2016 External Quality Review

UNITEDHEALTHCARE COMMUNITY PLAN MISSISSIPPI

Submitted: October 25, 2016

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. This review determines the level of performance demonstrated by *UnitedHealthcare Community Plan – Mississippi* (UHC). This report contains a description of the process and the results of the *2016 External Quality Review* (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The Goals of the review are to:

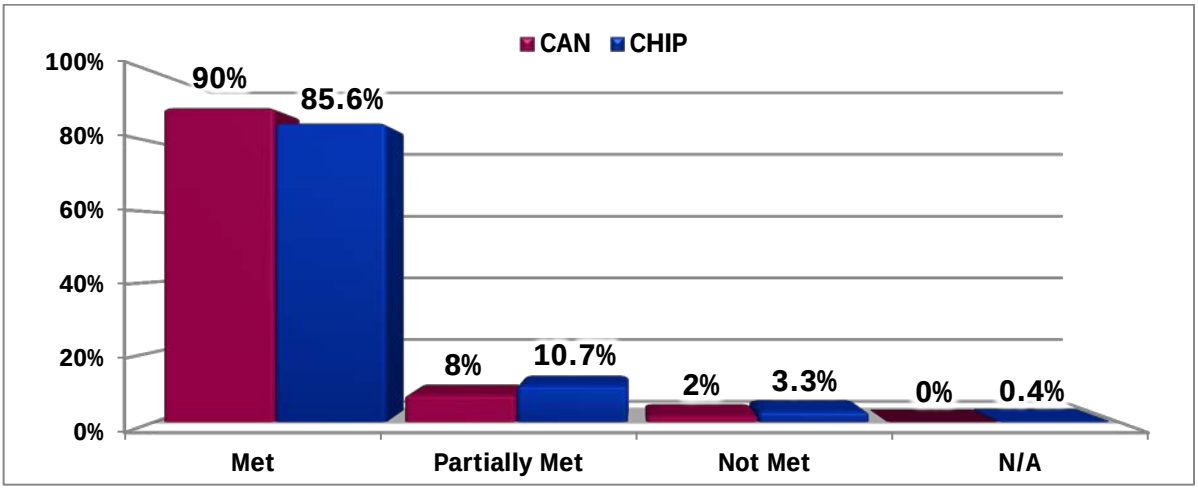
- Determine if UHC was in compliance with service delivery as mandated in the CCO contract with DOM.
- Provide feedback for potential areas of further improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

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 includes a desk review of documents, a three-day onsite visit, compliance review, validation of performance improvement projects, performance improvement measures, the member satisfaction survey and the provider satisfaction survey, an *Information System Capabilities Assessment (ISCA) Audit*, and a provider access study.

OVERVIEW

The 2016 annual EQR review of the CAN program shows that UHC has achieved a "Met" score in 90% of the standards reviewed. As the following chart indicates, 8% of the standards were scored as "Partially Met," and 2% of the standards scored as "Not Met." For the CHIP program 85.6% of the standards received a "Met" score, 10.7% of the standards were scored as "Partially Met," 3.3% of the standards scored as "Not Met," and the remaining 0.4% of the standards scored as "Not Applicable."

Figure 1: 2016 Annual EQR Review Results for CAN & CHIP



Overall Findings

An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable corrective action items and recommendations can be found further in the narrative of this report.

Administration:

The review found that UHC had sufficient staff to meet the needs of all their members in the CAN and in the CHIP programs. UHC has a comprehensive set of policies that consist of internal Mississippi specific policies, corporate policies, and other polices that have been adopted from Optum Health and other partners. The external policies did not always include the review or revision dates or which line of business they applied to. All other policies reflected the annual review and revisions. UHC has a *Compliance Plan and Fraud, Waste, and Abuse Plan* in place and employees receive appropriate training. The Compliance Committee attendance is an issue that can be remedied if the missing designated voting member sends a delegate in their place and this is recorded in the minutes as allowed by the committee charter. UHC completes nearly 100% of claims within 30 days. UHC has a Disaster Recovery and Business Continuity Plan and testing, which was last performed in March of 2016.

Provider Services

The *UnitedHealthcare Credentialing Plan 2015 – 2016* addresses the credentialing and recredentialing processes and guidelines for licensed independent practitioners and facilities. Specific credentialing criteria for Mississippi are detailed in a rider. The *Optum Physical Health Credentialing Risk Management Program 2016* and several policies address the credentialing and recredentialing process for the behavioral health network. The National Credentialing Committee (NCC) is the decision-making committee for the UHC credentialing process. UHC's Medical Director, is a member of NCC, however, his attendance is infrequent. There are no other UHC network providers represented on this committee. As mentioned in the previous EQR, the process UHC follows for credentialing and recredentialing of UHC providers is of concern.

The provider access study conducted by CCME showed no improvement in the access CAN members have to their PCP. The same study was conducted for the CHIP population which also showed a potential problem with access for those members as well.

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 all of the CMS protocol requirements.

Member Services

The *Member Handbooks* for the CAN and CHIP lines of business were written in plain and simple language for the ease of understanding. Both handbooks lacked complete information regarding advance directives as well as how and under what circumstances a member could request disenrollment for "cause." The UHC websites and member handbooks include very good information on health screenings, preventive health care and EPSDT/Well-Baby and Well-Child services. The website did not provide easy access for members to report fraud and abuse. UHC's call center performance measures consistently exceed specific goals as required by the contract. During the onsite visit, UHC provided a sample of recorded phone calls made to the call center. During these calls employees used scripts when appropriate, were respectful and courteous, and demonstrated a desire to meet the caller's needs. Grievances were handled within policy guidelines and resolved in a timely fashion following a thorough investigation. Response rates for the member satisfaction surveys were low. The low response rate is a common issue, for which UHC has taken several strategies to improve.

Quality Improvement

The only Quality Improvement (QI) concerns found during the review included the tracking of diagnoses identified during EPSDT screenings, the Well-Baby and Well-Child assessments, and the treatments or referrals provided as a result of the assessments. The performance measures were valid and scored within the fully compliant or compliant range. There were some minor documentation errors found in the performance improvement projects; however, all projects scored within the high confidence or confidence range.

Utilization Management

UHC incorporates all Utilization Management (UM) functions for the CAN and CHIP programs into an integrated UM Program, guided by the *UM Program Description and Mississippi Addenda* for CAN and CHIP, along with policies and procedures. Program documentation and UM files confirm appropriate processes are followed to meet the UM requirements.

Separate policies have been developed to address the differing appeals requirements and processes for the CAN and CHIP programs. Several errors and inconsistencies in information were noted in the appeals policies and other documents for both programs; however, no issues were identified in the CAN appeals files. Issues noted in the CHIP appeal files included failure to acknowledge receipt of appeals and resolution letters, which lacked references to the benefit or criteria used.

A concerning finding is that the UHC Community and State Person Centered Care Model program description and care management policies address only high-risk case management and do not address Mississippi-specific requirements for care management for the CAN and CHIP populations.

Delegation

Some of the delegated activities included prior authorizations for radiology, prescription drugs, and credentialing. Appropriate processes are in place for delegation initiation and oversight.

Table 1, Scoring Overview provides an overview of the scores for each review section for the CAN and the CHIP programs.

Table 1: Scoring Overview

2016	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
CAN	28	0	0	0	0	28
CHIP	28	0	0	0	0	28
Provider Services						
CAN	74	6	3	0	0	83
CHIP	64	10	6	0	1	81
Member Services						
CAN	30	3	0	0	0	33
CHIP	27	5	0	0	0	32
Quality Improvement						
CAN	17	1	1	0	0	19
CHIP	18	0	1	0	0	19
Utilization						
CAN	45	8	0	0	0	53
CHIP	45	8	0	0	0	53
Delegation						
CAN	2	0	0	0	0	2
CHIP	2	0	0	0	0	0

METHODOLOGY

On June 6, 2016, CCME sent notification to UHC that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN and CHIP programs.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for purposes of offering UHC an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials requested by CCME.

The review consisted of two segments. The first was a desk review of materials and documents received from UHC on July 8, 2016 for review at the CCME offices (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, case management, and appeal files.

The second segment was a three-day, onsite review conducted on September 12, 13 and 14, 2016, at UHC's office in Ridgeland, Mississippi. CCME's onsite visit focused on areas not covered by the desk review and for areas needing clarification (see Attachment 2). CCME's onsite activities included:

- Entrance and exit conferences (open to all interested parties)
- Interviews with UHC's administration and staff

The process used for the EQR was based on the CMS protocols for EQR of MCOs. This review focused on the three federally mandated EQR activities: compliance determination, validation of performance measures, and validation of performance improvement projects. The review also examined optional activity of member and provider satisfaction survey validations, an ISCA Audit and a provider access study.

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in 42 CFR § 438.358 and the contract requirements between UHC and DOM. Strengths, weaknesses, any corrective action items needed, and recommendations 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," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4). Separate tabular spreadsheets are included in Attachment 4 for the "CAN" and the "CHIP" program.

A. Administration

The review of the Administration section for MississippiCAN and MississippiCHIP lines of business focused on policies, procedures, staffing, information systems, compliance and confidentiality. Jocelyn Chisolm Carter serves as Chief Executive Officer (CEO) of UnitedHealthcare (UHC) Community Plan CAN and Community Plan CHIP of Mississippi. Dr. David Williams, the Chief Medical Director, is board certified in Internal Medicine and has the support of an Associate Medical Director and several other physicians such as Pediatricians and Behavioral Health Clinicians.

UHC incorporates local policies, United Behavioral Health policies, Optum policies, and national policies. Some policies include Mississippi addenda with state specific

information. Most policies included the last date of review or revision and the applicable business line; however, some policies adopted from external sources, such as Optum, failed to include this information.

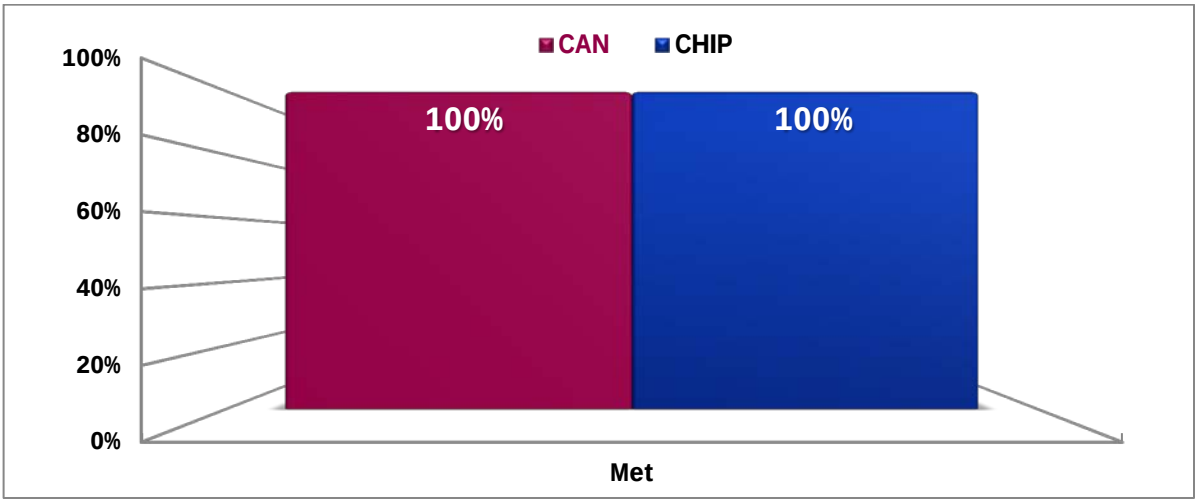
UHC has a comprehensive Compliance Plan and a Fraud, Waste, and Abuse Program in place that meets contract requirements. A Fraud and Abuse hotline number is provided to members; however, the numbers in both the *CHIP and CAN Provider Administrative Guides* do not appear to be hotline numbers or allow for anonymous reporting.

The Compliance Committee has developed a committee charter that defines designated members with voting privileges, attendance expectations, and a quorum for the committee. The charter allows a designated member to appoint a delegate to take their place if they cannot attend the meeting. The minutes showed poor attendance by two designated members, one attending only one meeting in nine months and another only two. It was not documented in the minutes if either member sent a delegate in their place. Terrence Christopher is the Compliance Officer, chairs the Compliance Committee, and reports directly to the CEO.

UnitedHealthcare has a Disaster Recovery Plan and Business Continuity Plan in place for the systems that service the CAN and CHIP programs. Table top testing disaster recovery exercises were last performed in March of 2016. Disaster recovery test results state that recovery exercises were completed successfully and without issue, but there was not much documentation provided to validate these claims. CCME requested additional information from UHC; however, the request was declined. UHC stated the results of the testing are considered proprietary and confidential. It is recommended that in the future, UHC develop a way to provide adequate information for evaluating the results of disaster recovery testing. UHC processes nearly 100% of provider claims within 30 days.

UHC received "Met" scores for 100% of the standards in Administration for both CHIP and CAN lines of business.

Figure 2: Administration Findings



Strengths

- UHC provides ongoing training for staff to ensure they are kept up to date when changes are made to the *CAN and CHIP Contract* or services.
- 100% or nearly 100% completed claims processing occurs within 30 days.
- UHC has a sufficient number of pediatricians available to address concerns specific to the CHIP population.
- Policies are in place for both CAN and CHIP that guide the release of member records only to those authorized and with properly executed consents.

Weaknesses

- It is noted that some external policies adopted by UHC CAN and CHIP do not include the most recent review or revision dates or the line of business as required.
- The UHC Plan of Mississippi organization chart and UHC Mississippi Medical Directors organization chart (CAN and CHIP) contain discrepancies with some names appearing on 1 chart, but not the other.
- Disaster recovery test results state that recovery exercises were completed successfully and without issue, but there was not much documentation provided to validate these claims.
- The 2015 Fall Member Newsletter and the *CAN and CHIP Provider Administrative Guides*, include phone numbers for providers that do not provide anonymous reporting of fraud and abuse.
- Attendance at Compliance Committee meetings from July 2015 through March 2016 revealed that 1 member attended only 2 meetings and another member attended just

1. The committee charter allows for a delegate to be sent in place of a designated member; however, the minutes did not include if an attendee was a delegate or not.

Recommendations

- Ensure the date of the last review or revision and the business line impacted (CAN or CHIP) is documented on all policies and procedures.
- Reconcile the organization charts with an accurate representation of medical directors making decisions for the Mississippi plan.
- It is recommended that UHC develop a way to provide adequate information for evaluating the results of disaster recovery testing.
- Ensure the fraud, waste, and abuse hotline phone number in the *CAN and CHIP Provider Administrative Guides* is accurate and allows for anonymous reporting if desired.
- Note in the Compliance Committee meeting minutes if an attendee is replacing a designated member for that meeting and follow the process outlined in the charter for replacing inactive members when possible.

