 3

EQR PM Validation Worksheets

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PM	**HEDIS MEASURES**
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2015

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software MedMeasures™ from General Dynamic Information Technology (GDIT). Review requirements for documentation have been met.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software MedMeasures™. Review requirements for documentation have been met.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software MedMeasures™. Review requirements for documentation have been met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software MedMeasures™. Review requirements for documentation have been met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software MedMeasures™. Review requirements for documentation have been met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Not being done.
S2. Sampling	Sample treated all measures independently.	**NA**	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Not being done.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software MedMeasures™. Review requirements for documentation have been met.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	State does not require any additional reporting requirements.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**MET**	**10**
D1	**10**	**MET**	**10**
D2	**5**	**MET**	**5**
N1	**10**	**MET**	**10**
N2	**5**	**MET**	**5**
N3	**0**	**NA**	**NA**
N4	**0**	**NA**	**NA**
N5	**0**	**NA**	**NA**
S1	**0**	**NA**	**NA**
S2	**0**	**NA**	**NA**
S3	**0**	**NA**	**NA**
R1	**10**	**MET**	**10**
R2	**0**	**NA**	**NA**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**50**
Measure Weight Score	**50**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PM	**ASTHMA RELATED ER VISITS**
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division Of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The source code provided appears to be counting members and not member months. The scaling factor for the denominator is only 100 instead of the required 1000. ***RECOMMENDATION*** Correct the source code to align with the measure specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The source code used includes any diagnosis that starts with 493 instead of diagnosis codes 493.0-2 and 493.9 as required by the specifications. The results may be selecting codes that should not be included. The measure specifications for CPT codes only include 99282, 99283, and 99285. The source code provided is looking at codes 99281-99285, and so including additional codes into the calculation. ***RECOMMENDATION*** Correct the source code to align with the state's specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Not being done.
S2. Sampling	Sample treated all measures independently.	**NA**	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Not being done.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**NOT MET**	The reported results could be incorrect due to issues with the numerator and denominator. ***RECOMMENDATION*** Correct the issues with the denominator and the numerator and recalculate the measure.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to all state specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	NOT MET	0
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	35
Measure Weight Score	55
Validation Findings	64%

AUDIT DESIGNATION
NOT VALID

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PM	**ASTHMA RELATED RE-ADMISSIONS**
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division Of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The source code provided appears to be counting members and not member months. The scaling factor for the denominator is only 100 instead of the required 1000. ***RECOMMENDATION*** Correct the source code to align with the state's specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The source code includes all diagnoses codes starting with 493 instead of 493.0-493.2 and 493.9 as required by the specifications. Codes may have been included in the numerator that should not have been included. Also, the inpatient specific codes (99221, 99222, etc.) do not appear to have been included in the provided source code. ***RECOMMENDATION*** Correct the source codes used for calculating the numerator.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Not being done.
S2. Sampling	Sample treated all measures independently.	**NA**	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Not being done.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**NOT MET**	The reported results could be incorrect due to issues with the numerator and denominator. ***RECOMMENDATION*** Correct the issues with the denominator and the numerator and recalculate the measure.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to all state specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	NOT MET	0
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	35
Measure Weight Score	55
Validation Findings	64%

AUDIT DESIGNATION
NOT VALID

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PM	**CONGESTIVE HEART FAILURE RE-HOSPITALIZATION**
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division Of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The source code provided appears to be counting members and not member months. The scaling factor for the denominator is only 100 instead of the required 1000. ***RECOMMENDATION*** Correct the source code to align with the state's specifications.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The specific codes (99221, 99222, etc.) do not appear to be included in the source code as required by the state specifications. ***RECOMMENDATION*** Include all of the diagnosis codes required by the state specifications.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Not being done.
S2. Sampling	Sample treated all measures independently.	**NA**	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Not being done.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**NOT MET**	The reported results could be incorrect due to issues with the numerator and denominator ***RECOMMENDATION*** Correct coding for the denominator and numerator and recalculate the measure.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to all state specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	NOT MET	0
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	35
Measure Weight Score	55
Validation Findings	64%

AUDIT DESIGNATION
NOT VALID

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Name of PM	**PRE AND POST NATAL COMPLICATIONS**
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division Of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Denominator is adhering to the appropriate specifications dictated by the state.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**NOT MET**	The prenatal complication codes being used were incorrect. The prenatal complications codes should only be in the range of 640-649, with only the .01 and .03 fifth digits. (For example 640.01, 640.03, 640.81, 640.83, 640.91, 640.93, 641.01, 641.03 etc….). ***RECOMMENDATION*** Correct the prenatal complication codes where more specific ranges of codes are required by the specification (i.e. not just the first three digits of the code).
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	Not being done.
S2. Sampling	Sample treated all measures independently.	**NA**	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	Not being done.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**NOT MET**	The reported results could be incorrect due to issues with the numerator and denominator. ***RECOMMENDATION*** Correct the issues with the denominator and the numerator and recalculate the measure.
R2. Reporting	Was the measure reported according to State specifications?	**MET**	Measure was reported according to all state specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	40
Measure Weight Score	55
Validation Findings	73%

AUDIT DESIGNATION
SUBSTANTIALLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Attachment 3

EQR Survey Validation Worksheets

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Survey Validated	**CONSUMER SATISFACTION (ADULT / CHILD / CHIP)**
Validation Period	2015
Review Performed	09/2015

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	-Uses CAHPS and its standardized purpose *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H for all three surveys administrated -Vendor: CSS

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H for all three surveys administrated -Vendor: CSS

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.1	Review that the definition of the study population was clearly identified.	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	-Uses standard NCQA definition for response rate calculation by their certified vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	- The results met the minimum number of responses considered by NCQA necessary for a valid survey (411 responses), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively). -Alternative approaches may be needed to increase the response rates, especially for the Medicaid Child population which suffered the lowest response rate. Response bias may be a large issue with that survey. ***RECOMMENDATION*** *Focus on strategies that would help increase response rates for this population. Solicit the help of your survey vendor.* *Documented:* -CAHPS Summary Report by UHC MS -Full report for all three surveys Response Rates (NCQA definition): Adult – 646 / 1847 = 34.98% Child – 543 / 2280 = 23.82% CHIP – 921 / 2277 = 40.45%

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their *HEDIS 2014, Volume 3: Specifications for Survey Measures and Quality Assurance Plan for HEIDS 2014 Survey Measures.* *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
6.1	Was the survey data analyzed?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documented:* -CAHPS Summary Report by UHC MS -2014 CAHPS SOW -Full report for all three surveys

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - CSS as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report. - Report includes trended results that allow analysis over time.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	- The response rate for the Medicaid Child population suffered from a very low response rate. Response rate bias should be a concern. ***RECOMMENDATION*** *Focus on strategies that promote higher response rates for the Medicaid Child population.*
7.4	What conclusions are drawn from the survey data?	Based on the vendor and plan results summaries, the following areas were identified as areas for quality improvement. Medicaid Adult - Improving member access to care (ease of getting needed care, tests, or treatment) - Improving saliency, availability, and clarity of information about how the health plan works in written materials or on the Internet - Improving the ability of the health plan customer service to provide members with necessary information or help - Improving the quality of specialists in health plan network - Improving member access to care (scheduling appointments for routine care) - No statistical increase or decreases in performance were noted. Medicaid Child - Improving access to personal doctor - Improving the quality of specialists in the plan's network - Improving member access to care (ease of getting needed care, tests, or treatment) - Improving the quality of physicians in the plan's network (personal doctors) - “Rating of All Health Care” increased by 7.76 percentage points and was statistically significant. Medicaid CHIP - Improving access to personal doctor - Improving the quality of physicians in the plan's network (personal doctors) - Improving member access to care (ease of getting needed care, tests, or treatment) - Improving the quality of specialists in the plan's network - No statistical increase or decreases in performance were noted.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	This assessment is done in part by the survey vendor and summarized in the survey summary by UHC MS.
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2015
Review Performed	09/2015

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	- Survey has a clearly written objective/purpose *Documented:* *- 2014 MSCAN Quality Improvement Evaluation*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	- Survey has a clearly written objective/purpose *Documented:* - 2014 MSCAN Quality Improvement Evaluation
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	- Survey has a clearly written objective/purpose that defines the intended audience. *Documented:* - 2014 MSCAN Quality Improvement Evaluation

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	- Survey instrument was administered by CSS, an experienced survey company and approved/certified by CMS and NCQA to administer and analyze surveys. *Documented:* - CSS Website, 10/7/2015
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	- Survey instrument was administered by CSS, an experienced survey company and approved/certified by CMS and NCQA to administer and analyze surveys. *Documented:* - CSS Website, 10/7/2015