B. Provider Services

A review of UnitedHealthcare's (UHC) 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 Advisory Committee (PAC) is chaired by Dr. David Williams and voting members of the committee include ten network providers with various specialties of pediatrics, psychiatry, dentistry, OB/GYN, internal medicine, family medicine and emergency medicine. Additional staff attends the meetings as non-voting guests. The committee chair votes in case of a tie and a review of committee minutes show that a quorum of at least 51% of the voting committee members is established at the beginning of each meeting. A report of the providers credentialed by the National Credentialing Committee (NCC) is presented at each quarterly PAC meeting. Detailed reports by month are also provided. However, the PAC only reviews reconsiderations and is not involved in the initial credentialing or recredentialing decisions.

The NCC performs credentialing/recredentialing for all lines of business and is the decision-making committee for the Mississippi (MS) credentialing process. The NCC is chaired by two physicians that do not have voting privileges. The voting members include 15 licensed independent practitioners (LIPs) located in various states with specialties such as pediatrics, obstetrics and gynecology, internal medicine, cardiology, surgery, podiatry, and family practice. Additional non-voting members include the Market Medical Directors that attend meetings periodically. Concerns regarding the NCC include: not all voting members of the committee are invited to the meetings; the quorum guidelines

defined in the credentialing plan are not being followed and as a result, four of the 14 NCC meetings reviewed did not meet quorum; committee meeting minutes do not mention the absent voting members of the committee; meeting minutes showed that the MS Medical Director only attended three out of 14 meetings; and while the NCC provides the credentialing decision-making for the committee, there is no representation of MS LIPs on the committee.

As mentioned in the previous 2015 EQR, the process UHC follows for credentialing and recredentialing of MS providers is of concern. Credentialing and recredentialing decisions are not made by MS providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *CAN Contract, Section 1 L*. This requirement is also listed in the *CHIP Contract, Section 1 L*.

The credentialing and recredentialing file review showed the files were organized and for the most part contained appropriate information. Common issues were identified in one or more files for CAN and CHIP regarding the following areas: Drug Enforcement Administration (DEA) license for nurse practitioner was not addressed; proof of malpractice insurance did not reflect the name of the provider; a provider office site visit was not conducted; there was no proof of a Clinical Laboratory Improvement Amendments (CLIA) certificate; and board certification was not verified.

UHC confirmed they were not collecting CLIA waivers and have changed their process to collect the information. For organizational providers a few files did not include proof of documentation of CLIA, System for Award Management (SAM) or the National Plan and Provider Enumeration System (NPPES) and one file did not include an ownership disclosure form.

Provider Access and Availability Study

As part of the annual EQR process for UHC, a provider access study was performed by CCME for CAN and CHIP focusing on primary care providers. Results of each provider access study are presented in the following table.

Table 2: Provider Access Study Results

CAN	CHIP
A list of current CAN providers was given to CCME by UHC, from which a sample of 177 primary care providers was randomly selected 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.	A list of current CHIP providers was given to CCME by UHC, from which a sample of 189 primary care providers was randomly selected 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.

CAN	CHIP
Calls were successfully answered by personnel at the correct practice for 71 out of 177 calls (40%), which equates to between 33% and 48% for the entire population, based on a 95% confidence interval. When compared to last years' results of 49%, this year's study proportion fell from the previous measure, though it was not a statistically significant drop , Z= 1.94, p= 0.05. For those not answered successfully (106 out of 177), the most common reason was because the provider was not at the listed number or is no longer at the practice (n=39, 37%). The next most common reason was because the number in the file was wrong (n=21, 20%).	Calls were successfully answered by personnel at the correct practice for 77 out of 189 calls (40.7%), which equates to between 34 and 48% for the entire population, based on a 95% confidence interval. For those not answered successfully (112 out of 189), the most common reason was because the provider was not at the listed number or is no longer at the practice (n=49, 44%); the next most common reason was because the number in the file was wrong (n=24, 21%).
Of the 71 calls that were answered successfully, 60 providers (85%) indicated they are accepting new Medicaid patients and 63 providers (89%) indicated that they accept UHC. Of the 60 providers that are accepting new Medicaid patients, 16 (27%) indicated than an application or prescreen was necessary. Nine of those 16 (56%) with a prescreening process required an application before accepting the patient. When the office was asked about the next available routine appointment, 45 out of 60 providers (75%) were within contract requirements.	Of the 77 calls that were answered successfully, 60 providers (78%) indicated they are accepting new Medicaid patients and 67 providers (87%) indicated that they accept UHC. Of the 60 providers that are accepting new Medicaid patients, 12 (20%) indicated than an application or prescreen was necessary. Eight of those 12 (67%) with a prescreening process required an application before accepting the patient. When the office was asked about the next available routine appointment, 47 out of 60 providers (78%) were within contract requirements.

Provider Satisfaction Survey Validation

UHC 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 sections of the validation worksheet relating to the provider satisfaction survey that were considered "Not Met," the reason for the finding, and recommendations for improvement are indicated in the table below.

Table 3: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Review whether there is a clear written statement of the survey's purpose(s).	Desk materials did not contain report offering a statement of survey's purpose.	Provide program evaluation or other document with clearly stated study objectives.
Review that the study objectives are clear,	Desk materials did not contain a report on study objectives. Study objective is not clearly	Provide program evaluation or other document with clearly

Section	Reason	Recommendation
measurable, and in writing.	defined in the *Provider Satisfaction Survey Results* document.	stated study objectives.
Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	No information on reliability was offered in the desk materials.	Provide documentation of reliability measures.
Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	No information regarding validity was offered by the desk materials.	Provide documentation of validity measures.
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 included in the documentation.	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.
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 response rate was 6.8%. Sources were not documented for the non-response and bias as well as the implications of response rate for the generalizability of survey findings.	Provide information regarding non-response and bias, as well as how small sample can impact the generalizability of the results.

The survey results were presented and discussed in meetings with a focus on areas of improvement. In an effort to increase the response rate, the following strategies are recommended:

- Create an incentive for those who complete the survey such as a lottery drawing for an electronic device.
- Offer information in the newsletter regarding how previous results were evaluated and used to effect change in programs and/or services.
- Provide information in the newsletter that compares practices, specialties, or professions to motivate a higher response.

The complete worksheet is available as an attachment to this report.

As noted in the charts below, UHC received "Met" scores for 89% of the standards in Provider Services. For the CHIP program the percentage of "Met" scores in Provider Services was 80%.

Figure 3: Provider Services Findings

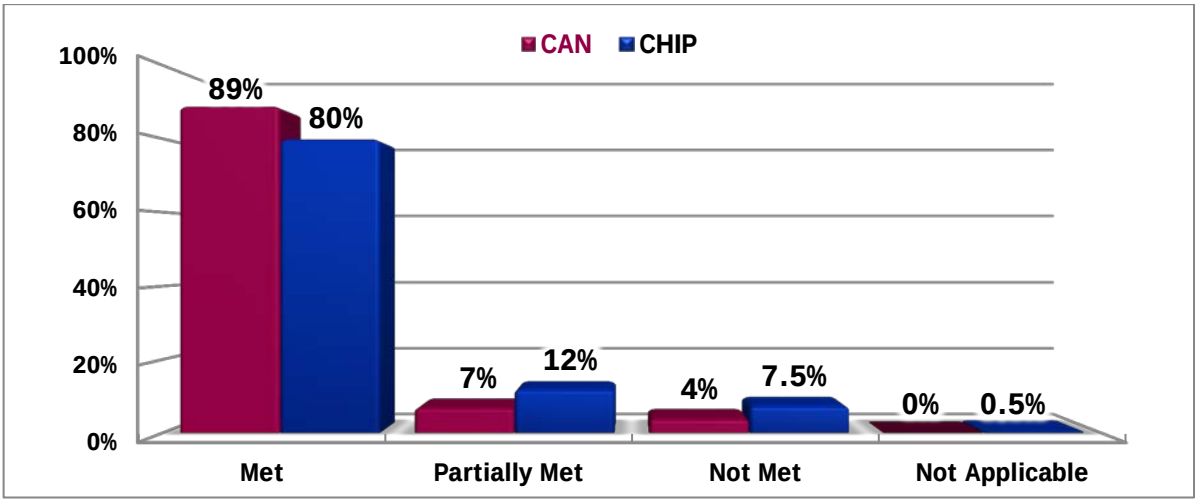


Table 4: Provider Services

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Partially 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	Not Met	Not 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	Partially Met	Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met
Adequacy of the Provider Network	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	Met	Partially Met

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Adequacy of the Provider Network	The *Telephonic Provider Access Study* conducted by CCME shows improvement from the previous study's results	Not Met	N/A
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Partially Met	N/A
	Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	N/A	Partially Met
	Recommended standards of care including Well-Baby and Well-Child screenings and services	N/A	Not Met
	A description of the role of a PCP and the reassignment of a Member to another PCP	Met	Partially Met
	The process for communicating the provider's limitations on panel size to the CCO	Met	Not Met
	Information regarding available translation services and how to access those services	Met	Partially Met
	A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Met	Not Met
	The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements	Partially Met	Partially Met
Primary and Secondary Preventive Health Guidelines	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	Met	Partially Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	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	Partially Met	Partially Met
Practitioner Medical Records	The CCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Met	Partially Met

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Practitioner Medical Records	The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Not Met
Provider Satisfaction Survey	A provider satisfaction survey was performed and met all requirements of the *CMS Survey Validation Protocol*	Not Met	Not Met

N/A = Standard is Not Applicable

Strengths

- In addition to GEO access reports for provider network evaluations, UHC utilizes quarterly compass reports which provide detailed provider and member access information to identify gaps in care.
- Provider advocates contact each new provider within 30 days of a new contract effective date to provide orientation; and the CAN and CHIP websites have provider portals that include information to help providers navigate the plan such as newsletters, bulletins, claims information, forms, clinical practice guidelines, etc.

Weaknesses

- The Optum Physical Health Credentialing Risk Management Program 2016, Attachment B, State Specific Requirements does not specify MS specific credentialing requirements.
- The Provider Advisory Committee (PAC) only reviews reconsiderations and is not involved in the initial credentialing or recredentialing decisions.
- The NCC performs credentialing/ recredentialing for all lines of business and is the decision-making committee for the MS credentialing process. The following concerns were noted:
  - Only 7 to 8 voting LIPs of the NCC are invited to each NCC meeting and a quorum is determined from a majority of LIPs that attend the particular meeting. This process is in direct conflict with the *UHC Credentialing Plan 2015-2016* for determining a quorum at the NCC meetings. The plan states that a quorum requires at least 51% of the LIP NCC membership to be present. A review of NCC minutes showed where decisions were made at the following meetings with only 6 voting LIPs in attendance: 1/6/16, 9/16/15, 9/21/15, and 8/15/15.
  - NCC committee meeting minutes do not notate the absent voting members of the committee. A few committee meetings mentioned 1 or 2 names, but since all committee members are not invited to each meeting, the information is inaccurate.

  - In the 14 NCC meeting minutes reviewed, Dr. David Williams was listed as only attending 3 meetings (1/6/16, 9/16/15, & 10/21/15).
  - The NCC is the credentialing decision-making committee and there is no representation of MS LIPs on the committee.
- As mentioned in the *2015 EQR*, the process UHC follows for credentialing and recredentialing of MS providers is of concern. Credentialing and recredentialing decisions are not made by MS providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *CAN Contract, Section 1 L*. This requirement is also listed in the *CHIP Contract, Section 1 L.*
- UHC should consider addressing the overall condition of the credentialing/ recredentialing files because many of the screen shots in the files were hard to read or unreadable; some of the queries did not contain dates of when the query was conducted; and in some cases the query date listed in the Aperture primary source verification section of the file did not match the date the query was performed, as indicated in the screen shot of the query.
- The following weaknesses relate to the CAN practitioner/provider credentialing and recredentialing file review:
  - 1 credentialing file, did not address whether the nurse practitioner had a DEA license.
  - For 1 credentialing file, the proof of malpractice insurance did not reflect the name of the provider as being insured.
  - 1 credentialing file did not have proof of the CLIA certificate or waiver.
  - 1 credentialing file showed that a provider office site visit had not been conducted.
  - 1 recredentialing file indicated “no” for CLIA but indicated “yes” for a CLIA waiver; however, there was no information in the file that the waiver was collected or verified. UHC stated they misinterpreted the CLIA requirements and only collected the CLIA if the provider indicated they had certification. Also, they were not verifying any other type of CLIA documentation. The “Partial Met” score is due to UHC not having a process in place to collect and verify CLIA waivers.
- The following weaknesses relate to the CHIP practitioner/provider credentialing and recredentialing file review:
  - 1 credentialing file did not have verification of board certification in the file.
  - 1 credentialing file showed that a provider office site visit had not been conducted.
  - 1 recredentialing file indicated a CLIA certification but it was not collected or verified.

- A few areas of concern were identified with the organizational provider file review for both CAN and CHIP, as follows:
  - For organizational providers, 2 hospital recredentialing files did not have proof of CLIA, SAM or NPPES queries, and 1 of the files did not have proof of malpractice insurance. UHC's response was that the facility credentialing process was not line specific. The overarching process verifies organization exclusion and eligibility for programs during processing, but the same standards for practitioner/provider are not applied specifically to the organization profiles.
  - 1 credentialing file for a Rural Health Center did not have an ownership disclosure form.
- UHC utilizes Dial America to make calls to provider offices to assess appointment availability and after-hours access. The quarterly reports of these assessments show high percentages of noncompliance for appointment availability and after-hours access.
- A review of the *CHIP Provider Administrative Guide*, page 62, shows incorrect information for the primary care appointment access standards as follows:
  - It states that urgent cases shall be seen within 48 hours of PCP notification when the *CHIP Contract, Section 7 B* (Table 5), states not to exceed 24 hours.
  - It states that routine cases shall be seen within 10 days of PCP notification when the *CHIP Contract* states not to exceed 7 calendar days.
  - It states that well-care visits shall be scheduled within 6 weeks of PCP notification when the *CHIP Contract* states not to exceed 30 calendar days.
- The *CHIP Contract, Section 7 B (Table 5),* lists appointment standards for routine and urgent dental care that are not addressed on page 63 of the *CHIP Provider Administrative Guide*.
- For the CAN program, 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 (41%). When compared to last year's results of 49%, this year's study proportion did fall from the previous measure, but statistically it was unchanged. So in both absolute terms and statistically, no improvement was seen. The CHIP program was scored as "Not Applicable" due to this year being the first year the study was conducted.
- For the CAN program, the following discrepancies were identified between the *Member Handbook* and the *Provider Administrative Guide*:
  - The *Member Handbook* states prior authorization is needed for items over $500 for durable medical equipment, hearing services, and orthotics and prosthetics; however, this is not mentioned in the *Provider Administrative Guide*.

- The *Member Handbook* information for hearing services states no prior authorization is required for hearing testing; however, this is not mentioned in the *Provider Administrative Guide*.
- The *Member Handbook* states a coverage limitation of 58 days per fiscal year for nursing facility services; however, this is not mentioned in the *Provider Administrative Guide*.
- The dental benefit for adults in the *Provider Administrative Guide* mentions coverage for preventive, diagnostic, restorative, and orthodontia which is incorrect as these only relate to the children's benefit. The *Member Handbook* for dental adults mentions palliative care, which is not mentioned in the *Provider Administrative Guide.*

- For the CHIP program, the following discrepancies or lack of information were identified:
  - The *Member Handbook* states the yearly maximum benefit for dental care is $2000 and the *Provider Administrative Guide* lists routine dental as a $1500 calendar year maximum benefit.
  - The *Provider Administrative Guide* states it is the PCP's responsibility to provide all Well-Baby and Well-Child services; however, detailed information is not addressed anywhere in the guide. The table of contents (page 1) shows that preventive health care standards and recommended childhood immunization schedules are addressed in the Medical Management section; however, this information is not listed in the document.
  - The *Provider Administrative Guide* does not state the PCP's responsibility to follow-up with non-compliant members for Well-Baby and Well-Child screenings and services.
  - The *Provider Administrative Guide* does not include information regarding the reassignment of a member to another PCP.
  - The *Provider Administrative Guide* does not include information regarding the process for communicating the provider's limitations on panel size to the CCO.
  - The *Provider Administrative Guide* does not include information regarding who provides translation services or how a provider would access those services for the member.
  - The *Provider Administrative Guide* does not include a statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.
- During an onsite discussion, UHC stated that non-participating providers do not have access to the online prior authorization system. So when a non-participating provider needs to submit a request for prior authorization, they must use a participating

provider to submit the request through the online prior authorization system. If this is UHC's practice, information should be included in the *Provider Administrative Guide* to educate participating providers that they need to work with non-participating providers in submitting online prior authorizations.

- *Policy NQM-052, Web-based Network Provider Directory Usability Testing*, states that new information is updated within 30 days of being received; however, the *CAN and CHIP Contracts, Section 6 E*, state the web-based *Provider Directory* must be updated within 5 business days upon changes to the provider network.
- The sample charts at the front of the *CAN Provider Directory* and *CHIP Provider Directory* which show the description for provider listings do not match the information that is displayed for each provider in the directory and needs to be updated.
- The *CHIP Provider Administrative Guide*, page 27, incorrectly states, "The UnitedHealthcare Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized clinical practice guidelines. The guidelines are then distributed to the National Quality Management Oversight Committee (NQMOC) and the Health Plan Quality Management Committee."
- The *2016 Clinical Practice Guidelines* document received in the desk materials included 2 guidelines that are not listed on the website: Dementia, and Violence and Abuse.
- The *CHIP Provider Administrative Guide* contains an outdated list of clinical practice guidelines.
- While policy NQM-025 states it applies to the CAN and CHIP programs, the policy addresses Early and Periodic Screening, Diagnostic and Treatment (EPSDT) which is specific to CAN; but does not address Well-Baby and Well-Child care which is the language used in the *CHIP Contract*.
- In addition, the *EPSDT Medical Record Review* tool and manual received in the desk materials does not include Well-Baby and Well-Child care language, and does not include dental and oral assessment which is required in the *CHIP Contract, Section 5 D.*
- It does not appear that UHC has conducted a provider medical record review to ensure EPSDT/Well-Baby and Well-Child services are being properly documented.
- 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.

Corrective Action

- Update the *Optum Physical Health Credentialing Risk Management Program 2016* to address MS specific credentialing requirements in Attachment B.

- The NCC should invite all LIP voting committee members to meetings and follow the UHC Credentialing Plan 2015-2016 for determining a quorum. Committee minutes should notate absent voting members in the meeting minutes.
- Credentialing/recredentialing decisions need to be made by a MS Credentialing Committee made up of UHC MS network providers and chaired by the MS Medical Director as required by the *CAN and CHIP Contracts, Section 1 L*.
- Ensure that CLIA waivers are collected/verified if the provider indicates a CLIA waiver has been issued.
- The UnitedHealthcare Credentialing Plan 2015–2016 or the MS Addendum needs to be updated to include the following requirements: that proof of verification for facilities should be in the files, proof of malpractice insurance, a CLIA certificate/waiver for laboratory services, and ownership disclosure forms. This information also needs to be reflected in the facility credentialing/recredentialing files.
- Update the *CHIP Provider Administrative Guide* to properly address appointment standards for primary care and dental care.
- Due to the low results (41%) of successfully answered calls for the telephonic Provider Access and Availability Study conducted by CCME for the CAN program, UHC should implement additional strategies to ensure provider files are updated in a timely and accurate manner.
- Correct benefit discrepancies or update lack of information between the *Member Handbook* and the *Provider Administrative Guides* for both the CAN and CHIP programs.
- Update policy NQM-052 to reflect the correct timeframe for updating the data in the online Provider Directory.
- Update the paper Provider Directory sample chart (at the front of the directory) that shows the description of provider listings. This chart, should match the information that is displayed for each provider in the directory. This applies to both CAN and CHIP.
- Update the *CHIP Provider Administrative Guide* to reflect the correct committees that review and approve clinical practice and preventive guidelines.
- Ensure that the UHC website includes all clinical practice guidelines adopted by the Plan.
- Update policy *NQM-025, Ambulatory Medical Record Review Process*, to address Well-Baby and Well-Child care. In addition, update the EPSDT Medical Record Review tool and manual to address Well-Baby and Well-Child care and include dental and oral assessment.
- Conduct a medical record review for EPSDT/Well-Baby and Well-Child care services.

- Provide information regarding the provider satisfaction survey's purpose/objective as well as the reliability and validity measures for the survey.

Recommendations

- UHC should improve the overall condition of the credentialing/recredentialing files to ensure that all information in the file is readable and dates in the Aperture primary source verification section of the files are consistent with the date the queries are performed.
- The following recommendations relate to the CAN credentialing/recredentialing file review:
  - Ensure the information that is verbally verified is indicated in the file, i.e., verification of no DEA license for a nurse practitioner when the DEA license section was not completed on the application.
  - Ensure the proof of malpractice insurance reflects the name of the provider being credentialed.
  - Ensure that CLIA certificates and/or waivers are collected if the applicant indicates they provide laboratory services. If the application section for the CLIA has not been completed by the applicant, a verbal verification to confirm no CLIA certificate or waiver is appropriate, but it must be indicated in the file.
  - Ensure provider office site visits are conducted at initial credentialing for PCPs and OB/GYNs.
- The following recommendations relate to the CHIP credentialing/recredentialing file review:
  - Ensure the verification for board certification is included in the file when board certification is claimed by the provider.
  - Ensure provider office site visits are conducted at initial credentialing for PCPs and OB/GYNs.
  - Ensure that CLIA information is collected/verified if the provider indicates a CLIA certification/waiver has been issued.
- Since the Dial America quarterly reports continue to show high percentages of noncompliance for appointment availability and after-hours access, UHC should investigate and implement interventions to address the issue.
- Clarify in the *CHIP Provider Administrative Guide* that it is the PCP's responsibility to follow-up with non-compliant members for Well-Baby and Well-Child screenings and services.

- Include information in the *Provider Administrative Guides* for CAN and CHIP to educate participating providers regarding working with non-participating providers in submitting online prior authorizations.

C. Member Services

The review of Member Services for UnitedHealthcare Community Plan (UHC) included the MississippiCAN and MississippiCHIP lines of business. CCME reviewed all policies and procedures, member rights, member informational materials, grievances, and the *Member Satisfaction Survey*. The *Member Handbook* produced by UHC is very thorough, very easily understood, and meets the sixth grade reading comprehension level as required by the contract with DOM.

The UHC website includes information for all age groups from adults to children and subjects which teen members may find helpful. The *Member Handbook* informs members about preventive health guidelines and available screenings that apply to all age groups and genders. The handbook is available in Spanish and alternate formats including, large font, audio, and Braille. Member services staff are available per contract requirements via a toll-free number and TTY. Members are informed that translation services are available for calls and during appointments with the doctor.

The *CAN and CHIP Member Handbooks* lacked information on Advance Directives and did not inform members on the process or circumstances when a member could request disenrollment for cause. The UHC websites do not include easy access to the Fraud and Abuse Hotline phone number or instructions on how to report fraud, waste or abuse.

The UHC Call Centers for CHIP and CAN meet or exceed contract requirements for speed of answer and abandonment rates. Training occurs for member services staff; however, there is no document stating this training must be conducted at least quarterly. The review of calls received in the member and provider call center confirmed scripts are in place to address different scenarios including how to handle emergencies. Member services staff demonstrated courteous and respectful interactions and a desire to meet the member's needs.

Grievance files reviewed for both CAN and CHIP reflected timely acknowledgement and thorough investigations. Resolution was achieved within 30 calendar days for both lines of business. Documentation of the grievance process was not consistent across policies, *Member Handbooks*, and *Provider Administrative Guides* for both CAN and CHIP and will require a few minor corrections.

Member Satisfaction Survey Validation

Member Satisfaction Surveys for both the CHIP and CAN populations underwent validation by CCME. The surveys were validated using the *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. The survey results were presented and discussed in committee meetings, and a focus on areas for improvement was noted. There is also a CAHPS Task Force in place to address problematic areas. The low response rate is a common issue and in effort to increase the response, the following strategies are recommended to enhance member response to the satisfaction survey:

- Offer incentives for completing surveys, such as stickers, pens, candy, or other small items.
- Create a lottery drawing for a movie or concert ticket, gift card, or electronic device.
- Place a stamp on the envelope instead of the standard pre-printed stamp—research has shown that this increases response rate.
- Make an announcement on the website that is readily viewable by members.
- Provide information in the newsletter that clearly states how the findings from previous satisfaction surveys have been used to effect change in the programs and services that are provided to members.
- Set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate). Based on UHC CHIP's most recent response rate of 31%, a 2% increase would be statistically significant if a similar sample size was utilized. Based on UHC CAN's most recent response rate of 26%, a 3% increase in the child and adult survey response rate would be statistically significant if similar sample sizes were utilized. Any member incentive program must be approved by DOM prior to implementation.

The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.*

For the CAN line of business UHC received a "Met" score for 91% of the standards for Member Services and 9% of standards received a score of "Partially Met." For the CHIP line of business the percentage of "Met" scores was 84% and "Partially Met" scores accounted for 16%.

Figure 4: Member Services Findings

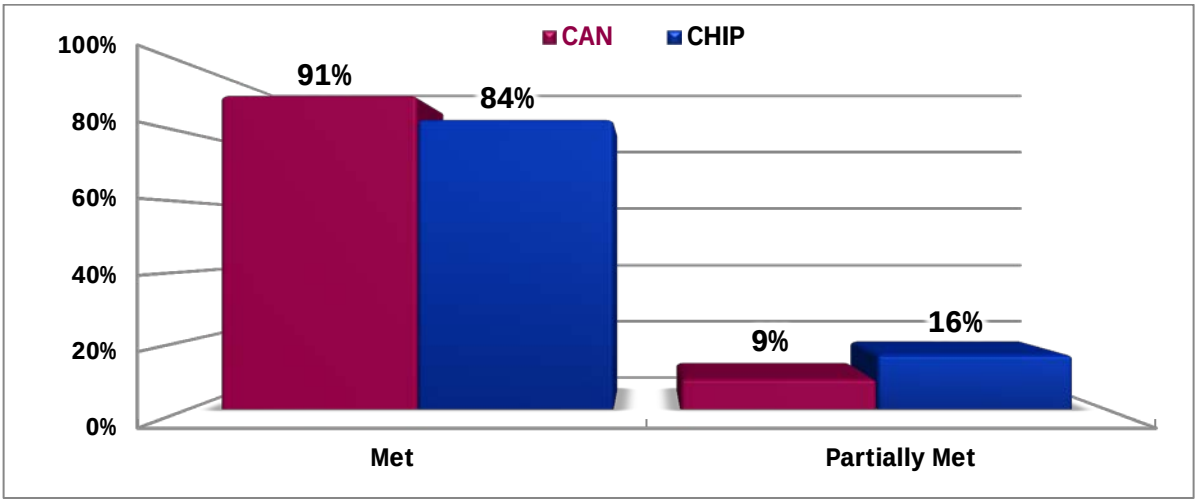


Table 5: Member Services

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Member Rights and Responsibilities	All ember rights are 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	Partially Met	Partially Met
Preventive Health and Chronic Disease Management Education	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	Met	Partially Met
Complaints/ Grievances	The procedure for filing and handling a complaint/grievance	Partially Met	Partially Met
	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	Partially Met	Partially Met

Strengths

- The *CHIP and CAN Member Handbooks* are written to an appropriate reading level and are very easy to understand.

- The *CAN and CHIP Member Handbooks* include very good information for members on preventive health care and screenings.
- The UHC website has resources and health information for all ages, including teens.