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.1	Review that the definition of the study population was clearly identified.	**MET**	- Study population is defined in the documentation *Documented:* - 2014 MSCAN Quality Improvement Evaluation - 2014 Provider Satisfaction Survey Results Summary
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	- Sample frame was clearly defined in the documentation. *Documented:* - 2014 MSCAN Quality Improvement Evaluation - 2014 Provider Satisfaction Survey Results Summary
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy and process was not included in the main documentation of the survey but secondary documentation was provided during the onsite. ***RECOMMENDATION*** *Include in the main survey documentation the sampling strategy used to create the sample for this survey.*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**NOT MET**	- Detailed information regarding the selection of the sample size was not in the documentation. The documents received during the onsite indicated a non-statistical rationale for sample size which is not consistent with the CMS protocol. ***RECOMMENDATION*** *Include in the survey documentation how the sample size was determined. Be sure to include the statistical assumptions such as acceptable margin of error and the level of certainty that was used in the sample size calculation.*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	- Sampling strategy and process was not included in the main documentation, but secondary documentation was provided through the onsite. ***RECOMMENDATION*** *Include in the main survey documentation the sampling strategy used to create the sample for this survey.*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**NOT MET**	- A response rate was documented in secondary documentation received at the onsite but no explanation of the calculation was provided. Only the number of complete surveys was documented in the main documentation. ***RECOMMENDATION*** *Include in the main survey documentation the response rate and its calculation.*
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	- A response rate was not calculated in the survey documentation. Only the number of complete surveys was documented. - With only 95 completed surveys, the power of the results could be severely limited. ***RECOMMENDATION*** *With such a small number of completed surveys it is assumed that the response rate is low. Seek different methods to administer the survey since the current method is not giving the response volume that most would expect from a survey.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	- CSS, their NCQA certified CAHPS vendor, was used for this survey. They adhered to all their normal processes. *Documented:* - 2014 Provider Survey SOW
5.2	Did the implementation of the survey follow the planned approach?	**MET**	- Vendor met deliverables as planned. *Documented:* - 2014 Provider Satisfaction Results Summary - 2014 Provider Survey SOW
5.3	Were confidentiality procedures followed?	**MET**	- CSS, their NCQA certified CAHPS vendor, was used for this survey. They adhered to all their normal processes. *Documented:* - 2014 Provider Survey SOW

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
6.1	Was the survey data analyzed?	**MET**	-Survey was analyzed by the vendor with those results summarized by the plan. *Documented:* - 2014 Provider Satisfaction Results Scorecard - 2014 Provider Satisfaction Results Summary
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Survey was analyzed by the vendor with those results summarized by the plan. *Documented:* - 2014 Provider Satisfaction Results Scorecard - 2014 Provider Satisfaction Results Summary
6.3	Were all survey conclusions supported by the data and analysis?	**NOT MET**	- While conclusions were made from the results of the survey, it is questionable how representative those results are of the provider population given the small number of responses received. ***RECOMMENDATION*** *Look for new ways and approaches to deliver the survey to help increase the number of responses received.*

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.1	Identify the technical strengths of the survey and its documentation.	- Survey was done by an experienced survey vendor.
7.2	Identify the technical weaknesses of the survey and its documentation.	- Survey documentation was missing pieces of important documentation regarding survey development, sample size calculation and creation, and response rate calculation. ***RECOMMENDATION*** *Include these items in the survey summary document to complete the documentation.*
7.3	Do the survey findings have any limitations or problems with generalization of the results?	- While conclusions were made from the results of the survey, it is questionable how representative those results are of the provider population given the small number of responses received. ***RECOMMENDATION*** *Look for new ways and approaches to deliver the survey to help increase the number of responses completed.*

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.4	What conclusions are drawn from the survey data?	Items where increases were observed in the high satisfaction rates: - Communication of the determination of claims appeals - Ease of prior authorization process - Effectiveness of care management programs - Availability of disease management and health education programs Opportunities for improvement that were noted: - Provider Call Center - Provider Manual - Provider Appeals - Pharmaceutical Prior Authorization - Specialty Network *Documented:* - 2014 Provider Satisfaction Results Summary
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	- The survey vendor provided a scorecard of the results and the plan summarized the results in a narrative. These items were addressed in these presentations. *Documented:* - 2014 Provider Satisfaction Results Summary
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

The Carolinas Center *for* Medical Excellence

UnitedHealthcare Community Plan - Mississippi

2015 External Quality Review

Attachment 4
Tabular Spreadsheet

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to Members, both directly and indirectly.	X					Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, details the process for policy adoption and review. UHC utilizes some local policies and also adopts national policies, adding riders or addendums to address state specific requirements. Policies are reviewed annually and accessible to all employees. Policies and procedures were much improved from the previous EQR. They are organized and for the most part appear to appropriately address state requirements.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. At a minimum, this includes designated staff performing in the following roles:						
1.1 Full time Chief Executive Officer;	X					Jocelyn Chisolm Carter serves as Chief Executive Officer of UnitedHealthcare Community Plan of Mississippi.
1.2 Chief Operations Officer;	X					Mitch Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Charles Gleason is the Chief Financial Officer
1.4 Chief Information Officer: A professional who will oversee information technology and systems to support CCO operations, including submission of accurate and timely encounter data;	X					Glenn Walsh is the Chief Information Officer.
1.4.1 Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 Provider Services Manager;	X					Morgan Jones is the Provider Relations Manager. Onsite discussion confirmed at the time of the onsite

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						UHC was interviewing to fill the Director of the Provider Services Call Center position that had been recently vacated.
1.6.1 Provider credentialing and education;	X					The National Credentialing Center is responsible for conducting provider credentialing. Provider education is conducted by the Provider Relations staff in addition to staff from other departments.
1.7 Member Services Manager;	X					Royal Walker is the Member Services and Community Outreach Director.
1.7.1 Member services and education;	X					Member education is performed through community outreach and collaboration between the clinical and quality areas.
1.8 Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals;	X					Rachel Clark serves as the Appeals and Grievance Manager.
1.9 Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions;	X					Reesheda Rhymes, RN is Utilization Management/Health Services Director.
1.9.1 Medical/Care Management Staff	X					
1.10 Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities;	X					Cara Robinson, RN is the Quality Management Director. The Chief Medical Officer and Medical Directors are responsible for ensuring all clinical services are administered in a manner consistent with accepted standards of care and provides direction and oversight for all clinical quality improvement activities.
1.11 Marketing and/or Public Relations;	X					
1.12 Medical Director: A physician licensed and actively practicing in the state of Mississippi, providing substantial oversight of the medical aspects of operation, including quality assurance activities, the functions of the Credentialing Committee, and services as Chair of the Credentialing Committee;	X					Dr. David Williams serves as the Chief Medical Officer. He is board certified in Internal Medicine, and is licensed and located in Mississippi. He provides clinical oversight for health plan staff and sits on the Quality Management Committee (QMC) and the National Credentialing Committee (NCC). Dr. Williams chairs the Healthcare Quality and Utilization Management Committee (HQUM) and the Provider Advisory Committee (PAC).

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Dr. Michael Soto is Medical Director of Behavioral Health. He holds a Mississippi license.
1.13 Compliance Officer who will act as a primary point of contact for the Division and a compliance committee that are accountable to senior management and that have effective lines of communication with all the CCO's employees.		X				Terrence Christopher is the Compliance Officer and reports directly to the CEO. He chairs the Compliance Committee which meets on a monthly basis. The 2015 Mississippi Committee Matrix received for the Compliance Committee identified the voting members of the committee; however, the Compliance Officer indicated during onsite discussion that the Compliance Committee is not a voting committee. In addition, a review of committee minutes showed poor attendance by committee members. The UHC Fraud and Abuse Compliance Plan contains a comprehensive compliance training curriculum and meets contract requirements. *Corrective Action: Change the format for the Compliance Committee so this committee is allowed to vote on actions that affect UHC and identify a quorum of voting members needed for each meeting. Also, identify attendance standards for the voting committee members.*
2. Operational relationships of CCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions.	X					Policy UCSMM 02 10, Staff Qualifications and Credentials, details how UHC defines requirements in job descriptions and monitors compliance with licensure requirements.
4. A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week.	X					
5. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					Member Services is available via a toll-free number from 8 a.m. until 5 p.m. except Wednesday, when they are available until 8 p.m. They are also available the first weekend of the month 8 a.m. until 5 p.m. per their contract with DOM.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.1 Call Center scripts are in-place and staff receives training as required by the contract.	X					
5.2 Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee.	X					
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					UHC processes 100% of clean claims well within the 30 day requirement of the contract. They also process 100% of all claims within 90 days. UnitedHealthcare has excellent systems and processes in place to meet these contract requirements.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					UHC has the necessary systems in place to capture and track enrollment and demographic data.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					The UHC management information system is sufficient to support data reporting to the State and internally for quality improvement and utilization monitoring activities. For HEDIS and HEDIS-like reporting, UHC uses General Dynamic Information Technology (GDIT) MedMeasures software which is NCQA certified. UHC transmits extracts of data that is loaded to a dedicated warehouse for purposes of performance measurement. All measure-related reporting is produced from this system, for example HEDIS reporting and state-specific reporting.
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					UHC has a Disaster Recovery Plan in place and the latest table top testing occurred in December 2014.
I D. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy USMM.02.11, Orientations, Training and Support Tools, addresses initial training that occurs prior to assuming job responsibilities and includes training on confidentiality and training in accordance with UnitedHealth Group Privacy Policy. HIPAA guidance is provided to customer service staff via the

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						State HIPAA Job Aid document that covers many scenarios and is very detailed. The Notice of Privacy Practices (NPP) is found in the Member Handbook which all new members receive at enrollment. The NPP is listed on the website and members receive the information annually.
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.	X					UHC MS has adopted the UnitedHealthcare Credentialing Plan 2015 – 2016 that addresses the credentialing and recredentialing processes and guidelines for licensed independent practitioners and facilities. A state specific rider addresses MS requirements.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.			X			The Provider Advisor Committee (PAC) meets on a quarterly basis and is chaired by Dr. David Williams, Chief Medical Officer MS. The PAC performs peer review activities, including review of credentialing and review and disposition of concerns about quality of clinical care provided to members as requested by the Health Plan CMO. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network. The voting members of the 2015 committee include 10 network physicians with various specialties, and the CMO votes in case of a tie. The UHC Credentialing Plan states that the National Credentialing Committee (NCC) will make credentialing decisions pursuant to the Credentialing Plan and will communicate those decisions to the Credentialing Entity. According to the credentialing plan, the committee will be comprised of participating practitioners from the various Credentialing Entities, Medical Directors, and a designated Chairperson

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						unless a different committee composition is required by applicable Credentialing Authorities. The list of committee members did not include UHC's Chief Medical Officer; Dr. Williams or any Mississippi network providers. Onsite discussion confirmed that Dr. Williams sits on the committee even though the list of committee members did not include Dr. Williams and committee minutes did not list Dr. Williams as in attendance. Decisions made by the NCC are reported to UHC's PAC on a quarterly basis. The process UHC follows for credentialing and recredentialing of Mississippi providers is of concern. Credentialing and recredentialing decisions are not made by Mississippi providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *DOM Contract, Section 1 (L).* *Corrective Action: UHC should establish a local credentialing committee that is chaired by the Mississippi Medical Director or Chief Medical Officer and includes a variety of network providers as voting members of the committee.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files reviewed were organized and contained appropriate documentation.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat Members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.12 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	X					
3.1.13 Ownership Disclosure Form.	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.		X				The Credentialing Plan State and Federal Regulatory Addendum for Mississippi states that initial site visits will be conducted during credentialing of PCPs and OB/GYNs. Evidence that provider office site visits were conducted was received in the credentialing files.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The UHC Provider Site Visit Tool received in the desk materials showed an incorrect appointment timeframe for non-urgent (symptomatic) care. It stated within 14 days, but appointment criteria for a routine sick visit is 7 calendar days. The correct appointment timeframe is found in other documents. *Corrective Action: Update the UHC Provider Site Visit Tool to reflect the correct appointment criteria for routine sick visits.*
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files reviewed were organized and for the most part contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat Members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					All but one recredentialing file contained verification of board certification if claimed by the physician.
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery the System for Award Management (SAM);	X					All but one recredentialing file contained proof of query for the System for Award Management.
4.2.8 Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline);	X					

STANDARD 2015	SCORE					COMMENTS
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4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	X					
4.2.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.12 Ownership Disclosure form.	X					
4.3 Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met.	X					Policy NQM-056 was retired and replaced with the corporate policy "Ongoing Monitoring of Office Site Quality". This policy states that Clinical Services, monitors complaints and referrals concerning participating physicians and facilities. Complaints about a physician's office site and facilities are recorded, investigated and appropriate follow-up is conducted to assure that members receive care in a clean, accessible, and appropriate environment. The Site Visit Vendor performs the Site Visit Review within 45 calendar days of the receipt of the complaint. If the office did not pass the office site visit (score less than 85%) overall or the site visit elements relevant to the complaint, the QOC department staff sends a letter to the physician outlining the findings of the site visit, requesting correction of the issue found, and notifying the office of a revisit within 6 months. Policy QM-02, Timeframes for Ongoing Monitoring of Office Site Visit Quality, states that UHC will conduct an additional provider office site visit within 45 calendar days when a complaint, grievance, and/or appeal threshold is met concerning participating physicians' office sites and facilities, in accordance

STANDARD 2015	SCORE					COMMENTS
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						with the requirements with Exhibit D and the MississippiCAN contract. During the look back period of July 1, 2014 – June 30, 2015, there were no providers who met the threshold requiring an onsite visit.
4.4 Review of practitioner profiling activities.	X					Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization, defines the process for demonstrating to state, federal, and accreditation agencies that UHC has systems and processes in place to monitor under and over use of services and to communicate information on member utilization using provider profiles to primary care physicians and other appropriate specialists. The expectation is that the health plan chief medical officer and quality staff will utilize the data to build relationships with network providers and educate them about expectations relative to utilization and the quality of care. Examples of MS CAN Primary Care Provider Profile reports were received that show utilization management profiles for measurements such as discharges, hospitals days, ER visits, prescriptions, etc. The reports also include HEDIS measures for quality management. The reports are measured at the practice level and individual physician reports are provided as well. At a minimum the profiles are generated annually. Policy NCC 130, Quality of Care Monitoring at Recredentialing, defines the process of obtaining and reviewing quality of care data for providers in the recredentialing process.
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy NQM-023, Provider Suspension or Termination process, defines the procedures for suspending or terminating a provider's participation in the network and notifying the provider of this action. Policy POL.UHC.1630, Quality of Care Appeal

STANDARD 2015	SCORE					COMMENTS
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						Policy, establishes a process for physicians and health care professionals to submit an appeal of an adverse action and provides a mechanism which includes notification and the timely resolution of an appeal. Policy POL.UHC.1890, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy & Procedure, describes the process Clinical Services follows to investigate, track, and resolve quality of care (QOC) issues related to network participants. This document also describes the process Clinical Services follows to manage, track, and implement improvement action plans and disciplinary actions that result from the identification of QOC issues relating to network participants.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of Members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the Members assigned.	X					Policy PS10a, PCP Panel Notification, states UHC notifies PCPs of the enrollees assigned to them, including notification of panel changes, within five business days of the date on which UHC receives the Member Listing Report from DOM. Notification of the PCP assigned is communicated to members via provider identification on the Member ID card.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, states that participating providers may access member enrollment via the secure online provider portal. All providers, including out-of-network providers, may call a telephone number on the member ID card to verify enrollment.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Policy PS10a, PCP Panel Notification, states that during initial credentialing and/or contracting setup, PCPs may communicate desired restrictions regarding

STANDARD 2015	SCORE					COMMENTS
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						member panel composition to UHC. If they have a closed panel, no members will be assigned to them. PCPs can request changes to their panel profile information at any time, and this information is updated in the provider data and applied to member assignment processes. In order to notify providers of panel composition and keep them informed of any changes to their member panels, UHC makes member panel details available to all participating PCPs via the secure provider portal.
1.4 Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties.	X					Policy PS3, Geographic Access Standards, defines provider access standards that comply with contract requirements and evidence of the GEO reports were received in the desk materials. Policy PS10b, Member Assignment to PCP, states that it is the policy of UHC to ensure that each member has the opportunity to choose from at least two PCPs within the specified geographic accessibility standards.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the Member may utilize an out-of-network specialist with no benefit penalty.	X					
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Policy PS3, Geographic Access Standards, states that geographic access reports are developed on a quarterly basis to assess network compliance with contract standards. These reports are delivered each quarter to DOM, as well as to the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis.
1.7 Providers are available who can serve Members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy ADM9a, Cultural Competency, states that UHC promotes the delivery of services in a culturally competent manner to all members, including those who have special needs, those who have limited reading proficiency, and those with cultural and ethnic backgrounds. The Provider Portal of the UHC Community Plan

STANDARD 2015	SCORE					COMMENTS
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						website contains a cultural competency library to educate providers. The MS Provider Agreement states the provider shall participate in efforts to promote the delivery of services in a culturally competent manner to all covered persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds. It also states providers shall provide interpreter services in a covered person's primary language and for the hearing impaired for all appointments and emergency services.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy PS2, Access Standards – Appointment Availability Requirements, defines the appointment availability requirements for providers contracted by UHC to provide services to members. The standards meet contract requirements are referenced in the Provider Administrative Guide, and reinforced through provider education.
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			Results of the telephonic Provider Access and Availability Study conducted by CCME continued to be low in the areas of calls being answered successfully by personnel at the correct practice (49%). When compared to last year's results of 54%, this year's study proportion did fall from the previous measure, but statistically it was unchanged. So in both actual terms and statistically, no improvement was seen. For those not answered successfully, 19% of the time the physician was not at the practice or phone number listed. UHC identified barriers for not meeting some of the HEDIS measures goals. Barriers identified were associated with members not being able to schedule

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appointments. In addition, UHC identified member access issues in the 2014 CAPHS survey and conducted an after-hours survey that showed only 46.01 percent of the surveyed providers met the after-hours standards. *Corrective Action: Implement interventions to address the member access issues.*
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy PS11, Provider Orientation Plan, states that a Provider Advocate places a welcome call to each new provider within the first 30 days of a new contract effective date to welcome them to the network, answer any immediate questions, and schedule an onsite orientation meeting at the provider's earliest convenience. The Standard Operating Procedure (SOP) PS11, Provider Orientation Plan Summary & Checklist, provides an Onsite Provider Orientation Checklist. Orientation activity is recorded in the online Advocate Resource Tool.
2. Initial provider education includes:						The *DOM Contract, Section 7 (H)*, specifies minimum criteria that a Provider Manual must include. Issues were identified in the Provider Administrative Guide and they are explained in the following standards.
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;		X				Discrepancies exist between the benefits listed in the Provider Administrative Guide (PAG) and the Member Handbook (MH). Some examples include: •For eye care, the MH states prior authorization for children after the first pair per calendar year and the PAG states after the second pair per year. Also, the