Weaknesses

- Page 36 of the *CAN Member Handbook* includes a table of services covered and paid for by Medicaid. Hospital Care-Inpatient services are included in the table. Per the *CAN Contract, Section 12 (H) and Section 17*, beginning December 1, 2015, UHC is responsible for inpatient services provided to members.
- Page 21 of the *CAN Member Handbook* and page 19 of the *CHIP Member Handbook* state members can get a second opinion from a network provider for any covered benefit. The information on page 21 is incorrect because it does not include obtaining a second opinion out-of-network or that second opinions are provided at no cost to the member.
- The *CHIP Contract, Section 7, (B) (4),* states the contractor shall have policies and procedures for rendering second opinions by providers within the network, or by non-participating providers. No policy was found for CAN or CHIP that addressed second opinions.
- The *CHIP Member Handbook* and the *CHIP Provider Administrative Guide* do not include that members are free to exercise their rights and the exercise of those rights do not adversely affect the way the Contractor and its provider's treat the member. See *CHIP Contract, Section 6, (I) (g).*
- The *CHIP Member Handbook* includes notifying DOM if you move and have a new address. It does not address changes in family size or obtaining other health care coverage. See *CHIP Contract, Section 6, (D) (16).*
- The *CHIP Member Handbook* does not inform members that they can obtain family planning services from non-contracted providers. See the *CHIP Contract, Section 6 (D).*
- The *CHIP Contract, Section 7 (B) (2),* lists appointment scheduling timeframes required of CHIP providers. Page 17 of the *CHIP Member Handbook* also includes expected timeframes for scheduling appointments; however, it only includes the timeframe for PCP visits. It fails to include the following timeframes:
  - Specialists not to exceed 45 days
  - Routine dental care not to exceed 45 days
  - Urgent dental care not to exceed 48 hours
  - Behavioral Health routine visit not to exceed 21 calendar days
  - Behavioral Health Urgent visit not to exceed 24 hours

  - Behavioral Health post discharge from an acute psychiatric hospital not to exceed 7 days

- Page 10 of the *CAN Member Handbook* and page 10 of the *CHIP Member Handbook* state Member Services is available 7 days a week; however, the hours listed indicate they are available 7 days a week for the first week in every month and 5 days per week thereafter.
- No information is given to members in the *CAN or CHIP Member Handbooks* about the right to request disenrollment for cause at any time and the process for doing this. Reference *CAN Contract, Section 4 (G, H, I and M), and CHIP Contract, Section 4 (F).*
- The *CAN Member Handbook* includes a brief paragraph about fraud and abuse and a toll-free hotline phone number for members to report any suspicion of fraud. The UHC website did not appear to have any additional information or the hotline number for reporting fraud.
- The information in the *CAN and CHIP Member Handbooks* regarding Advance Directives does not include a description of all aspects of advanced care planning including living wills, durable power of attorney for health care, and the process for establishing an advance care plan.
- *Policy MBR15a, Advanced Directives*, states members are informed of the opportunity for advance care planning in the *Evidence of Coverage (Member Handbook)* and other member documents. Onsite discussion revealed no other document is provided to members on advance directives, except what is found in the *Member Handbook*. This policy also states that UHC informs members that complaints concerning non-compliance with an advanced directive may be filed with the State Survey and Certification Division of the State Department of Health; however, this information is not found in the *CAN* or *CHIP Member Handbook*. See the *CAN Contract, Section 5 (K).*
- The *CAN and CHIP Member Handbooks* do not include information about the WIC program or include it in a discussion of care management or coordination with other health or social programs.
- According to the *CAN Contract, Section 6 (a) (4),* and the *CHIP Contract, Section 6 (A) (4)*, Member Services call center staff must receive trainings at least quarterly. No policy was found that included the requirement for quarterly trainings or the quarterly submission to DOM detailing the trainings conducted.
- The *CHIP Member Handbook* defines a grievance, an action, and an appeal. It does not include a form members can use to file a grievance or appeal.
- The *CHIP Provider Administrative Guide* does not include the definition of a complaint or grievance.

- No policy was found that addressed the contract requirement for UHC to notify DOM within 7 calendar days of CHIP members identified with a diagnosis of pregnancy as found in *CHIP Contract, Section 4 (F).*
- There was a low response rate to the *CAN and CHIP Member Satisfaction Surveys*.
- *Federal Regulation § 438.406* requires the health plan to acknowledge the receipt of each grievance or appeal. Regarding the acknowledgement of grievances, the following issues were identified:
  - The *CAN and CHIP Member Handbooks* do not list a timeframe for acknowledgement.
  - The *CAN Provider Administrative Guide*, pages 35 and 37, lists the timeframe as 10 working days; whereas, the *CHIP Provider Administrative Guide* states grievances are acknowledged not later than 5 days from receipt.
  - CAN *Policy AG-01 Complaint, Grievance and Appeal Procedures*, states oral grievances can be acknowledged orally; however, the *CAN Member Handbook* states UHC will send the grievant a letter informing them the grievance was received.
  - CHIP *Policy AG-03* states within 10 calendar days of receipt.
  - Behavioral Health policy Complaints and Grievances states within 10 calendar days of receipt and the *CHIP Member Handbook* do not include providing assistance to file a grievance.
- CAN *Policy AG-01,* CHIP *Policy AG-03, Complaints, Grievances and Appeals Procedures, and Behavioral Health Complaints and Grievances* policy do not address *Federal Regulation § 438.406 (b) (2)* which includes:
  - Ensuring individuals deciding grievances or appeals are individuals who were not involved in any previous level of review, or a subordinate of any such individual.
  - Who, if deciding any of the following, are individuals with the appropriate clinical expertise in treating the enrollee's condition or disease, as determined by the State.
    a. An appeal of a denial based on the lack of medical necessity.
    b. A grievance regarding the denial of an expedited resolution of an appeal.
    c. A grievance that involves clinical issues.
- CHIP *Policy AG-03* states the timeframe to resolve expedited grievances is 72 hours, standard grievances within 30 calendar days, and both timeframes may have a possible 14 day extension. The issues noted with timeframes include:
  - The *CHIP Member Handbook* states UHC will respond to a grievance within 30 days from receipt; however, the expedited 72 hour timeframe and possible 14 day extension are not found.

- Behavioral Health Complaints and Grievances policy does not include a 14 day extension.
- The *CHIP Provider Administrative Guide* does not include the timeframe for a grievance resolution or a timeframe extension.

- CAN grievance file review indicate that not all employees handling grievances are informed about the entire grievance process.
- CHIP grievance resolution letters that included the language provided to UHC by an external vendor such as VSP or dental providers were not in easy to understand language or did not contain an explanation of the resolution. Onsite discussion confirmed UHC has recognized this issue.
- Onsite discussion confirmed UHC does tally and trend grievances by category, volume, and resolution timeframes looking for trends and outliers. This process is not defined in any CAN or CHIP policy or document.

Corrective Actions

- Include in the *CHIP Member Handbook* and *CHIP Provider Administrative Guide* a statement that members/parents or guardians can exercise their rights without adversely affecting the way the CCO and its providers treat the member/parent or guardian.
- Update the *CAN Member Handbook* by removing the misinformation on second opinions from page 21. Update the *CHIP Member Handbook* with the information on second opinions required by the contract. Develop a policy or add to an existing policy the process UHC uses to provide second opinions to in-network and non-participating providers.
- Update the *CHIP Member Handbook* to include all appointment scheduling timeframes members can expect from providers, including specialists, dentists and behavioral health providers.
- Update the *CAN and CHIP Member Handbooks* with information on disenrollment for cause and other reasons for disenrollment as stated in the contract.
- Add a visible link on the UHC website informing members how to report fraud and abuse on the hotline and provide the hotline phone number.
- Update the *CAN and CHIP Member Handbooks* and *Policy MBR15a, Advanced Directives,* to include all aspects of advance directives and the process for obtaining these. Inform members that complaints concerning non-compliance with advance directives may be filed with State Survey and Certification Division of the State Department of Health.

- Update the *CAN Member Handbook* and *Provider Administrative Guide* with the correct timeframe for acknowledging grievances and the *Member Handbook* with the method of acknowledging grievances received orally.
- Include in *Policy AG-01 Complaints, Grievances and Appeals Procedures* and the *Behavioral Health Complaints and Grievances* policy all the requirements from *Federal Regulation § 438.406 (b) (2)* as noted in the preceding weaknesses section.
- Include in the *CHIP Member Handbook* a toll-free number for members to file a grievance.
- Clarify the timeframe for acknowledging grievances across all CHIP documents.
- Include in a policy the process UHC will use to meet the requirement to notify DOM of a CHIP member with a diagnosis of pregnancy.
- Update the *CHIP Member Handbook* to include information regarding the WIC program.
- Include in the *CHIP Member Handbook* and *Behavioral Health Complaints and Grievances* policy that assistance to file a grievance is provided.
- Include in *Policy AG-03 Complaints, Grievances and Appeals Procedures* all the requirements from Federal Regulation § 438.406 (b) (2).

Recommendations

- Ensure the *CAN Member Handbook* contains the updated information on UHCs responsibility for coverage of inpatient hospitalizations.
- Update the *CHIP Member Handbook* to include the responsibility of members to report if the family size changes, any address change or if they move out of state, or obtain other health care coverage.
- Update the *CHIP Member Handbook* to include how members may obtain family planning services from non-contracted providers.
- Include a form for members to file a grievance or appeal in the *CHIP Member Handbook*.
- Include a definition of a complaint/grievance in the *CHIP Provider Administrative Guide*.
- Clarify the timeframe for grievance and expedited grievance resolution across all CHIP documentation. Include that the timeframe may be extended by 14 days as defined in the *Federal Regulation § 438.408*.
- Update the misleading statement in the *CAN and CHIP Member Handbooks* regarding the availability of Member Services 7 days per week.

- Update the *Member Handbook* to include coordination with community resources such as WIC, IDEA, and Head Start. Reference the *CAN Contract, Section 8 (2) (f).*
- Include in a policy that quarterly training is required for Member Services call center staff and the contract requirement to submit information on the trainings conducted.
- Implement at least 1 of the strategies listed in the report to increase the response rate to the *CAN and CHIP Member Satisfaction Surveys*. UHC must submit all incentive award packages to the Division for approval prior to implementation.
- Ensure employees handling grievances are educated on all aspects of the grievance process.
- Review language added to grievance resolution letters to ensure it is appropriate and easy for members to understand.
- Ensure that employees handling grievances are aware of the contract requirement to provide second opinions when requested as well as the process to do so.
- Include your process for tracking, trending, and evaluation of grievance data in a new or existing policy or document.

D. Quality Improvement

UnitedHealthcare's (UHC) *2016 Quality Improvement (QI) Program Description* for the MississippiCAN and the Mississippi CHIP programs outline the processes in-place for measuring and improving the care and services received by its members and their providers. Dr. David Williams serves as the Regional Chief Medical Officer and provides support for the Quality Management Program in Mississippi for the CAN and CHIP programs.

UHC has a number of National Committees listed in both (CAN and CHIP) *2016 Quality Improvement Program Descriptions*. According to the descriptions, the oversight of the health plan's quality improvement activities has been delegated to the National Quality Oversight Committee. This committee's membership includes health plan staff throughout the national organization. The Mississippi plan is only represented by one non-voting member. This committee interfaces with other national and regional committees as applicable. Locally, the Quality Management Committee has been established and is responsible for the implementation and coordination of all QI activities throughout the organization in MS. Monitoring of QI activities is the responsibility of the Provider Advisory Committee.

The *CAN Contract, Section 5 D,* and the *CHIP Contract, Section 5 D,* require the health plan to establish a tracking system for reporting all screening and assessment results; and diagnosis and/or treatment for members. UHC has systems in place for tracking initial visits for newborns, EPSDT screenings, and Well-Baby and Well-Child services. However,

the health plan does not track any diagnoses identified during the assessments and treatments, nor are referrals provided as a result of the assessments.

UHC evaluated the effectiveness of their QI Program annually. This evaluation is presented to the Quality Management Committee and the Board of Directors. The results of the annual evaluations are used to develop and prioritize activities for the next year's annual work plan.

Performance Measure Validation

As part of the EQR for UHC, CCME conducted a validation review of the HEDIS® and non-HEDIS® performance measures following the protocols developed by CMS. 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.

HEDIS measures were reviewed and validated in accordance with the HEDIS 2016 technical specifications. The reporting year is 2015. All relevant HEDIS performance measures for UHC's CAN and CHIP programs are reported in the table below.

Table 6: HEDIS Performance Measure Results

Measure/Data Element	CAN Rates	CHIP Rates
Effectiveness of Care: Prevention and Screening		
Adult BMI Assessment (aba)	73.22%	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)		
BMI Percentile	34.06%	
3-11 years		30.36%
12-17 years		31.02%
Total		30.66%
Counseling for Nutrition	39.90%	
3-11 years		43.75%
12-17 years		36.90%
Total		40.63%
Counseling for Physical Activity	39.90%	
3-11 years		35.71%
12-17 years		37.97%

Measure/Data Element	CAN Rates	CHIP Rates
Total		36.74%
Childhood Immunization Status (cis)		
DTaP	76.64%	79.72%
IPV	90.51%	86.36%
MMR	90.75%	91.61%
HiB	87.83%	83.92%
Hepatitis B	90.27%	86.36%
VZV	91.00%	91.61%
Pneumococcal Conjugate	79.08%	80.42%
Hepatitis A	80.54%	71.68%
Rotavirus	65.21%	72.73%
Influenza	20.92%	36.36%
Combination #2	75.18%	75.87%
Combination #3	72.02%	74.13%
Combination #4	64.96%	59.79%
Combination #5	56.45%	64.69%
Combination #6	17.76%	32.87%
Combination #7	51.58%	52.80%
Combination #8	16.79%	28.32%
Combination #9	12.90%	30.42%
Combination #10	12.41%	26.22%
Immunizations for Adolescents (ima)		
Meningococcal	47.93%	47.93%
Tdap/Td	79.81%	88.56%
Combination #1	47.20%	47.93%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	11.53%	9.89%
Lead Screening in Children (lsc)	65.45%	39.16%
Breast Cancer Screening (bcs)	47.78%	
Cervical Cancer Screening (ccs)	60.00%	
Chlamydia Screening in Women (chl)		

Measure/Data Element	CAN Rates	CHIP Rates
16-20 Years	45.57%	37.51%
21-24 Years	66.58%	NA
Total	58.71%	37.51%
Appropriate Testing for Children with Pharyngitis (cwp)	54.36%	57.71%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.06%	
Pharmacotherapy Management of COPD Exacerbation (pce)		
Systemic Corticosteroid	35.34%	
Bronchodilator	63.15%	
Medication Management for People With Asthma (mma)		
5-11 Years - Medication Compliance 50%	64.32%	66.81%
5-11 Years - Medication Compliance 75%	35.24%	32.75%
12-18 Years - Medication Compliance 50%	58.06%	53.17%
12-18 Years - Medication Compliance 75%	31.34%	29.27%
19-50 Years - Medication Compliance 50%	62.77%	NA
19-50 Years - Medication Compliance 75%	36.80%	NA
51-64 Years - Medication Compliance 50%	66.67%	
51-64 Years - Medication Compliance 75%	45.10%	
Total - Medication Compliance 50%	62.12%	60.55%
Total - Medication Compliance 75%	35.26%	31.42%
Controlling High Blood Pressure (cbp)	43.07%	
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	53.85%	
Comprehensive Diabetes Care (cdc)		
Hemoglobin A1c (HbA1c) Testing	78.59%	NA
HbA1c Poor Control (>9.0%)	67.64%	NA
HbA1c Control (<8.0%)	26.76%	NA
Eye Exam (Retinal) Performed	71.05%	NA
Medical Attention for Nephropathy	93.19%	NA
Blood Pressure Control (<140/90 mm Hg)	45.99%	NA
Antidepressant Medication Management (amm)		
Effective Acute Phase Treatment	56.19%	26.32%

Measure/Data Element	CAN Rates	CHIP Rates
Effective Continuation Phase Treatment	41.55%	23.68%
Follow-Up Care for Children Prescribed ADHD Medication (add)		
Initiation Phase	49.19%	49.62%
Continuation and Maintenance (C&M) Phase	67.65%	65.38%
Follow-Up After Hospitalization for Mental Illness (fuh)		
30-Day Follow-Up	60.83%	76.02%
7-Day Follow-Up	38.96%	54.59%
Annual Monitoring for Patients on Persistent Medications (mpm)		
ACE Inhibitors or ARBs	87.07%	
Digoxin	50.00%	
Diuretics	86.48%	
Total	86.42%	
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	4.45%	2.55%
Appropriate Treatment for Children With URI (uri)	62.04%	52.99%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	34.75%	
Use of Imaging Studies for Low Back Pain (lbp)	71.82%	
Adults' Access to Preventive/Ambulatory Health Services (aap)		
20-44 Years	85.44%	
45-64 Years	91.55%	
65+ Years	87.18%	
Total	87.49%	
Children and Adolescents' Access to Primary Care Practitioners (cap)		
12-24 Months	96.37%	98.96%
25 Months - 6 Years	92.06%	91.15%
7-11 Years	92.36%	94.31%
12-19 Years	89.06%	91.89%
Annual Dental Visit (adv)		
2-3 Years	35.13%	53.45%
4-6 Years	64.27%	75.23%

Measure/Data Element	CAN Rates	CHIP Rates
7-10 Years	70.28%	79.14%
11-14 Years	63.86%	73.29%
15-18 Years	54.92%	64.00%
19-20 Years	37.37%	67.02%
Total	59.61%	71.62%
Initiation and Engagement of AOD Dependence Treatment (iet)		
Initiation of AOD Treatment: 13-17 Years	72.84%	53.13%
Engagement of AOD Treatment: 13-17 Years	9.91%	3.13%
Initiation of AOD Treatment: 18+ Years	44.45%	55.88%
Engagement of AOD Treatment: 18+ Years	7.92%	14.71%
Initiation of AOD Treatment: Total	46.22%	54.08%
Engagement of AOD Treatment: Total	8.04%	7.14%
Prenatal and Postpartum Care (ppc)		
Timeliness of Prenatal Care	69.85%	NA
Postpartum Care	53.35%	NA
Call Answer Timeliness (cat)	97.30%	97.30%
Frequency of Ongoing Prenatal Care (fpc)		
<21 Percent	9.78%	
21-40 Percent	5.21%	
41-60 Percent	7.00%	
61-80 Percent	12.24%	
81+ Percent	65.76%	
Well-Child Visits in the First 15 Months of Life (w15)		
0 Visits	2.92%	2.19%
1 Visit	2.43%	1.46%
2 Visits	4.38%	1.46%
3 Visits	7.54%	6.57%
4 Visits	10.95%	5.11%
5 Visits	21.41%	18.25%
6+ Visits	50.36%	64.96%

Measure/Data Element	CAN Rates	CHIP Rates
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	56.51%	58.29%
Adolescent Well-Care Visits (awc)	41.61%	40.15%
Developmental Screening in the First 3 Years of Life (non-HEDIS)		NR

NA: Indicates denominator was too small; NR: Not reported

The validation of the non-HEDIS® measure 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

Three of the four the non-HEDIS measures for the CAN program were found to be "*Fully Compliant"* and one measure was "*Substantially Compliant"* as noted in the table that follows. UHC reported they were having issues with their software used to abstract the data for the non-HEDIS measure and results could not be reported at this time.

Table 7: Non-HEDIS Performance Measure Validation Results

Measure	CAN Validation Scores
Asthma Related Readmissions	100% Fully compliant
Asthma Related ER Visits	73% Substantially compliant
CHF Rehospitalizations	100% Fully compliant
Pre Post Natal Complications	100% Fully compliant

The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.*

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted 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

UHC Healthcare CAN submitted four PIPs for the CAN program and four PIPS for the CHIP program. The tables below display all the projects that were submitted, the current and previous validation scores (CAN Program), any errors, and recommendations identified. The tables start with the CAN PIP results.

Table 8: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Use of Appropriate medications for People with Asthma	105/106=99% High Confidence in Reported Results	85/95=90% High Confidence in Reported Results
Reducing Adult, Adolescent, and Childhood Obesity	127/136=93% High Confidence in Reported Results	103/116=89% Confidence in Reported Results
Comprehensive Diabetes Care	111/116=96% High Confidence in Reported Results	106/116=91% High Confidence in Reported Results
Annual Monitoring for Patients on Ace/ARB Inhibitors	95/11=86% Confidence in Reported Results	86/96=90% High Confidence in Reported Results

The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 9: Use of Appropriate medications for People with Asthma

Section	Reasoning	Recommendation
Was the study question stated clearly in writing?	Research question is clearly stated although the measures do not allow for the measurement of medication management.	Re-write the research question to clarify that medication management is related to pharmacy claims data and its appropriate use is related to other data sources.
Was an analysis of the findings performed according to the data analysis plan?	Analyses were conducted yearly, although data analysis was documented as once a quarter only.	Document that analyses are conducted yearly and quarterly in the data analysis cycle section.

Table 10: Reducing Adult, Adolescent, and Childhood Obesity

Section	Reasoning	Recommendation
Was an analysis of the findings performed according to the data analysis plan?	Data were analyzed yearly, whereas the data analysis plan indicates quarterly.	Document that analyses are conducted yearly and quarterly in Section C.4. Data Analysis Cycle.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results for annual rates and quarterly rates are presented clearly. The comparison goal rates were not explained in the documentation.	Add the justification and sources for comparison goal rates to the documentation.
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	Improvement was sustained for Measure 1 and Measure 2c. Measures 2a and 2b have remained the same or decreased since last measure.	Provide attention to interventions that will impact BMI percentile rates and nutrition counseling.

Table 11: Comprehensive Diabetes Care

Section	Reasoning	Recommendation
Was an analysis of the findings performed according to the data analysis plan?	Analyses were conducted yearly, although data analysis was documented as once a quarter only.	Document that analyses are conducted yearly and quarterly in the data analysis cycle section.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Rates for all measures were presented in a table in a concise and clear manner. HEDIS 2012 rates are not of relevance to the study: so, chi square analyses should not be conducted to compare	Remove documentation of HEDIS 2012 values and omit chi square analyses of comparison between HEDIS 2012 and HEDIS 2013. Explain basis for comparison goal rates for each measure.

Section	Reasoning	Recommendation
	HEDIS 2012 to HEDIS 2013 since HEDIs 2013 is considered the baseline. Comparison goal rates are not explained in documentation.	

Table 12: Annual Monitoring for Patients on Ace/ARB Inhibitors

Was an analysis of the findings performed according to the data analysis plan?	Analyses were conducted yearly, although data analysis was documented as once a quarter only.	Document that analyses are conducted yearly and quarterly in data analysis cycle section.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Rates for all measures were presented in a table in a concise and clear manner. In the Results Table, the time period measurement of 1-1-2013 to 12-31-2013 was labeled as HEDIS 2013.	Correctly label the time period measurement years to assist with an accurate results interpretation.

The results of the validation for the CHIP program Performance Improvement Projects follows.

Table 13: CHIP Performance Improvement Project Validation Scores

Project	Validation Score
Use of Appropriate Medications for People with Asthma	85/95= 90% High Confidence In Reported Results
Adolescent Well Care	109/109=100% High Confidence In Reported Results
Reducing Adolescent and Childhood Obesity	109/109= 100% High Confidence In Reported Results
Follow-up after Hospitalization for Mental Illness	90/96=94% High Confidence In Reported Results

The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 14: Use of Appropriate medications for People with Asthma

Section	Reasoning	Recommendation
Was/were the study question(s) stated clearly in writing?	Research question is clearly stated although the measures do not allow for the measurement of medication management.	Re-write the research question to clarify how medication management and its appropriate use are separately measured to allow the reader clarification on how both are being addressed in the PIP.
Was an analysis of the findings performed according to the data analysis plan?	Results are conducted for yearly data, although the data plan indicates quarterly data analysis.	Revise the data analysis plan to reflect the yearly analysis with quarterly updates.

Table 15: Follow-Up After Hospitalization for Mental Illness

Section	Reasoning	Recommendation
Is there any statistical evidence that any observed performance improvement is true improvement?	The most recent comparisons for both measures were not significant from Remeasurement 3 to Remeasurement 4	Implement a plan of action to increase rates more substantially.
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	Rates increased steadily, but then declined from Remeasurement 3 to Remeasurement 4 for the 7 day follow-up measure.	Continue to track data to ensure rates improve; revise interventions if necessary.

Details of the validation activities for the performance measures and PIPs, and specific outcomes related to each activity may be found in *Attachment 3, CCME EQR Validation Worksheets*.

Figure 5, Quality Improvement Findings indicate that for the CHIP program, 90% of the standards received a "Met" score, 5% received a "Partially Met" score and 5% received a "Not Met" score. For the CHIP program, 95% of the standards received a "Met" score, and 5% received a "Not Met" score. The "Partially Met" score was related to the documentation in the CAN performance improvement projects. The "Not Met" score for CAN and CHIP were related to the tracking of any diagnoses identified during EPSDT screenings or the Well-Baby Well-Child assessments and treatments, or the referrals provided as a result of the assessments.

Figure 5: Quality Improvement Findings

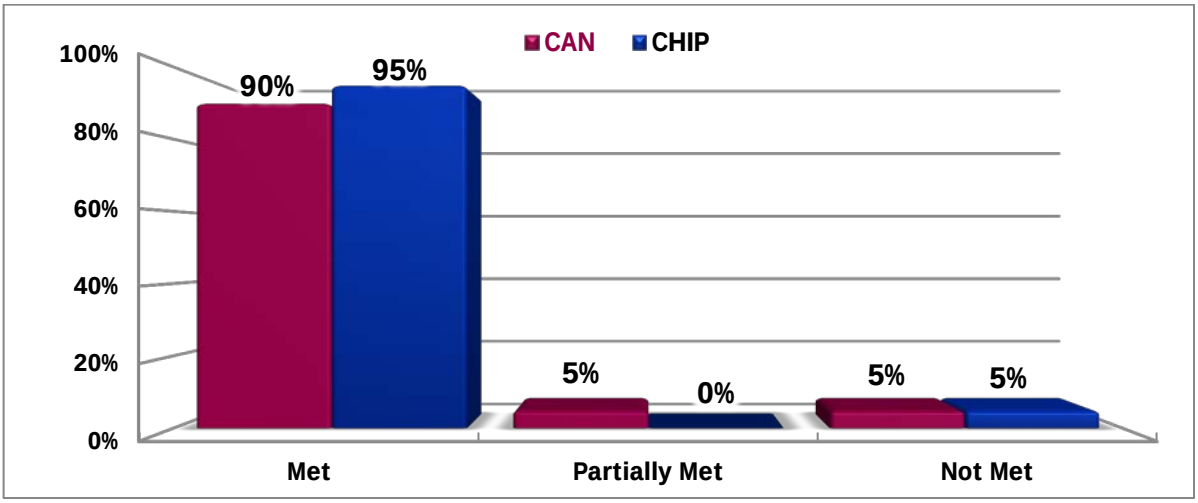


Table 16: Quality Management

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met
Provider Participation in Quality Improvement Activities	The CCO tracks provider compliance with EPSDT service provision requirements for: The diagnosis and/or treatment for children	Not Met	N/A
	The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: The diagnosis and/or treatment for children	N/A	Not Met

N/A = Standard is Not Applicable

Strengths

- Performance improvement projects were based on analysis of comprehensive aspects of enrollee needs and services. In addition, the rationale for each topic was documented.
- All of the performance improvement projects for the CHIP program received a validation score within the "*High Confidence*" range.
- HEDIS performance measures were fully compliant.

Weaknesses

- The National Quality Oversight Committee has oversight of the health plan's quality improvement activities. This committee's membership includes health plan staff

throughout the organization. However, there are no voting members from Mississippi represented on this committee.

- The non-HEDIS measures for the CHIP program were not being reported due to software issues.
- The health plan does not track any diagnoses identified during EPSDT screenings or the Well-Baby and Well-Child assessments and treatments, or the referrals provided as a result of the assessments.

Corrective Action

- Correct the errors identified in the performance improvement project documents.
- Develop a system for tracking any diagnoses identified during an EPSDT screenings or a Well-Baby and Well-Child assessment and the treatment and/or referrals provided.

Recommendations

- Consider adding a voting member to the National Quality Oversight Committee from Mississippi.
- Work with the appropriate department to fix software issues related to data being abstracted to ensure accuracy and reporting on the non-HEDIS performance measure rates.

E. Utilization Management

The *UHC 2016 Utilization Management (UM) Program Description* and *2016 Mississippi (MS) CAN and CHIP Addenda to the UM Program Description* describe UHC's UM program for both the CAN and CHIP lines of business. The program description and addenda define the structure, departmental roles, and responsibilities for the national and local UM programs. In addition, departmental policies and procedures guide staff in the performance of various functions for the CAN and CHIP UM Programs. *The UM Program Description* is reviewed and approved annually by the National Medical Care Management Committee (NMCMC). Dr. David Williams, UHC's Chief Medical Officer (CMO), is board certified in internal medicine and provides oversight for all aspects of clinical operations for the CAN and CHIP lines of business. An evaluation of the overall effectiveness of the UM Program is conducted annually. The *UM Evaluation* for 2015 was thoroughly documented and included goals, barriers, interventions, and recommendations for 2016.

The NMCMC reviews and approves clinical policies, criteria, and guidelines recommended by the Medical Technology Assessment Committee (MTAC), which is composed of a diverse mix of medical and surgical specialists. Clinical review criteria are reviewed, evaluated and approved annually. It is unclear in UM policies and the *UM Program Description/Addenda* which criteria are used for medical necessity determinations for the CAN and CHIP populations. The documents referenced the use of both *MCG™ Care*

Guidelines and *InterQual® Guidelines*, but did not specify which are actually used. Onsite discussion confirmed UHC uses *MCG™ Care Guidelines* for medical determinations and internal policies for behavioral health determinations.

UM approval and denial files for CAN and CHIP members reflected appropriate attempts to obtain additional clinical information, use of correct criteria and reviewers, and timely determinations and notifications. Denial letters contained the required information.

Onsite discussion confirmed that, for both the CAN and CHIP populations, after an initial denial has been formally issued, the original reviewer can change the denial decision based on a peer-to-peer conversation. CCME cautioned that this practice is prohibited by *Federal Regulation § 438.406 (a) (3) (i)*, and that any changes to the original determination must be issued by a reviewer who was not involved with the original decision.

Appeals processes for CAN members are defined in *Policies AG-01, Complaint, Grievance and Appeal Procedures, and AG-02, Expedited Review Process*. Appeals processes for CHIP members are defined in *Policies AG-03, Complaint, Grievance and Appeal Procedures*, and *AG-04, Expedited Review Process*. Behavioral health appeals processes are documented in the *United Behavioral Health (UBH) Appeals of Adverse Actions* policy, which applies to both the CAN and CHIP lines of business.