STANDARD 2015	SCORE					COMMENTS
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						MH mentions two eye exams per year for children and one eye exam per year for adults, and this is not mentioned in the PAG. • The MH states home health services for adults are limited to 25 visits per calendar year and the PAG states per fiscal year (July 1 – June 30). •The MH has prior authorization limits for hearing services that not mentioned in the PAG. •The PAG lists limitations for coverages such as medical supplies and outpatient PT/OT/ST that are not mentioned in the MH. *Corrective Action: Update the Provider Administrative Guide and the Member Handbook to correct the member benefit discrepancies.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;		X				Page 10 states EPSDT is limited to beneficiaries under 21 years of age but there is no detailed information. Page 63 states a responsibility of the PCP is to provide all EPSDT services to members up to 21 years, but the EPSDT screening requirements and services could not be found in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include the recommended standards of care including EPSDT screening requirements and services.*
2.7 Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services;			X			This requirement could not be found as being addressed in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include the provider responsibility to follow-up with members who are non-compliant with EPSDT*

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						screenings and services.
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and Member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;		X				Pharmacy services, prescription limitations/prior authorization, and the preferred drug list are addressed; however, the emergency supply of medication until authorization is complete could not be found as being addressed in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include the information regarding emergency supply of medication until authorization is complete.*
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a Member to another PCP;		X				The role of the PCP is stated; however, the reassignment of a member to another PCP could not be found in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include instructions for the reassignment of a member to another PCP.*
2.13 The process for communicating the provider's limitations on panel size to the CCO;			X			This requirement could not be found as being addressed in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include the process for communicating the provider's limitations on panel size to the CCO.*
2.14 Medical record documentation requirements;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.15 Information regarding available translation services and how to access those services;			X			This requirement could not be found as being addressed in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include information regarding available translation services and how to access those services*
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.			X			This requirement could not be found as being addressed in the Provider Administrative Guide. *Corrective Action: Update the Provider Administrative Guide to include a statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.*
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.		X				The *DOM Contract, Section 6 (E)* states the Provider Directory shall include identification of hours of operation including identification of providers with non-traditional hours; however, the Provider Directory received in the desk materials does not include provider office hours. The website Provider Directory has a field for office hours but it appears that many of the providers listed indicate "Not Available". *Corrective Action: Update the Provider Directory (paper and electronic) to include the providers' hours of operation as required by the DOM Contract, Section 6 (E).*
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, Member benefits, standards, policies, and procedures.	X					UHC offers ongoing education through the website, provider forums/town hall meetings, provider office visits, provider newsletters and bulletins, and the Provider Administrative Guide.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its Members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive guidelines for use by UnitedHealthcare Community Plan. Maintenance of guidelines is completed by the Medical Policy Development Team. These guidelines are approved locally by the Provider Advisory Committee (PAC). The preventive health guidelines were last updated on May 7, 2015.
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO Members to providers.	X					Preventive Health Guidelines are available on the provider portal and hard copies may be requested by contacting the Provider Services Center. When new guidelines are added or current guidelines are revised, UHC notifies providers of these changes in the Provider Newsletter. The Provider Administrative Guide states a PCP responsibility is to take steps to encourage all members to receive all necessary and recommended preventive health procedures. In addition, PCPs must make use of any member lists supplied by the health plan indicating which members appear to be due for preventive health procedures or testing.
3. The preventive health guidelines include, at a minimum, the following if relevant to Member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.6 Recommendations specific to Member high-risk groups.	X					
3.7 Behavioral Health	X					
4. The CCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, states that on an annual basis, UHC measures provider performance of at least two clinical guidelines. The clinical guideline selection addresses a portion of the population that reflects a high volume or high risk condition. Data analysis is performed annually on the selected clinical guideline outcomes using statistical analysis techniques. Opportunities for improvement are identified, including a barrier analysis, based on outcomes. Interventions are selected that are known to make a difference and to address specific root causes or barriers. Corrective action is implemented for opportunities for improvement identified during the final analysis.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its Members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					Nationally recognized, evidence-based clinical criteria and guidelines are integrated into UHC's clinical system. UHC adopts clinical practice guidelines as the clinical basis for the Disease Management Programs. Clinical guidelines are systematically developed, evidence-based statements that help providers make decisions about appropriate health care for specific clinical circumstances. The clinical guidelines are adopted from recognized sources.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO Members to providers.	X					When new guidelines are added or current guidelines are revised, UHC notifies providers of these changes in the Provider Newsletter and provides training for providers and their staff on how best to integrate practice guidelines into everyday physician practice. When a provider demonstrates a pattern of noncompliance with clinical practice guidelines, the medical director may contact the provider by phone or in person to review the guideline and identify any

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						barriers that can be resolved.
3. The CCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					In 2014 UHC conducted a study to measure performance against two clinical practice guidelines: Comprehensive Diabetic Care and Attention Deficit Disorder. Results of the study showed improvement over 2013 and interventions were put into place to address identified gaps.
II F. Continuity of Care						
1. The CCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy UCSMM.06.21, Out-of-Network Requests and Continuing Care, addresses network gaps, transition of care, and continuity of care. The 2015 Quality Improvement Program Description states that an annual quantitative and qualitative analysis is conducted to review the continuity and coordination of medical care provided to UHC members across settings and/or during transitions of care. The scope of activities includes managing and coordinating aspects of medically necessary care between inpatient and various outpatient settings and between primary physicians and specialists through care coordination and providing communications to bridge gaps between treating practitioners and providers.
II G. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the Member medical records maintained by primary care physicians.	X					Policy NQM-025, Ambulatory Medical Record Review Process, says it is the policy of UHC MS to require that member medical records be maintained in a manner that is current, detailed and organized, and permits effective and confidential patient care and quality review. Standards will be in accordance with state and federal regulations as well as any applicable accreditation standards. The National Quality Management Oversight Committee will annually review and approve documentation standards and the Medical Record Review Tool.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Medical record charting standards are listed in the Provider Manual.
2. Medical Record Audit						
2.1 The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					UHC completed a medical record audit in December 2014. A total of 90 records were reviewed and 30 providers were included in the sampling for the record review process. Several areas of noncompliance were identified with education provided and follow-up. Results of the medical record audit were presented to PAC in the February, 2015 meeting.
3. The CCO ensures that the Members' medical records or copies thereof are available within 14 calendar days from receipt of a request to change providers.	X					
II H. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.			X			UnitedHealthcare performed a provider satisfaction survey administered by the Center for the Study of Services (CSS), a survey vendor. As a part of this EQR, this survey was validated using the EQR Protocol 5, Validation and Implementation of Surveys *(version 2.0, September 2012)*. The survey did not meet the CMS protocol requirements. For the provider survey, the low number of responses and low response rate could bias results and not provide reliable information on the underlying population. The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report. *Corrective Action: Implement interventions to increase the response rate in the provider satisfaction survey and improve survey documentation.*

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining Member rights and responsibilities and procedures for informing Members of these rights and responsibilities.	X					Member rights and responsibilities are published in the member and provider handbooks and distributed to all new members and new practitioners. Annually, UHC publishes and distributes rights and responsibilities information via newsletters or manuals, or annually notifies members and providers of their availability on the UHC website. Members and providers are also notified that printed copies are available upon request.
2. Member rights include, but are not limited to, the right:		X				Issues with member rights are addressed in the individual standards below.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;						Not found in policy NQM-051 (or the corresponding Rider or Attachment A), the Member Handbook, or the Provider Administrative Guide.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Include the right to receive services that are not denied or reduced solely because of diagnosis, type of illness, or medical condition in policy NQM-051 (or its Rider or Attachment), the Member Handbook, and the Provider Administrative Guide.
2.6 To voice complaints/grievances about the CCO or about the medical care and/or services they receive;						
2.7 To appeal decisions adversely affecting coverage, benefits, services, or their relationship with the CCO;						
2.8 To formulate advance directives;						
2.9 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.10 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						Not found in policy NQM-051 (or the corresponding Rider or Attachment A), or the Provider Administrative Guide. The Member Handbook contains information regarding interpreter services, but there is no indication that interpreter services are free for members. *Corrective Action: Update policy NQM-051 (or its Rider or Attachment), the Member Handbook, and the Provider Administrative Guide to include the members right to oral interpretation services free of charge.*
2.11 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.12 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the Member.						
2.13 To be furnished with health care services in accordance with 42 CFR § 438.206 – 438.210.						
3. Member Responsibilities include the responsibility;		X				Issues with member responsibilities are addressed in the individual standards below.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the Member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff.						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						The Member Handbook, page 46, informs members of this responsibility; however, it is not addressed in policy NQM-051 (or the corresponding Rider and Attachment A) or the Provider Administrative Guide. *Corrective Action: Update policy NQM-051 (or the corresponding Rider or Attachment) and the Provider Administrative Guide to include the member's responsibility to inform the plan of changes in family size, address changes, or other health care coverage.*
III B. Member CCO Program Education						
1. Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:		X				Per policy MBR2a, Information Packets to Members, UHC provides each member, prior to the first day of the month in which their enrollment starts, an information packet indicating the member's first effective date of enrollment. The information is

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provided no later than 14 days after receipt of notice of the member's enrollment. The information packet contains an introduction letter, an ID card, a Provider Directory, and a Member Handbook. Issues related to member education are addressed in the individual standards below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include direct access for female Members to a women's health specialist in addition to a PCP;						Page 21 of the Member Handbook states members can get a second opinion from a network provider for any covered benefits. Page 27 of the Member Handbook states if the member cannot find a second network provider, the second opinion can be obtained from an out-of-network provider with prior authorization. This page also contains the information that there is no charge for a second opinion. *Recommendation: Revise the Member Handbook so that all information on second opinions is found in one location, rather than being separated by multiple pages.*
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary;						
1.2 Limits of coverage, maximum allowable benefits and claim submission procedures; including that no cost is passed on to the Member for out-of-network services;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *DOM Contract, Section 5 (F)*, states a minimum of a three-day supply of medication must be provided pending prior authorization. The Member Handbook; policy RX-036, Emergency Medication Supply / Temporary Coverage Override (TCO), Attachment II; and onsite discussion confirmed that UHC provides a three-day supply of medication while a prior authorization is pending.
1.8 Policies and procedures for notifying Members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The Member Handbook, page 27, informs that affected members will be notified within 15 days when a provider is no longer in the network. There is no information in the Member Handbook that informs members they will be notified of changes to benefits/services. Refer to the *DOM Contract, Section 4 (D) (8) (g)*. *Corrective Action: Revise the Member Handbook to inform members that they will be notified of changes to benefits and services. Include the timeframe and method of notification.*
1.9 A description of the Member's identification card and how to use the card;						
1.10 Primary care provider's role and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, the nurse advice line, and the Member portal;						
1.13 A description of the EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						The Member Handbook instructs members to use the "Find a Provider" function on the UHC website for the most current information or to call Member Services for assistance in finding an MD. Members may also request a Provider Directory to be mailed. Review of the Provider Directory confirms that alternate languages are included in the provider information. The website provider search functionality includes the ability to search by languages spoken.
1.17 Instructions on reporting suspected cases of Fraud and Abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management Team;						
1.19 Information on advance directives;						Page 48 of the Member Handbook defines the purpose of an advance directive and informs members they have the right to formulate an advance directive. *Recommendation: Include more information on advance directives, such as Member Services staff can provide more information about how to formulate an advance directive, etc.*
1.20 Additional information as required by the contract and by federal regulation.						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Requirements for member notification of changes in benefits and providers are detailed in policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, and in policy MBR8b, 15 Day Written Notices of Termed Provider.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					As stated in policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension, member materials are written in language that does not exceed the sixth grade level of reading comprehension. Policy MBR1a, DOM's Limited English Proficiency Policy, states all written information will be made available in prevalent non-English languages in the State of Mississippi.
4. The CCO maintains and informs Members of how to access a toll-free vehicle for 24-hour Member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					The Member Services department is available Monday through Friday, from 8 am to 5 pm and from 8 am to 5 pm the first Saturday and Sunday of each month. The NurseLine is available 24/7 for information, support, and education for any health-related questions or concerns. NurseLine also has behavioral health staff available for member questions and assistance. A toll-free phone number for Member Services is provided in the Member Handbook, along with information that TTY services are available.
5. Member complaints/grievances, denials, and appeals are reviewed to identify potential Member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential Members are consistent with the state and federal requirements applicable to Members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MBR9, Open Enrollment Period, details the differences between voluntary and mandatory members and their ability to disenroll completely or to switch plans within the initial and annual enrollment

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						periods. The Member Handbook contains a statement that members must contact DOM in writing or by phone to request disenrollment and that the effective date of disenrollment is the last day of the month in which the request is received.
III D. Preventive Health and Chronic Disease Management Education						
1. The CCO enables each Member to choose a PCP upon enrollment and provides assistance as needed.	X					Policy MBR3a, Assignment of Primary Care Provider (PCP), states all members are matched to a PCP, if not provided on the 834 file, and the assignment is based on age, sex, family history, and zip code, within 24 hours of receipt from the State. When a member decides to change his/her PCP, customer service staff will assist with the change, will make the initial appointment if requested, and will arrange to have the medical records transferred to the new PCP.
2. The CCO informs Members about the preventive health and chronic disease management services that are available to them and encourages Members to utilize these benefits.	X					The Member Handbook contains a schedule for well child checkups and vaccination information; a statement that UHC recommends following the recommendations of the care guidelines from the US Preventive Services Task Force; charts of recommended preventive health services by age for men, women, and children; and states UHC has programs and tools such as classes on smoking cessation, pregnancy care and parenting, nutrition classes, and well-care reminders. Links to health information are found on the UHC website.
3. The CCO identifies pregnant Members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant Members in their recommended care, including participation in the WIC program.	X					Pregnant members are identified using various methods including claims data, health risk assessments, member outreach, etc. UHC's Healthy First Steps program is free and provides personal care managers who will help pregnant members find an MD, set up transportation

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for appointments, provide information on pregnancy and baby care, and offer post-partum support. High-risk pregnancies are also managed through the Healthy First Steps program.
4. The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages Members to utilize these benefits.	X					UHC uses a universal tracking database to monitor and track EPSDT utilization. The database generates notifications when services are missed, and members receive reminders by phone. Members are informed of EPSDT services via information in the new member welcome packet and the Member Handbook.
5. The CCO provides educational opportunities to Members regarding health risk factors and wellness promotion.	X					
III E. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of Member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.			X			Results of the validation found the member satisfaction survey did not meet the CMS protocol requirements. The response rate for the survey fell below the response rate targets. The survey met the minimum number of responses considered by NCQA to be necessary for a valid survey (411 responses), but fell below the response rate targets set by AHRQ and NCQA (50 and 45 percent respectively). Response bias may be a large issue with that survey. *Corrective Action: Focus on strategies that would help increase response rates for the Medicaid Child population. Consider soliciting the help of the survey vendor.*
2. The CCO analyzes data obtained from the Member satisfaction survey to identify quality problems.	X					
3. The CCO reports the results of the Member satisfaction survey to providers.			X			Inadequate evidence that UHC reports the results of the member satisfaction survey to providers. Information provided was not Mississippi specific and did not offer actual results.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Develop and implement a process to ensure that providers are notified of the results of the member satisfaction survey.
4. The CCO reports to the appropriate committee on the results of the Member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results of the member satisfaction survey were reported to the QMC on 9/29/14.
III F. Complaints/Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to Member complaints/grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy AG-01, Complaint, Grievance, and Appeal Procedures, defines UHC's policies and processes related to filing and handling complaints and grievances. Any issues identified are addressed in the individual standards below.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;	X					Appropriate definitions of the terms "complaint" and "grievance" were noted in policy AG-01, Complaint, Grievance, and Appeal Procedures; the Member Handbook; and the Provider Administrative Guide. The Provider Administrative Guide, page 43, states, "A member or his/her authorized representative as designated in writing or a provider, may file a grievance…" This does not clearly indicate that a provider must also have the member's written consent to file a grievance on the member's behalf. *Recommendation: Update the Provider Administrative Guide, page 43, to clearly indicate that providers need the member's written consent to file a grievance on the member's behalf.*
1.2 The procedure for filing and handling a complaint/grievance;	X					Policy AG-01, Complaint, Grievance, and Appeal Procedures, states UHC provides language assistance for appeal and grievance processes, and states UHC provides assistance with the written appeal process, but does not state UHC provides assistance (other than language assistance) for the grievance process.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Member Handbook informs that grievances will be acknowledged, but does not provide the timeframe. *Recommendation: Revise policy AG-01 to indicate that assistance is provided with filing grievances. Update the Member Handbook to include the timeframe for grievance acknowledgement.*
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;		X				Policy AG-01, Complaint, Grievance, and Appeal Procedures, states standard grievances are resolved within 30 calendar days of receipt, and expedited grievances are resolved within state specified timeframes not to exceed 72 hours from receipt. Onsite discussion confirmed these timeframes are correct. Issues with the timeframes for grievance resolution include: •There is no state-specified timeframe for resolution of expedited grievances; therefore, the reference to the state-specified timeframe should be removed. •Policy AG-01 does not address the processes followed for expedited grievances, including extensions of the resolution expedited grievance resolution timeframe; and requirements for notification of members that the grievance will be processed under a standard timeframe due to failure to meet expedited grievance criteria. •Expedited grievances are not addressed in the Member Handbook or the Provider Administrative Guide. Issues related to extensions of grievance resolution timeframes were noted in additional documents, as follows: •The Member Handbook does not address extensions of grievance resolution timeframes. •The Provider Administrative Guide states UHC may extend timeframes by up to 14 calendar days "in accordance with 42 C.F.R. § 438.408(c)". Rather than referring to a federal regulation, this should specify the

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						language from the contract that the timeframe can be extended by up to 14 calendar days if the member requests the extension or if UHC determines there is a need for additional information and the extension is in the member's best interest. Also, information that if UHC requests the extension, the member will be notified within two business days of the reason for the extension should be included. •The grievance acknowledgement letter does not address extensions of grievance resolution timeframes. The grievance resolution letter template contains the following statements which are not applicable to grievances: •"You have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your APPEAL, GRIEVANCE, or COMPLAINT, as well as copies of any internal rule, guideline or protocol that we relied on to make this payment decision." •"You also have the right to receive, upon request and free of charge, an explanation of the scientific or clinical judgment that we relied on in making this benefit decision as well as the diagnosis or treatment codes, and their corresponding meaning." •"Please understand that your request for information will not change the time you have to file any subsequent appeals." *Corrective Action:* *•Remove the reference to the state-specified timeframe for expedited grievance resolution from policy AG-01.* *•Update policy AG-01 to include all processes for handling expedited grievance requests, including requirements for extensions of resolution timeframes and for notification of members when the grievance does not meet expedited grievance criteria and will be processed under the standard grievance resolution*