CAN appeals files were found to have timely determinations issued by appropriate reviewers and resolution letters contained the required information. However, errors and inconsistencies in documentation of CAN appeals processes were noted in the *CAN Provider Administrative Guide*, *Policies AG-01 and AG-02*, and other documents. These issues are specified in the Weaknesses section below.

Errors and inconsistencies were noted in the documentation of the CHIP appeals processes in the *CHIP Provider Administrative Guide*; *Policies AG-03 and AG-04*; and the *Member Handbook*. In addition, onsite discussion confirmed UHC does not acknowledge the receipt of CHIP appeals. However, *Federal Regulation §438.406 (b) (1)* requires acknowledgement of each appeal.

A review of CHIP appeal files revealed that appeals reviewed by the dental vendor generally do not provide a reference to the benefit or criteria used in the appeal resolution letter and standard appeal files do not contain evidence of a written acknowledgement of the appeal. One resolution letter from an appeal file reviewed and upheld by the dental vendor contained an incorrect rationale for upholding the determination, and one determination for an expedited appeal request was untimely and contained no evidence that the request to expedite the appeal was denied.

The *2016 UHC Community and State Person Centered Care Model (PCCM) Program Description* applies to both the CAN and CHIP member populations and provides general information on the program's overall purpose, scope, member identification, program components, staff qualifications, etc. Various care management (CM) policies and procedures address general CM functions and processes. However, the *PCCM Program Description* and CM policies and procedures are national documents that address only high-risk CM and do not address all the CM requirements found in the *CAN Contract, Section 8,* and *CHIP Contract, Section 8*. No policy riders or addenda have been created to include specific MS requirements. CM files, however, confirmed that appropriate processes and functions are being performed for both the CAN and CHIP populations.

As noted in the charts below, UHC received "Met" scores for 85% of the standards in the UM section of the review for CAN and 85% of the standards in the UM section of the review for CHIP. Scores of "Partially Met" were related to the documentation of appeals processes, issues noted in appeal files, and lack of MS specific information regarding CM requirements.

Figure 6: Utilization Management Findings

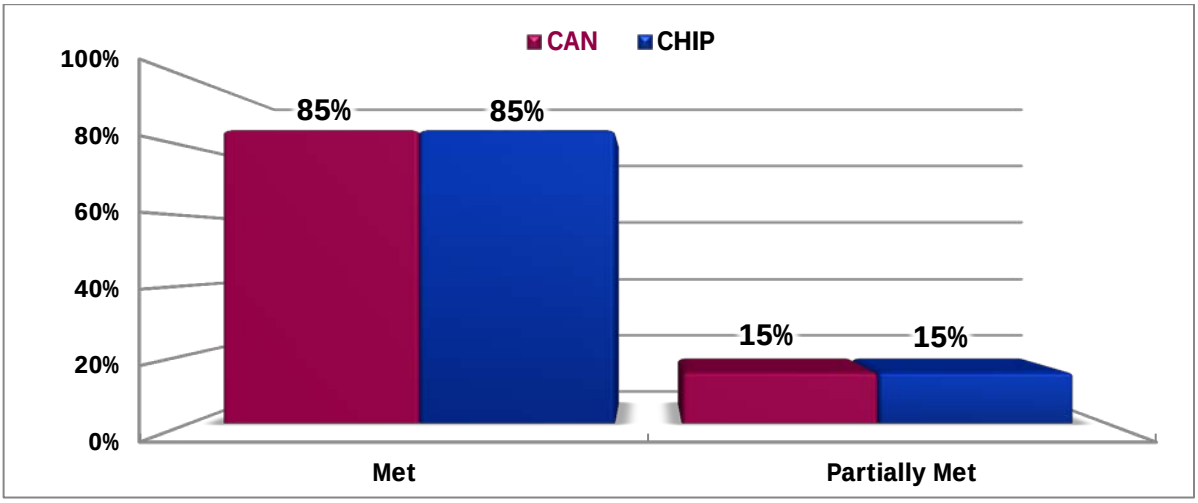


Table 17: Utilization Management

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Appeals	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 the definitions of an action and an appeal and who may file an appeal	Partially Met	Partially Met

Section	Standard	CAN 2016 Review	CHIP 2016 Review
Appeals	The procedure for filing an appeal	Partially Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Partially Met
	Other requirements as specified in the contract	Partially Met	Met
	The CCO applies the appeal policies and procedures as formulated.	Met	Partially Met
Care Management	The CCO assess the varying needs and different levels of care management needs of its Member population	Partially Met	Partially Met
	A health risk assessment is completed within 30 calendar days for Members newly assigned to the high or medium risk level	Partially Met	Partially Met
	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	Partially Met	Partially Met
	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	Partially Met	Partially Met

Strengths

- The inter-rater reliability scores were all between 90 and 100 percent, indicating proficiency in interpreting criteria and consistency in decision making among clinical staff.
- A review of UM approval files for CAN and CHIP members indicate that Medical Directors consider individual member characteristics and needs when issuing medical necessity determinations.
- UHC has developed a process to hold resolved appeals in an "open" status until the claim payment has been verified.

Weaknesses

- It is unclear in *Policies UCSMM.06.10, Clinical Review Criteria*, and the *UM Program Description/Addenda* the criteria being used for medical necessity determinations for the CAN and CHIP populations. Onsite discussion confirmed UHC uses *MCG™ Care Guidelines* for medical determinations and internal policies for behavioral health determinations.

- The *CHIP Addendum* to the *UM Program Description* provides an overview of provider appeals, but does not address the member appeals process. Onsite discussion confirmed this is an oversight.
- The *UCS Annual MCG™ Care Guidelines Interrater Reliability Standard Operating Procedure* (SOP) addresses when remediation will be required, but does not describe the remediation process.
- HQUM minutes from May 31, 2016 incorrectly reported the 2015 inter-rater reliability (IRR) scores for MDs who participated. The minutes reported that 2 MDs scored 10%; however, onsite discussion confirmed the MD scores of 10% are incorrect and the correct scores were 90%.
- The *CAN and CHIP Provider Administrative Guides* do not address post-stabilization services.
- The *CAN and CHIP Addenda to the 2016 UM Program Description* state, "UnitedHealthcare shall distribute its criteria for approval or denial of outside services to all outside providers to whom members are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities providing Emergency Medical Services known to UnitedHealthcare and located within a thirty (30) mile radius." Onsite discussion confirmed that this statement should not be included in the *CAN and CHIP Addenda to the 2016 UM Program Description*, and will be removed.
- The term "action" is defined in the *CAN Provider Administrative Guide* and *UBH Appeals of Adverse Actions* policy, but the definitions are not consistent with the definition found in *Policies AG-01 and AG-02* or the *CAN Member Handbook*. The terms "action" and "appeal" are not defined in the *CHIP Provider Administrative Guide*.
- The *CAN Provider Administrative Guide* does not mention that the provider needs written consent from the member to file the appeal on the member's behalf.
- *Policy AG-03 (CHIP)* defines who may file an appeal, but fails to include the legal representative of a deceased member's estate.
- UHC allows an appeal to be filed up to 45 calendar days from the date on the notice of action letter. Discrepancies in the timeframe were noted in *Policy AG-03 (CHIP)*, the *CHIP Member Handbook*, and the *CHIP Provider Administrative Guide*.
- The process for acknowledgement of an expedited appeal is not addressed in *Policy AG-02 (CAN). Policies AG-03 (CHIP) and AG-04 (CHIP)* do not address the process for acknowledgement of appeals. Onsite discussion revealed that UHC does not provide an acknowledgement of receipt of CHIP appeals.
- *CHIP Policies AG-03* and *AG-04*, and the *CHIP Provider Administrative Guide* do not address the requirement that in the appeals process, the enrollee is provided a

reasonable opportunity to present evidence, provide testimony, and make legal and factual arguments.

- The *CHIP Member Handbook* does not inform members that they can review the appeal case file and related documentation.
- *Policy AG-03 (CHIP)* does not mention that reviews of appeals involving medical necessity or clinical issues are to be performed by a practitioner with appropriate medical expertise.
- Onsite discussion confirmed that after an initial denial has been formally issued, the original reviewer can change the initial denial decision based on a peer-to-peer conversation. However, this is prohibited by *Federal Regulation § 438.406 (a) (3) (i)*. Any changes to the original determinations must be issued by a reviewer who was not involved with the original decision.
- *Policy AG-01 (CAN)* states, "Expedited Appeals must be resolved within three 72 hours of receipt of the request for an Expedited Appeal."
- The *CHIP Provider Administrative Guide* incorrectly states the notice of decision for third level appeals will be sent within 30 calendar days of receipt of the request. All other documents correctly state a 15 calendar day timeframe.
- The *CAN Contract, Exhibit D, Section C*, states the timely filing for requesting benefit continuation is within 10 days of the appeal notice of action or within 30 calendar days from the date on the notice of action for a *State Fair Hearing*. The following documents state the timeframe to request continuation of benefits is within 10 days of receiving the notice of action:
  - The *CAN Member Handbook*, page 57
  - The CAN appeal uphold letters for UHC and UBH
  - The Your Appeal Rights attachment to the CAN initial denial and reduction in service letters
- Review of CHIP appeal files revealed the following issues:
  - Appeals reviewed by the dental vendor do not include a reference in the appeal resolution letter regarding the benefit or criteria used for upheld appeals.
  - Standard appeal files do not contain evidence of a written acknowledgement of the appeal.
  - One appeal file reviewed by the dental vendor contained an incorrect rationale for upholding the denial in the resolution letter.
  - One expedited appeal contained no evidence that the request to expedite the appeal was denied nor that the determination was provided within the expedited appeal resolution timeframe requirement.

- The *PCCM Program Description* and CM policies and procedures are all national documents and do not address the MS-specific requirements for CM found in the *CAN Contract, Section 8, and CHIP Contract, Section 8*. No riders or policy addenda were found to address specific MS requirements. In addition, policies address only high-risk CM.
- *Policy NCM 001, Identification of High Risk Members for Case Management*, discusses stratifying members into groups of those receiving long-term services and support (LTSS) and those not receiving LTSS. Onsite discussion with UHC staff confirmed this is not applicable to CAN and CHIP members.
- *Policy NCM 002, High-Risk Case Management Process*, defines the timeframe for completion of the comprehensive assessment for members initially stratified into high-risk level, but does not define the timeframe for completion of the assessment for members initially stratified into the medium-risk level.
- *Policy NCM 002, High-Risk Case Management Process*, does not specify the timeframe for completion of the individual care plan.
- UHC has no policy that addresses CM for members assigned to the medium and low risk levels.

Corrective Actions

- Remove the unnecessary part of the definition of the term "action" from the *CAN Provider Administrative Guide* and the *UBH Appeals of Adverse Actions* policy.
- Revise the *CHIP Provider Administrative Guide* to include definitions of the terms "action" and "appeal."
- Revise the *CAN Provider Administrative Guide* to mention providers needs written consent from a member to file an appeal on their behalf.
- Update *Policy AG-03 (CHIP)* to include language stating the legal representative of a deceased member's estate may also file an appeal.
- *Revise policy AG-03 (CHIP)*, the *CHIP Member Handbook*, and the *CHIP Provider Administrative Guide* to state appeals may be filed 45 calendar days from the date on the notice of action letter.
- Revise *Policy AG-02 (CAN)* to include the process for the acknowledgement of an expedited appeal request.
- Implement a process to ensure that CHIP appeals are acknowledged.
- Include information in *Policy AG-03 (CHIP), Policy AG-04 (CHIP),* and the *CHIP Provider Administrative Guide* stating the enrollee has the ability to present evidence and testimony and make legal and factual arguments regarding the appeal.

- Revise the *CHIP Member Handbook* to inform members that they can review the appeal case file and all related documentation.
- Correct the timeframe for the resolution of expedited appeals in *Policy AG-01 (CAN).*
- Revise the *CHIP Provider Administrative Guide* to include the correct timeframe for third level appeal resolution and notification.
- Correct the timeframe for requesting a continuation of benefits in the *CAN Member Handbook*, UHC and UBH appeal uphold letters (CAN), and the *Your Appeal Rights* attachment to the initial CAN denial and reduction in service letters.
- Ensure CHIP appeal resolution letters contain a reference to the benefit or criteria used in the review when the decision is to uphold the denial.
- Ensure that CHIP appeal resolution letters contain the correct rationale for upholding the initial denial.
- Develop a *MS addendum* to the *PCCM Program Description* and riders/addenda for the CM policies that address the MS-specific CM requirements for CAN and CHIP members.
- Include in policies the timeframe for completing comprehensive assessments of members initially stratified into the medium-risk category.
- Revise *Policy NCM 002* to include the timeframe for completion of the individual care plan.
- Develop a policy, or add to an existing policy, the CM services provided to medium and low-risk levels.

Recommendations

- Revise the *CAN and CHIP Addenda to the 2016 UM Program Description* and *Policy UCSMM.06.10* to mention the *MCG™ Care Guidelines* are used for medical necessity determinations for the CAN and CHIP populations.
- Revise *CHIP Addendum to the UM Program Description* to address member appeals.
- Revise the *UCS Annual MCG™ Care Guidelines Interrater Reliability SOP* to include the process for remediation for IRR scores below the benchmark.
- Ensure HQUM Committee minutes reflect accurate information regarding IRR scores.
- Include information on post-stabilization requirements and processes in the *CAN and CHIP Provider Administrative Guides*.
- Remove the following statement from *CAN and CHIP Addenda to the 2016 UM Program Description*: "UnitedHealthcare shall distribute its criteria for approval or denial of outside services to all outside providers to whom members are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities

providing Emergency Medical Services known to UnitedHealthcare and located within a thirty (30) mile radius."

- Revise *Policy AG-03 (CHIP*) to include a statement that a review of any appeal involving medical necessity or clinical issues is performed by a practitioner with the appropriate medical expertise.
- Update UHC's peer-to-peer processes to ensure peer-to-peer reviews either occur before a denial determination has been issued or that a different reviewer changes the initial denial determination.
- Update *Policy NCM 001* to indicate that LTSS services are not applicable to the CAN and CHIP membership.