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						timeframe, etc. *•Include information on expedited grievance resolution in the Member Handbook and the Provider Administrative Guide.* *•Update the Member Handbook to include information on extensions of grievance resolution timeframes.* *•Provide the information on extensions of grievance resolution timeframes in the Provider Administrative Guide rather than referencing a Federal Regulation.* *•Update the grievance acknowledgement letter to include information on extensions of grievance resolution timeframes.* *•Update the grievance resolution letter to remove language related to appeals.*
1.4 Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Policy AG-01, Complaint, Grievance, and Appeal Procedures, states grievances involving clinical issues will be reviewed by a health care professional.
1.5 Notification to the Member of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated;	X					
1.6 Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					Review of grievance files revealed the following issues: •Two files revealed members were not sent resolution letters. •One file contained evidence that not all issues identified in the grievance were investigated and included in the grievance resolution. Information received via email after the onsite visit confirmed that "the protocol was not followed in this case which lead to only partial resolution for the member". •An appeal acknowledgement letter was sent instead of a grievance acknowledgement letter for 1 of 12 files. The mistake was realized and a grievance acknowledgement letter was sent on day 18.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure that appropriate processes are followed for grievances, including written notification of resolution, investigation and notification of all issues related to each grievance, and timely acknowledgement of grievances.
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Review of SQIS, QMC, and HQUM minutes confirm that grievance data is reported and discussed. The QI Work Plan includes activities to analyze trends in complaints and appeals to identify opportunities for improvement.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The CCO investigates all Member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Onsite discussion confirmed that requests for PCP changes related to dissatisfaction are tracked and monitored. Information related to this process was not noted in any of the Plan's policies, however. *Recommendation: Include, in either an existing or a new policy, UHC's process for handling requests for PCP changes due to dissatisfaction.*
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to Members.		X				UnitedHealthcare has developed a Quality Improvement program designed to monitor, evaluate, and implement strategies to improve the quality, appropriateness, accessibility, and availability of the

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						care and services for its members. The 2015 Quality Improvement Program Description defines the program's goals, objectives, structure, and scope. The following issues were identified in the program description: •Page nine discusses the Quality Improvement Program Structure and Organizational Chart and provides a description of the organization's committees. A description for the Compliance Committee was not included nor was this committee included in the Organizational Chart. •A description for the National Integrated Behavioral Health Steering Committee was not included. •A description of the following committees was included in the QI program description but not included in the chart on page nine: National Peer Review Committee, National Provider Sanctions Committee, and the Regional Peer Review Committee. •Page 24 includes a section regarding Ambulatory Medical Record Review. This section states "UHC conducts Ambulatory Medical Record Review for its plans when required by state contract." This section should be Mississippi specific. *Corrective Action: Correct the deficiencies noted in the Quality Improvement Program Description.*
2. The scope of the QI program includes monitoring of services furnished to Members with special health care needs and health care disparities.	X					Included as part of the program activities listed on page eight of the program description. United also has several performance improvement projects to address health care disparities in members with asthma, diabetes, and obesity.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Annual primary care provider utilization and quality profiles are used to identify potential over-utilization or under-utilization.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annual work plans have been created and include all required elements. The work plans are developed annually and submitted to the Quality Management Committee for review and modifications as needed.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The 2015 Quality Improvement Program Description includes a description of the Board of Directors, National Committees, Regional Committees, and Health Plan Committees. The Quality Management Committee has been established and is ultimately responsible for all quality improvement activities. The Provider Advisory Committee is responsible for evaluating and monitoring quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the health plan's network.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership for the Quality Management Committee includes UnitedHealthcare senior level staff members and representatives from program areas. Network primary care and subspecialty physicians serve on the Provider Advisory Committee.
3. The QI Committee meets at regular intervals.	X					Both committees meet at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					The discussions and decisions made by both committees are well documented in committee minutes.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".		X				The non-HEDIS® measures did not meet the validation requirements. One measure was found to be *Substantially Compliant* and three of the measures were *Not Valid*. Issues with the way the numerators and denominators were calculated were of concern. *Corrective Action: Correct the coding issues with the numerators and denominators for all of the non-*

STANDARD 2015	SCORE					COMMENTS
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						HEDIS® performance measures and re-run the results.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the Member population or as directed by DOM.	X					Topics for the projects included asthma, monitoring patients on ACE/ARB inhibitors, diabetes, and obesity.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Three of the projects scored within the *High Confidence* range and one in the *Confidence* range. Some of the deficiencies identified with the projects included: •The study question for the ACE/ARB project focuses on members with CHF but the indicator is anyone on an ACE inhibitor or ARB. •Some interventions underway for one project actually pertained to other projects. •Improvements were not statistically significant. •Reported results were not always accurate. *Corrective Action: Correct the deficiencies identified in the performance improvement projects.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					United provides their network providers with a Quality Management Provider Profile that includes results of some of their performance measures.
IV F. Annual Evaluation of the Quality Improvement Program						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					An assessment of the overall effectiveness of the QI Program is conducted annually as evident by the 2013 – 2014 summary provided in the desk materials.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The 2015 UM Program Description and the 2015 Mississippi Addendum, along with policies and procedures, guide UM functions and processes. Page 12 of the MS Addendum details the mechanisms used to monitor for over and under-utilization.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The UM Program Description Mississippi Addendum, page seven, details the timeframes for standard and expedited authorization requests, and includes information on timeframe extensions. Policy UCSMM 06.16, Initial Review Timeframes, documents timeframes for standard and expedited authorization determinations. However, page two, item four, states if the physician or consumer fails to follow the procedure for requesting a review, they must be notified of the proper procedure within 24 hours for expedited and five calendar days for standard review requests. The five-day timeframe will cause UHC to be out of compliance with the three calendar day/two business day timeframe for a standard authorization determination required by the *DOM Contract, Section*

STANDARD 2015	SCORE					COMMENTS
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						5 (J) (4). Timeframes for utilization decisions for standard and expedited authorizations are not included in: •The Member Handbook •The Provider Administrative Guide *Corrective Action: Correct policy UCSMM 06.16 to reflect an appropriate timeframe for notification of the proper procedure when a physician or consumer fails to follow the procedure for requesting a review. The updated timeframe should allow for compliance with contractually required determination timeframes. Revise the Member Handbook and Provider Administrative Guide to include standard and expedited authorization timeframes.*
1.5 Consideration of new technology;	X					Policy UCSMM 06.15, Peer Clinical Review, confirms that cases that were not approved by initial screening or initial clinical review process (all cases in which medical necessity cannot be certified, or in which benefit determination is not explicitly excluded and cannot be approved based on information provided) are reviewed by a peer clinical reviewer.
1.6 The appeal process, including a mechanism for expedited appeal;		X				The MS Addendum to the UM Program Description, pages 15 through 19, seems to address provider appeals with only the occasional mention of members. This section should be revised to reflect that the appeals process is available to members, per requirements of the *DOM Contract, Exhibit D*, and *Federal Regulation § 438.400-410*. *Corrective Action: Revise the MS Addendum of the UM Program Description, pages 15-19, to clearly reflect appeals rights and processes for both members and providers.*

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 The absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 The absence of quotas establishing a number or percentage of claims to be denied.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions.	X					An evaluation of the overall effectiveness of the UM Program is conducted annually to determine how well resources have been deployed to improve UM activities and clinical care/service provided to members. The evaluation of the UM Program included both barriers and interventions. Minutes of the Provider Advisory Committee confirm review of clinical practice guidelines and criteria. There are seven external providers on this committee, and overall attendance is good.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files confirmed that UM determinations are made using appropriate criteria and that additional information was requested when necessary.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all Members across all reviewers.		X				Onsite discussion confirmed that clinical review staff participate in inter-rater reliability testing annually and that when there are changes in policies and/or procedures, staff participate in IRR more frequently. Onsite discussion revealed that the threshold for IRR

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						testing is 100 percent. A discrepancy was noted in policy UCSMM 06.10, Clinical Review Criteria, page nine, which states reviewers must exceed a score of 90 percent. Also, this policy does not clearly define the processes UHC follows for IRR testing and there is no information on processes used for scores below the established threshold. *Corrective Action: Update policy USCMM 06.10 to include the correct IRR threshold and clear documentation of UHC's IRR process, including follow-up activities for scores below the established threshold (re-education, re-testing, etc.)*
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.		X				Policy RX-012, Pharmacy Coverage Reviews, page one, states UHC provides a prescription drug list (PDL); however, the policy does not indicate that UHC must use the current version of the Medicaid Program PDL, as required by the *DOM Contract, Section 5 (F)*. *Corrective Action: Revise policy RX-012 to state that UHC uses the current version of Medicaid Program PDL.*
5.2 The CCO has established policies and procedures for the prior authorization of medications.		X				Policy RX-012, Pharmacy Coverage Reviews, does not include the timeframe requirement for pharmacy authorization reviews. Onsite discussion confirmed UHC adheres to the contractually required timeframe of 24 hours for pharmacy authorization determinations for both standard and expedited requests. *Corrective Action: Update policy RX-012 to include the timeframe requirement for standard and expedited pharmacy authorization requests.*

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					During onsite discussion, UHC staff informed CCME that policies COV 2a and COV 3a, which addressed this standard in the previous review, had been retired. Subsequent to the onsite visit, CCME was informed that these policies had not been retired and were submitted for review.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Policy USCMM.06.14, Initial Clinical Review, details the qualifications of those performing initial clinical reviews. Policy UCSMM.06.15, Peer Clinical Review, states peer reviewers are qualified health professionals with current license to practice medicine or current license in the same category as the ordering provider.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					The approval files reviewed were found to be timely, using appropriate criteria, and decisions were communicated as required. All the files submitted for review were complete and well organized.
10. Denials						
10.1 A reasonable effort that is not burdensome on the Member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Denial files reviewed contained documentation of requests for additional information when appropriate.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files reviewed confirmed appropriate physician reviewers issued the determinations.
10.3 Denial decisions are promptly communicated to the provider and Member and include the basis for the denial of service and the procedure for appeal.		X				Denial files reviewed confirmed determinations are communicated within required timeframes, and include the basis for denial as well as the criteria used for review. However, review of policies pertaining to notice of action requirements contained the following issues: •Policy UCSMM 06.18, Initial Adverse Determination Notices, page two, item seven (i), states that if an urgent request results in an adverse determination and

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the review is either concurrent or retroactive, and the member is not at financial risk, only the provider must be notified of the determination. This is incorrect—members are to be notified of <u>any</u> decision to deny, suspend, terminate, or reduce services. Refer to the *DOM Contract, Section 5 (J) (4)* and *Federal Regulation § 438.210 (b) (3) (c)*. •Policy AG-01, page eight, states the notice of action <u>shall be mailed within 14 days of the date of the action</u> for newly requested services. Notices are to be mailed within the timeframe for resolution of an authorization request. See the *DOM Contract, Section 5 (J) (4),* which states, "The Contractor must make standard authorization decisions <u>and provide notice</u> within three (3) calendar days and/or two (2) business days." •The Provider Administrative Guide, page 42, states for standard service authorization decisions that deny services, the notice of action will be sent no later than 14 calendar days of receipt of the request. *Corrective Action: Correct policy UCSMM 06.18, page two, item seven (i), to state that members are notified of <u>all</u> decisions to deny, suspend, terminate, or reduce services. Ensure that UHC follows the correct process for adverse determinations of concurrent or retroactive reviews, even if the member is not at financial risk. Correct the timeframe for notification of adverse determinations in policy AG-01, page eight, and in the Provider Administrative Guide, page 42.*
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to Member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					Policy AG-01, Complaint, Grievance and Appeal Procedures, defines UHC's process for handling and responding to appeals. Issues identified are addressed in the individual standards below.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Policy AG-01, Complaint, Grievance and Appeal Procedures; policy AG-02, Expedited Review Process;

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Member Handbook; and the Provider Administrative Guide appropriately define an action and an appeal. Information on who may file an appeal is correct in in policy AG-01 and in the Member Handbook. The following documents do not include that someone acting on the member's behalf may also file an appeal: •The Provider Administrative Guide •Policy AG-02, Expedited Review Process *Corrective Action: Update the Provider Administrative Guide and policy AG-02 to indicate that in addition to the member and provider, a representative acting on the member's behalf may also file an appeal.*
1.2 The procedure for filing an appeal;		X				Per the *DOM Contract, Exhibit D, Section D*, appeals may be filed orally or in writing within 30 calendar days of the receipt of the notice of action, and follow-up with a written appeal request is needed only for standard appeals. Issues noted with the procedure for filing an appeal include: •The Member Handbook, page 53, states that an oral request for an appeal must be followed by a written request; however, it does not include this applies only to standard appeal requests. •The Provider Administrative Guide, page 42, incorrectly states the timeframe to file an appeal is within 30 calendar days from the date of the notice of action. The *DOM Contract, Exhibit D, Section D*, requires the Plan to provide the member or the member's representative the opportunity to present evidence of the facts or law, and the opportunity to examine the case file, including medical/clinical records and any other documents/records considered during the appeals

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process. This information is not documented in the following: •Policy AG-02, Expedited Review Process •The Provider Administrative Guide •The Member Handbook *Corrective Action: Update the Member Handbook to indicate that expedited appeal requests do not require a written appeal to follow. Update the Provider Administrative Guide, page 42, with information that the timeframe to file an appeal is within 30 calendar days from the date of receipt of the notice of action. Include information that members may present evidence or examine the case file/information used in the appeal process in policy AG-02, the Member Handbook, and the Provider Administrative Guide.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the Member would be jeopardized by delay;	X					Policy AG-02, Expedited Review Process, describes UHCs process for an expedited appeal.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Onsite discussion confirmed the standard appeal determination timeframe is within 30 calendar days of receipt of the appeal, as stated in policy AG-01, Complaint, Grievance and Appeal Procedures. However, page seven of the United Behavioral Health policy titled "Appeals of Adverse Actions" states standard (non-urgent) pre-service appeal resolutions are determined within 15 calendar days. Onsite discussion confirmed that the expedited appeal resolution timeframe is within 72 hours from request, as stated in policy AG-02, Expedited Review Process. Issues with resolution timeframes for expedited

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appeals include: •Policy MBR 13a, Plan Members are Informed about Complaint and Grievance Procedure, page five, states that the expedited appeal resolution timeframe is three working days. •Page seven of the "Appeals of Adverse Actions" policy for United Behavioral Health states the expedited appeal resolution timeframe is three working days. Policy USCMM 07.11, Appeal Review Timeframes, lists state and federal requirements in a table in the policy addendum, but does not state what timeframes UHC adheres to for standard and expedited appeal resolutions. Onsite discussion revealed that UHC does not use this policy. CCME recommended that if this policy is not used, it should refer the reader to the appropriate policy to obtain information on appeal resolution timeframe requirements. Alternatively, the policy should be retired. Regarding extensions of appeal resolution timeframes, policy AG-02, page six, states UHC sends a request for an extension letter to the member within three business days of determining the need for an extension. This will place UHC out of compliance with the expedited appeal resolution timeframe, which must be determined within 72 hours of the request. If an extension of an expedited appeal is requested by UHC, the member must be notified within 72 hours of the request. Regarding the denial of an expedited appeal: •The Member Handbook does not inform members that a request for an expedited appeal may be denied if expedited criteria are not met, and that if denied, UHC will transfer the appeal to the standard appeal timeframe, and notify the member verbally on the day of the decision to deny and in writing within two days.

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						Corrective Action: *•Correct the timeframe for standard and expedited appeal resolutions in the "Appeals of Adverse Actions" policy for United Behavioral Health, page seven.* *•Correct the timeframe for expedited appeal resolutions in policy MBR 13a.* *•If policy UCSMM 07.11 is not used by UHC, the policy should be updated to refer the reader to the appropriate policies to obtain timeframes for appeal resolutions, or the policy should be retired.* *•Update the timeframe for notifying members of requests for extensions of expedited appeal timeframes in policy AG-02.* *•Update the Member Handbook to include information that a request for an expedited appeal may be denied if expedited criteria are not met, and that if denied, UHC will transfer the appeal to the standard appeal timeframe, and notify the member verbally on the day of the decision to deny and in writing within two days.*
1.6 Written notice of the appeal resolution as required by the contract;			X			The *DOM Contract, Exhibit D, Section F*, states a member may request a State Fair Hearing within 30 days of the final decision by the contractor, and must exhaust all plan-levels of appeals prior to requesting a State Fair Hearing. Issues noted with information on filing a State Fair Hearing include: •The appeal upheld letter (UHC-041613), page one, states members must file a request for a State Fair Hearing within 30 days from the original notice of denial from UHC. This was an issue in the previous EQR and has not been corrected. •Policy MBR 13a, Plan Members are Informed about Complaint and Grievance Procedure, page five, states the filing timeframe for a State Fair Hearing is within 30 calendar days from receipt of UHC's notice of

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						action. • Policy MBR 13a, page five, also contains a statement that, "a member who chooses to seek a State Fair Hearing without pursuing the UnitedHealthcare's process must do so within 30 calendar days of receipt of the UnitedHealthcare's notice of Action." This is outdated information and no longer allowed per the *DOM Contract, Exhibit D, Section F*. *Corrective Action: Correct the timeframe to file a request for a State Fair Hearing in the appeal upheld letter (UHC-041613) and policy MBR 13a. Remove the outdated reference to requesting a State Fair Hearing before exhausting the plan-level appeal process from policy MBR 13a.*
1.7 Other requirements as specified in the contract.		X				Regarding requests for continuation of benefits, the following issues were noted: •Policy AG-01, Complaint, Grievance and Appeal Procedures, page 11, and the "Appeals of Adverse Actions" policy for United Behavioral Health, page 10 (item 7.1.1), state, "UnitedHealthcare shall continue the member's benefits if all of the following are met: (1) The member or the service provider files a timely appeal of an Action …" This should specify the timeframe to request benefits pending a plan-level appeal is within 10 days of the notice of action. •The MS CAN Reduction in Service letter, page four, states, "But you must appeal within 10 receiving the notice of contractor's action." (Incomplete) •The Provider Administrative Guide does not address continuation of benefits pending an appeal or State Fair Hearing. *Corrective Action: Revise policy AG-01, the United Behavioral Health policy titled "Appeals of Adverse Actions", and the MS CAN Reduction in Service letter to contain correct information regarding the timeframe to request continuation of benefits pending*