F. Delegation

UnitedHealthcare (UHC) has delegation agreements with the following entities:

Table 18: Delegated Entities and Services

Delegated Entities	Delegated Services
OptumHealth	Behavioral health services
Dental Benefit Providers	Dental network services and third party dental administration
eviCore National	Radiology and cardiology management services and prior authorizations
Vision Service Providers	Vision and eye care services
MTM, Inc. (CAN Only)	Non-emergency transportation benefit services
MHG and Physician Corporation Hattiesburg Clinic River Region HubHealth University Physicians	Credentialing

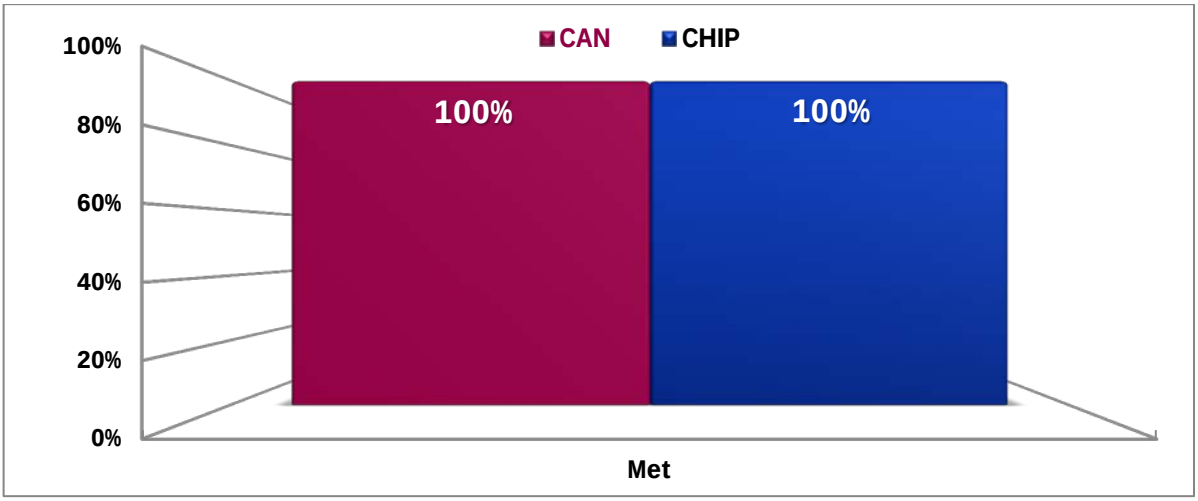
UHC has established policies to define the requirements for delegation, including monitoring and oversight of the delegated vendors' functions. *UHC's Master Services Agreement* specifies tasks to be performed, and includes compensation arrangements and remedies for substandard performance. The Chief Operating Officer retains responsibility for delegation oversight, and oversight includes vendor reporting, conducting joint

operating committee meetings and ad hoc meetings, and distributing email communications. In addition, annual oversight is performed for each delegate.

Documentation of monitoring and oversight activities for all delegated entities was reviewed and revealed several minor issues. These included lack of documentation of authorization turnaround times, unclear average resolution timeframe documentation of appeals, etc. These are specified in the "Weaknesses" section below. Onsite discussion and additional information presented confirm that appropriate metrics are monitored.

As indicated in the following chart, all standards in the Delegation section were scored as "Met."

Figure 7: Delegation Findings



Weaknesses

- Documentation of monitoring and oversight activities for all delegated entities was provided. Issues discovered in review of delegation oversight documentation include:
  - Oversight documentation for OptumHealth contains no evidence that authorization turn-around times are monitored.
  - Oversight documentation for Dental Benefit Providers documented the average resolution time for appeals, but it was unclear if this included only standard appeals or if expedited appeals resolution timeframes were included in this average.
  - Oversight documentation for MTM, Inc. does not indicate that MTM is monitored for compliance with the contractual requirement that transportation requests are authorized and scheduled within 3 business days after receipt of the request. (This applies to the CAN program only).

Recommendations

- Ensure that delegated entity oversight documentation includes all standards for which the health plan is held accountable.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
12040 Regency Parkway, Suite 100, Cary, NC 27518-8597 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

June 6, 2016

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

Dear Ms. Carter:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2016 External Quality Review (EQR) of UnitedHealthcare Community Plan is being initiated. The review will include the MississippiCAN and Mississippi Children's Health Insurance Program (CHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The onsite visit will be conducted at UnitedHealthcare Community Plan's office on **September 12th and September 13th for the MississippiCAN Program** and **September 14th and September 15th for the Mississippi CHIP**.

In preparation for the desk review, the items on the enclosed **MississippiCAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **July 8, 2016**.

Submission of all the desk materials will be different than in the past. This year we have a new secure file transfer website for uploading desk materials electronically to CCME. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will simultaneously be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance.

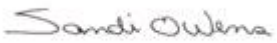
We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site and we have included written desk instructions on how to use the file transfer site as well. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support. Of course, additional information and technical assistance will be provided as needed.

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DOM, to describe the review process and answer any questions prior to the onsite visit, is being offered as well.

Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,



Sandi Owens, LPN
External Quality Review Manager

Enclosure(s)
cc: DOM

UnitedHealthcare Community Plan - MS

External Quality Review 2016 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MSCAN program, 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. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

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

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the MSCAN program. 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 lists 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 for MSCAN 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 MSCAN members.

8. A copy of the current Fraud, Waste & Abuse/Compliance plan for the MSCAN program.

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

10. The Quality Improvement work plans for MSCAN for 2015 and 2016.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program 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 MSCAN 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 MSCAN 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 for the MSCAN program collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities for the MSCAN program 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. Please identify which reviews were conducted for a MSCAN provider.

18. A complete list of all members for MSCAN enrolled in the Care Management program from July 1, 2015 through May 30, 2016. 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. Evidence of any training provided to call center staff on the MSCAN program and changes.

20. A copy of the MSCAN 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 surveys for the MSCAN program with 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 newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the MSCAN program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the MSCAN program.

24. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of July 1, 2015 through May 30, 2016.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements for the MSCAN program.

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

27. Preventive health practice guidelines for the MSCAN program 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. Clinical practice guidelines for the MSCAN program 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.

29. A list of physicians for the MSCAN program currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual for MSCAN program.

31. A sample provider contract for the MSCAN program.

32. 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.

33. A listing of all MSCAN 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.

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

35. 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.
36. All performance measures calculated and required to be reported to the state for the MSCAN program. 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-9/10 and/or 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.

37. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) 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 (<u>including signed Ownership Disclosure Forms</u>) 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. Twenty-five medical necessity denial files for the MSCAN program made in the months of July 1, 2015 through May 30, 2016. Of the 25 requested files, include

five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of July 1, 2015 through May 30, 2016, 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://eqr.thecarolinascenter.org/
- **should be submitted in the categories listed.**

UnitedHealthcare Community Plan - MS

External Quality Review 2016 for Mississippi CHIP

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the CHIP program, 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. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

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

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

5. A complete list of network providers for the Mississippi CHIP members. The lists 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 for CHIP 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 the CHIP members.

8. A copy of the current Fraud, Waste & Abuse/Compliance plan for the CHIP program.

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

10. The Quality Improvement work plans for CHIP for 2015 and 2016.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year 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.).

d. 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.

e. 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.

f. 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 Mississippi CHIP 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 CHIP 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 for the CHIP program collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities for the CHIP program 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. Please identify which reviews were conducted for a CHIP provider.

18. A complete list of all members for CHIP enrolled in the Care Management program from July 1, 2015 through May 30, 2016. 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. Evidence of any training provided to call center staff on the CHIP program and changes.

20. A copy of the CHIP 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 surveys for the CHIP program with 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 newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the CHIP program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the CHIP program.

24. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of July 1, 2015 through May 30, 2016.

25. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements. For the CHIP program. Please also include the letter template used to notify CHIP members that their annual out-of-pocket maximum has been met.

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

27. Preventive health practice guidelines for the CHIP program 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. Clinical practice guidelines for the CHIP program 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.

29. A list of physicians for the CHIP program currently available for utilization consultation/review and their specialty.

30. A copy of the provider handbook or manual for the CHIP program.

31. A sample provider contract for the CHIP program.

32. 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.

33. A listing of all CHIP 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.

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

35. 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.
36. All performance measures calculated and required to be reported to the state for the CHIP program. Required data and information include the following:
    h. 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;
    i. reporting frequency and format;
    j. specifications for all components used to identify the eligible population (e.g., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/10 and/or CPT-4 codes, member months/years calculation, other specified parameters);
    k. if non HEDIS, programming specifications that include data sources such as files/databases and fields with definitions, programming logic, and computer source codes;
    l. 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;
    m. 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;
    n. calculated and reported rates.

37. Provide electronic copies of the following files for the CHIP program:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) 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 (<u>including signed Ownership Disclosure Forms</u>) 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. Twenty-five medical necessity denial files for the CHIP program made in the months of July 1, 2015 through May 30, 2016. Of the 25 requested files, include

five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP program made in the months of July 1, 2015 through May 30, 2016, 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://eqr.thecarolinascenter.org/
- **should be submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Materials provided to members about Advance Directives.

3. A copy of the UM Program Evaluation for 2015.

4. A copy of any policy addressing UHC's inter-rater reliability testing process.

5. A copy of the UCS Annual Milliman IRR SOP.

6. A copy of policy MS Rx 001, MS Pharmacy Benefit.

7. A copy of any policy addressing post-stabilization services and coverage requirements.

8. A copy of DOM approval for scripts and marketing materials used for members or potential members. (A few examples)

9. A copy of policies regarding the False Claims Act, special Investigations Unit and Code of Conduct.

10. Screenshots of decision dates and provider notification dates for UBH approval files #3, 5, 7, and 9.

11. List of OPTUM Credentialing Committee Members with their titles and/or specialty, voting privileges and states represented.

12. For OPTUM credentialing, copy of the OPTUM Mississippi Addendum to the Credentialing Policies, or information OPTUM uses that specifies MS specific credentialing criteria.

13. Please provide an explanation as required or the following documents that were not received as part of the Credentialing Files. Please note the file review has not been completed at time of this release, so additional information may needed for other files.
    a. Alexander, Laura E – Onsite visit not addressed in cred. file;
    b. Chapman, Clyde R –
        i. Application (app) indicated, pg 15, board certification in pediatrics but did not list the specific board information. Indicated yes applied for other boards but none listed. No verification of board certification in file;
        ii. Section XVII, pg 18 of app is not completed and checklist says no info provided for hospital affiliations. Confirm if name Derek Davis written in on the checklist is the admitting physician;

iii. Section III, pg 13, Laboratory Services, not answered on app. Checklist says no info provided for a CLIA number. A note on pg 6 says CLIA missing, but no indication it was collected.
iv. Page 35 shows the survey start date of 2/8/006 and survey complete date of 6/22/2006. Which date was the onsite survey completed?

c. Jackson, Randall –
   i. Checklist pg 3 says unable to obtain DEA and provider who prescribes drugs on his behalf. Pg 15 of app does not indicate a DEA registration. Was this information confirmed?
   ii. NP collaborative agreement was requested on page 6 of checklist but it is not in the file.
   iii. Pg 15, of app indicates American Academy of Nurse Practitioners, expires 2020 for board certification, but cannot tell in file if this was verified.
   iv. CLIA not answered on app, pg 13, and the checklist says no info provided for CLIA. Was this verified?

d. Prather, Susan –
   i. Pg 16 of app indicates American Academy of Nurse Practitioners, expires 2020 for board certification, but cannot tell in file if this was verified.
   ii. Malpractice insurance, pg 43, does not list practitioner as named insured and does not match the insurance listed on the app pg 18.

e. Mallette, Kathryn –
   i. Checklist, pg 4, says the Residency was verified via the AMA Masterfile on 7/29/15 but no proof in the file.
   ii. Onsite visit is not addressed in the file.

14. Please provide an explanation as required or the following documents that were not received as part of the Recredentialing Files. Please note the file review has not been completed at time of this release, so additional information may needed for other files.
    a. Ajagbe, Olukunle - The application, pg 16 indicates no for CLIA but a Yes for CLIA waiver; however the CLIA waiver is not in the file or mentioned on the checklist.
    b. Dial, Christina – Copy of the Medicare Opt Out verification could not be found in the file.
    c. Committee approval letters for recredentialing files were not in the files. Please provide copies of the letters.

15. Provide explanation of how UHC tracks the credentialing/recredentialing process to ensure they are meeting the contract requirements in the *MSCAN Contract, Section 7 E* which requires credentialing all completed application packets within 90 calendar days and within 45 calendar days in cases of network inadequacy. Include copies of reports for the past 6 months.

Materials should be uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org

UnitedHealthcare Community Plan – MississippiCHIP

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. A copy of the 2015 UM Program Evaluation.

3. A copy of any policy addressing UHC's inter-rater reliability testing process for CHIP.

4. A copy of the UCS Annual Milliman IRR SOP.

5. A copy of any policy/procedure that addresses post-stabilization coverage requirements and processes.

6. The 2015 Quality Improvement Program Evaluation for the CHIP program.

7. List of OPTUM Credentialing Committee Members with their titles, voting privileges and states represented.

8. For OPTUM credentialing, copy of the OPTUM Mississippi Addendum to the Credentialing Policies, or information OPTUM uses that specifies MS specific credentialing criteria.

9. Provide explanation of how UHC tracks the credentialing/recredentialing process to ensure they are meeting the contract requirements in the MSCHIP Contract, Section 7 E which requires credentialing all completed application packets within 90 calendar days and within 45 calendar days in cases of network inadequacy. Include copies of reports for the past 6 months.

Materials should be uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN and CHIP
- Member Satisfaction Survey Validation CAN
- Member Satisfaction Survey Validation CHIP
- HEDIS PM Validation CAN
- HEDIS PM Validation CHIP
- NON-HEDIS PM Validation CAN
  - ASTHMA READMISSIONS
  - ASTHMA RELATED ER VISITS
  - CHF RE-HOSPITALIZATION
  - PRE AND POST NATAL COMPLICATIONS
- PIP Validation CAN
  - ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS
  - USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA
  - COMPREHENSIVE DIABETES CARE
  - REDUCING ADULT, ADOLESCENT AND CHILDHOOD OBESITY
- PIP Validation CHIP
  - USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA
  - ADOLESCENT WELL CARE
  - FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS
  - REDUCING ADOLESCENT AND CHILDHOOD OBESITY

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare Community Plan MS CAN and CHIP**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2015
Review Performed	08/2016

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 PURPOSE(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).	**NOT MET**	Desk materials did not contain report offering statement of survey's purpose. According to desk materials, the *2015 QI Program Evaluation* will be provided onsite for surveyor review. ***RECOMMENDATION:*** *Provide program evaluation or other document with clearly stated study objectives.*
1.2	Review that the study objectives are clear, measurable, and in writing.	**NOT MET**	Desk materials did not contain report on study objectives; the *2015 QI Program Evaluation* will be provided onsite for surveyor review. ***RECOMMENDATION*** *Provide program evaluation or other document with clearly stated study objectives.*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Audience for survey findings is identified. Documentation *10a 2015 Provider Satisfaction Survey Results.*

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).	**NOT MET**	No information on reliability was offered in desk materials. ***RECOMMENDATION:*** *Provide documentation of reliability measures.*
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).	**NOT MET**	No information on validity was offered in desk materials. ***RECOMMENDATION:*** *Provide documentation of validity measures.*

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 was clearly identified and submitted in the desk materials. Documentation *10a 2015 Provider Satisfaction Survey Results.* PSS Excel data file.
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:* PSS Excel data file.
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Sampling strategy and process was included in the main documentation of the survey. Documentation *10a 2015 Provider Satisfaction Survey Results.*
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 nonstatistical rationale for sample size which is not consistent with 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.	**NOT MET**	Random sampling was used. Documentation *10a 2015 Provider Satisfaction Survey Results.*

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 survey results document. Documentation *10a 2015 Provider Satisfaction Survey Results.*
4.2	Assess the response rate, potential sources of nonresponse 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 completed surveys was documented. With only 95 completed surveys, the credibility 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	**NOT MET**	Information on quality assurance was not included in desk materials. ***RECOMMENDATION*** *Provide statement of work that delineates quality assurance plan.*
5.2	Did the implementation of the survey follow the planned approach?	**NA**	Planned approach was not provided, thus, unable to judge.
5.3	Were confidentiality procedures followed?	**NOT MET**	Confidentiality procedures were not included in desk materials ***RECOMMENDATION:*** *Provide statement of work that delineates confidentiality procedures.*

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?	**NOT MET**	Survey was not analyzed by the plan. ***RECOMMENDATION:*** *Provide data analysis narrative and summary.*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Survey results were presented with statistical comparisons by the Market Strategies International *Documented:* Provider Satisfaction Results Scorecard
6.3	Were all survey conclusions supported by the data and analysis?	**NA**	Survey was not analyzed by the plan—unable to judge.