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						an appeal. Refer to the DOM Contract, Exhibit D, Section D. Revise the Provider Administrative Guide to include information on continuation of benefits pending an appeal or State Fair Hearing.
2. The CCO applies the appeal policies and procedures as formulated.	X					A review of the appeals files confirmed timely acknowledgements, appropriate MD reviewers, timely determinations, and timely notification of determinations. Appeal resolution letters contained clear documentation of the denial rationale.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. D Care Management						
1. The CCO assess the varying needs and different levels of care management needs of its Member population.	X					The UHC Community and State Person Centered Care Model (PCCM) document serves as the Case Management program description and defines the purpose, scope, and program components of UHC's Case Management program. Various policies address requirements specific to Mississippi.
2. The CCO uses varying sources to identify and evaluate Members' needs for care management.	X					The UHC PCCM document and policy NCM 001, Identification of High Risk Members for Case Management, address methods of identifying members with possible case management (CM) needs.
3. A health risk assessment is completed within 30 calendar days for Members newly assigned to the high or medium risk level.	X					Case management files reviewed demonstrated complete HRA and comprehensive assessments as well as timely care plan development.
4. The detailed health risk assessment includes:						Clinicians use tools to help validate diagnoses, additional risk factors, current and past medical history, behavioral health needs, personal health behaviors/lifestyle choices, family history, social

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						history, and environmental risk factors. An assessment of functional abilities is also completed and for those leaving the hospital, this assessment identifies gaps in care that, if filled, may prevent re-hospitalization.
4.1 Identification of the severity of the Member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					Case managers develop and implement a person-centered plan of care (POC) for high risk members. Member progress is reviewed and the POC is adjusted to ensure that the member continues to receive appropriate interventions. The POC may be modified at any time depending on the member's need.
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments.	X					Per policy NCM 002, High Risk CM Process, the case manager will complete the initial comprehensive assessment as soon as the member's condition requires but no later than 30 calendar days from identification as appropriate for high risk case management. The individualized POC is developed with the member, caregiver/family, and PCP. Review of CM files confirms adherence to this process.
6. The risk level assignment is periodically updated as the Member's health status or needs change.	X					Policy NCM 001, Identification of High Risk Members for Case Management, Section A, Item 2, states members identified as high risk are stratified into two groups, those receiving long term services and support (LTSS) and those not receiving LTSS. Members identified as high risk and are receiving LTSS (community or facility based) will be referred for Case Management as outlined in Policy NCM 015, Care Coordination for Members Receiving LTSS. Policy NCM 015 was requested during the onsite visit,

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						and UHC's written response was, "United Healthcare Community and State of MS does not have LTSS as a benefit for our MS membership." *Recommendation: Remove from policy NCM 001 the reference to policy NCM 015 and the statement found in Section A (2) regarding stratification of members receiving LTSS. Alternatively, develop an addendum to this policy that references Mississippi-specific information.*
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all Members through the following minimum functions:	X					Interdisciplinary case conferences and joint clinical rounds are conducted, internally and/or externally, to establish collaborative goals.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management Team Member and provided instructions on how to contract their assigned team;						
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the Member requests otherwise;						Comprehensive health care member information from the assessment and plan of care is shared with PCP and BH providers.
7.3 Appropriate referral and scheduling assistance for Members needing specialty health care services, including behavioral health and those identified through EPSDT;						
7.4 Documentation of referral services and medically indicated follow-up care in each Member's medical record;						
7.5 Monitoring and treatment of Members with ongoing medical conditions according to appropriate standards of medical practice;						A comprehensive list of accepted clinical practice guidelines are available to CM.
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						

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7.7 Coordination of discharge planning;						Transitional Case Management (TCM) focuses on members transitioning from an acute care hospital to home by providing members with the tools and supports to prevent re-admission. This is primarily short term CM.
7.8 Determination of the need for non-covered services and referral of Members to the appropriate service setting, utilizing assistance as needed from the Division;						The CM will provide members with alternative resources for continuing care.
7.9 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.10 Ensuring that when a provider is no longer available through the Plan, the Contractor allows Members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.11 Procedure for maintaining treatment plans and referral services when the Member changes PCPs;						Case managers are the link between the member and provider and can assist in medical records transfer. Case managers communicate existing care plans and seek new input into the plan of care.
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network, at no cost to the Member;						
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular Member, the Contractor must adequately and timely cover these services out of network for the Member, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						

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7.14 The Contractor must produce a treatment plan for Members determined to need a course of treatment or regular care monitoring. The Member and/or authorized family Member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with Members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides Members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					
9. The CCO provides Members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the Member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Disease specific interventions are provided for members in the high and moderate risk levels. These are well done and give clear guidance to case managers/disease managers.
V E. Evaluation of Over/ Underutilization						
1. The CCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					UHC has a policy in place to evaluate over- and under-utilization at least annually with results reported to the Provider Advisory Committee and the Healthcare Quality Utilization Management committee.
2. The CCO monitors and analyzes utilization data for under and over utilization.	X					UHC analyzes data on the following topics in regards to utilization: •Outpatient Visits per 1000 •ER visits per 1000 •Readmission rate •Average Inpatient length of stay

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V. F Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The UHC 2014 Utilization Management Program Evaluation dated July 29, 2015 details the 2014 objectives, program changes, quality improvement projects, interventions, and program-specific outcomes.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The UM Program Evaluation was submitted to the QM committee.
VI. DELEGATION						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					UHC has delegation contracts with Optum Behavioral Solutions/UBH, Dental Benefit Providers, MTM, Inc., CareCore National, Vision Service Providers (VSP), MHG and Physician Corporation, Hattiesburg Clinic, River Region, HubHealth, and University Physicians. The Medical Intersegment Base Template, the UBH Individual Participating Provider Agreement, and the UBH Facility Participating Provider Agreement were received and reviewed. The agreements specify the delegated activities and contain information on requirements for corrective action plans for substandard or non-performance, up to and including termination of the contract. The Mississippi addendum to credentialing policies for Optum Behavioral Health appropriately addresses credentialing requirements specific to Mississippi.
2. The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.			X			Delegation oversight documentation was reviewed, and revealed the following issues: •The Dental Program Monthly Report Card 2015 contains an incorrect timeframe for standard authorization turn-around times, and does not include the timeframe for expedited authorization turn-around times.

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						•The CareCore National Dashboard spreadsheet contains an incorrect timeframe for standard authorization turn-around times. •The Optum Behavioral Health 2015 CR Audit Report tab titled "Audit Tool" does not address all Mississippi-specific requirements. Items missing are: •Query of the System for Award Management (SAM); •Copy of CLIA certificate/waiver; and •Collection of the ownership disclosure form. UHC's corrective action response for the previous EQR included a form titled, "UnitedHealthcare Community Plan Mississippi Delegation Oversight Tool", which did address all Mississippi requirements for credentialing delegation. It was CCME's understanding that this tool would be implemented and used; however, it appears that UHC has not implemented use of the tool submitted in the corrective action plan. Failure to include all Mississippi-required elements for delegated credentialing was noted as an issue on the previous EQR. Because this has not been corrected, this standard is scored as Not Met. *Corrective Action:* *•Correct the timeframe for standard authorization turn-around times, and include the timeframe for expedited authorization turn-around times, on the Dental Program Monthly Report Card.* *•Correct the timeframe for standard authorization turn-around times on the CareCore National Dashboard spreadsheet.* *•Correct the Optum Behavioral Health 2015 CR Audit Report or implement another tool that clearly addresses all Mississippi-specific requirements for delegated credentialing. The tool should include query of the System for Award Management (SAM); a copy of CLIA certificate/waiver; and collection of the*

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						ownership disclosure form.
VII. STATE-MANDATED SERVICES						
1. The CCO tracks provider compliance with:						
1.1 Initial visits for newborns;	X					The 2014 Quality Improvement Program Description states annual PCP utilization and quality profiles summarize utilization history on five utilization and nine quality indicators for PCPs, and include visits by age range for children. Additionally, initial visits for newborns are monitored via medical record documentation reviews.
1.2 EPSDT screenings and results;	X					UHC monitors for EPSDT service utilization via claims and encounter data, as well as medical record documentation reviews, and conducts outreach to members and practitioners as part of its EPSDT program. This outreach includes written education related to the components of EPSDT comprehensive screening exams and the periodicity schedule. Additionally, UHC reports to practitioners on assigned members in need of services.
1.3 Diagnosis and/or treatment for children.	X					
2. Core benefits provided by the CCO include all those specified by the contract.	X					UHC provides all services required by the *DOM Contract.*
3. The CCO addresses deficiencies identified in previous independent external quality reviews.			X			The following issues were noted in the previous EQR and have not been corrected: •The appeal upheld letter (UHC-041613), page one, states members must file a request for a State Fair Hearing <u>within 30 days from the original notice of denial</u> from UHC. •The Optum Behavioral Health 2015 CR Audit Report/Audit Tool does not address all Mississippi-specific requirements.

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						Corrective Action: Correct the deficiencies noted above. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.