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	Provider scorecard and provider sample was submitted as part of the desk materials.
7.2	Identify the technical weaknesses of the survey and its documentation.	Survey documentation was missing pieces of important documentation regarding quality assurance and survey development, sample size calculation and creation, response rate calculation, conclusions drawn from results, and the statement of work. ***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?	Survey findings are not documented in desk materials. However, a score card does reveal a small sample size. ***RECOMMENDATION:*** *Look for new ways and approaches to deliver the survey to help increase the number of responses completed.*
7.4	What conclusions are drawn from the survey data?	A review the committee minutes found the following discussion: Provider Satisfaction Michael Parnell provided a summary report of the 2015 MS CAN Provider Satisfaction Survey Results. Michael advised there was improvement in two domains Timeliness of Information Exchange and Usefulness of Information Exchanged. The scores fell below median range in case management, customer service and overall Image from the prior year. Action items: The low response rate of 6.8% is an obvious limitation of this survey. Michael advised there are meetings occurring to develop actions to increase the number of responses and include a coordinated advertising campaign, engaging the provider advocate team to promote better responses and increase the number of surveys distributed. He pointed out that the provider advocate team has added new positions and the PRISM team is working to improve provider satisfaction. Also, UHN is hoping to implement a simultaneous credentialing and contracting process. Better communication of the disclosure contract limiting the loading process will help out. Jocelyn states this is on everyone's radar, verified there is an action plan, and suggested regular meetings with the provider advocates and the provider call center. Michael confirmed he meets every other week with the two supervisors of the provider call center. ***RECOMMENDATION:*** Provide a provider survey results summary that offers conclusions that are drawn from the survey.
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 but there is no assessment of the results. ***RECOMMENDATION:*** *Produce a provider survey results summary that offers conclusions that are drawn from the provider scorecard.*
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare Community Plan MS CAN**
Survey Validated	**MEMBER SATISFACTION (CAN PROGRAM)**
Validation Period	2015
Review Performed	08/2016

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 PURPOSE(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 for its standardized purpose. *Documented:* DSS Research *2015 CAHPS 5.0 Member Survey Report* June 2015 for MS CAN Adult Medicaid
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses CAHPS for its standardized objectives. *Documented:* DSS Research *2015 CAHPS 5.0 Member Survey Report* June 2015 for MS CAN Adult Medicaid
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:* DSS Research *2015 CAHPS 5.0 Member Survey Report* June 2015 for MS CAN Adult Medicaid

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 administrated Vendor: DSS Research
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 administrated Vendor: DSS Research

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:* Full report from DSS Research
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:* Full report from DSS Research
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Full report from DSS Research
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:* Full report from DSS Research
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:* Full report from DSS Research

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:* Full report from DSS Research
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	The results met the minimum number of responses considered by NCQA necessary for a valid survey, 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 and strategies to increase response rate have been included in the final report recommendations. *Documented:* Full report from DSS Research

ACTIVITY 5: REVIEW THE SURVEY IMMPLEMENTATION

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 2015, Volume 3: Specifications for Survey Measure.* *Documented:* Full report from DSS Research
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:* Full report from DSS Research
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documented:* Full report from DSS Research

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:* Full report from DSS Research
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Full report from DSS Research
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Full report from DSS Research

ACTIVITY 7: DOCUMENT THE EVALUATION 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. DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report. All measures are compared to the 2014 quality compass average and the 2015 UHC adult Medicaid average.
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?	Response rate was below the response rate target (see Element 4.2 for recommendations).
7.4	What conclusions are drawn from the survey data?	Customer Service, treated with courtesy/respect, is an important item on which the Plan received below average performance ratings. Improvements in this area could have a large impact on the overall health plan rating. Since the performance of the health care overall measure has a large impact on the health plan, focusing on this measure is another opportunity for improvement. MSCAN Adult program significantly improved on the overall health plan rating compared to last year and the year before. - Almost eight out of ten (78.14%) gave their health plan an overall rating of 8, 9 or 10 on a 0 to 10 scale, which is significantly larger proportion than last year, but not significantly different from two years ago. Significant improvements were seen on the following overall ratings and composite scores compared to last year and two years ago: - Rating of Health Care - Rating of Personal Doctor - Getting Needed Care Also, compared to two years ago, a significant improvement was seen on the following composite: *How Well Doctors Communicate* *Documentation:* 08 2015 MSCAN CAHPS results 8.3.15
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 assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in QMC meeting minutes.
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare Community Plan MS CHIP**
Survey Validated	**MEMBER SATISFACTION (CHIP/ CCC)**
Validation Period	2015
Review Performed	08/2016

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 PURPOSE(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 for its standardized purpose. *Documented:* DSS Research *2015 CAHPs 5.0 Member Survey Report* June 2015
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Uses CAHPS for its standardized objectives. *Documented:* DSS Research *2015 CAHPs 5.0 Member Survey Report* June 2015
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:* DSS Research *2015 CAHPs 5.0 Member Survey Report* June 2015

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 administrated vendor: DSS Research
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 administrated vendor: DSS Research

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:* Full report from DSS Research
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:* Full report from DSS Research
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Full report from DSS Research
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:* Full report from DSS Research
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:* Full report from DSS Research

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:* Full report from DSS Research
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	The results met the minimum number of responses considered by NCQA necessary for a valid survey, 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 and strategies to increase response rate have been included in the final report recommendations. *Documented:* Full report from DSS Research

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 2015, Volume 3: Specifications for Survey Measure.* *Documented:* Full report from DSS Research
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:* Full report from DSS Research
5.3	Were confidentiality procedures followed?	**MET**	Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documented:* Full report from DSS Research

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:* Full report from DSS Research
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Full report from DSS Research
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Uses standard CAHPS for measurement via a certified vendor. *Documented:* Full report from DSS Research

ACTIVITY 7: DOCUMENT THE EVALUATION 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. DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report. All measures are compared to the 2015 UHC child Medicaid without CCC average (2015 Gen. Pop. Avg.) and the 2015 UHC child Medicaid with CCC average (2015 CCC Pop. Avg.).
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?	Response rate was below the response rate target (see Element 4.2 for recommendations).
7.4	What conclusions are drawn from the survey data?	CHIP child program performed similar to last year. - Almost 9 in 10 (86.19%) of the general population gave their health plan an overall rating of 8, 9 or 10 on a 0 to 10 scale, which is similar to last year. - Almost nine 9 out of 10 of the child CCC gave their health plan an overall rating of 8, 9 or 10 on a 0 to 10 scale, which is similar to last year. Gap analysis is the difference between the maximum possible mean score and the actual mean score received. The gap was closed compared to last year on all the following measures: • Rating of health plan • Rating of health care • Rating of personal doctor • Rating of specialist • Getting needed care composite • Getting care quickly composite • How well doctors communicate composite However, the gap increased on this measure: • Customer service composite *Documentation:* 08a 2015 CHIP CAHPS results 7.28.15
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).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in QMC meeting minutes and CAHPS results document. *Documentation:* 08a 2015 CHIP CAHPS results 7.28.15
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR PM Validation Worksheet

Plan Name	**UnitedHealthcare Community Plan MS CAN**
Name of PM	**HEDIS MEASURES**
Reporting Year	2015
Review Performed	08/2016

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2016

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation (10)	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. Review requirements for documentation have been met.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator (10)	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. Review requirements for documentation have been met.
D2. Denominator (5)	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. Review requirements for documentation have been met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator (10)	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. Review requirements for documentation have been met.
N2. Numerator (5)	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, ICD-10, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
N3. Numerator–Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
N4. Numerator–Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
N5. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling (5)	Sample was unbiased.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
S2. Sampling (5)	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
S3. Sampling (5)	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting (10)	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
R2. Reporting (5)	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	**5**	**MET**	**5**
N4	**5**	**MET**	**5**
N5	**5**	**MET**	**5**
S1	**5**	**MET**	**5**
S2	**5**	**MET**	**5**
S3	**5**	**MET**	**5**
R1	**10**	**MET**	**10**
R2	**5**	**NA**	**NA**

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

Plan's Measure Score	**80**
Measure Weight Score	**80**
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 MS CHIP**
Name of PM	**HEDIS MEASURES**
Reporting Year	2015
Review Performed	08/2016

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2016

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G2. Documentation (10)	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. Review requirements for documentation have been met.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D3. Denominator (10)	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. Review requirements for documentation have been met.
D4. Denominator (5)	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. Review requirements for documentation have been met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N6. Numerator (10)	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. Review requirements for documentation have been met.
N7. Numerator (5)	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, ICD-10, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
N8. Numerator–Medical Record Abstraction Only (5)	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
N9. Numerator–Hybrid Only (5)	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
N10. Numerator Medical Record Abstraction or Hybrid (5)	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S4. Sampling (5)	Sample was unbiased.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
S5. Sampling (5)	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
S6. Sampling (5)	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R3. Reporting (10)	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software. Review requirements for documentation have been met.
R4. Reporting (5)	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	**5**	**MET**	**5**
N4	**5**	**MET**	**5**
N5	**5**	**MET**	**5**
S1	**5**	**MET**	**5**
S2	**5**	**MET**	**5**
S3	**5**	**MET**	**5**
R1	**10**	**MET**	**10**
R2	**5**	**NA**	**NA**

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

Plan's Measure Score	**80**
Measure Weight Score	**80**
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 MS CAN**
Name of PM	**ASTHMA READMISSIONS**
Reporting Year	2015
Review Performed	9/2016

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 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).	**MET**	Appropriate ICD-9 and ICD-10 codes are included in logic.
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**	Measure reported accurately.
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	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	5	MET	5

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

Plan's Measure Score	**55**
Measure Weight Score	**55**
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 MS CAN**
Name of PM	**ASTHMA RELATED ER VISITS**
Reporting Year	2015
Review Performed	9/2016

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 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 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 logic does not appear to include the following codes: 99202,99203,99204,99205, 99211,99212,99213,99214,99215. The following code is included in the logic but should be omitted: 99281. **RECOMMENDATION:** Fix source code to align with 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**	Identified issues should be fixed to ensure compliance with specifications. **RECOMMENDATION:** Fix issues and recalculate 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

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.

CCME EQR PM Validation Worksheet

Plan Name	**UnitedHealthcare Community Plan MS CAN**
Name of PM	**CHF RE-HOSPITALIZATION**
Reporting Year	2015
Review Performed	9/2016

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 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 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).	**MET**	Data table with ICD9 and ICD10 codes were provided. Logic includes all necessary 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?	**MET**	Measure was accurately reported.
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	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	5	MET	5

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

Plan's Measure Score	55
Measure Weight Score	55
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 MS CAN**
Name of PM	**PRE AND POST NATAL COMPLICATIONS**
Reporting Year	2015
Review Performed	9/2016

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 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).	**MET**	The performance measure numerator adhered to all numerator 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 was 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**	Measure was reported accurately.
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	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	5	MET	5

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

Plan's Measure Score	55
Measure Weight Score	55
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 PIP Validation Worksheet

Plan Name:	**UnitedHealthcare Community Plan MS CAN**
Name of PIP:	**ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	CVD is the leading cause of death in MC and accounts for 41% of the deaths in MS.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is 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**	Measure is related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
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**	Sampling is not used for this PIP.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling is not used for this PIP.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling is not used for this PIP.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage using HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Analyses were conducted yearly, although data analysis was documented as once a quarter only. **Recommendation:** Document that analyses are conducted yearly and quarterly in data analysis cycle section.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	Rates for all measures were presented in a table in a concise and clear manner. In the Results Table, the time period measurement of 1-1-2013 to 12-31-2013 was labeled as HEDIS 2013. **Recommendations**: Correctly label the time period measurement years to assist with accurate results interpretation.
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**	Repeat measurements were presented.
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**	Conclusions were offered and revisions were made to increase success.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Yes, general improvement was documented for measure.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical tests were conducted and showed that some improvements were statistically supported and others were not. However, rates are increasing and statistical testing is not required when sampling is not utilized to show increase is true improvement.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement was demonstrated through repeated measurements over annual time periods.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	0
3.2	1	1		8.2	10	5
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	1	1
Step 6				Step 10		
6.1	5	5		10.1	5	5
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	86
Project Possible Score	96
Validation Findings	90%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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 MS CAN**
Name of PIP:	**USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	There are a significant percentage of members in MS that have an asthma diagnosis.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Partially Met**	The research question does not specify how each measure is applicable to outcomes. **Recommendation:** Re-write the research question to clarify how medication management is related to pharmacy claims data.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measure is related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
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**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage using HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Analyses were conducted yearly, although data analysis was documented as once a quarter. **Recommendation:** Document that analyses are conducted yearly and quarterly in data analysis cycle section.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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**	There was an increase in rates over time.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up	**Met**	Conclusions were offered and revisions were made to increase

Component / Standard (Total Points)	Score	Comments
activities were planned as a result? **(1)**		success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Yes, improvement was documented.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Used the population, so increases in rates are considered accurate.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Yes, improvements were shown over time.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	5		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	0
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	5	5
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	85
Project Possible Score	95
Validation Findings	90%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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 MS CAN**
Name of PIP:	**COMPREHENSIVE DIABETES CARE**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B. Measures #5 and #6 have been retired.
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**	Measure is related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
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**	CDC HEDIS specifications for determining sample size were used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	CDC HEDIS specifications for determining sample size were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	CDC HEDIS specifications for determining sample size were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage using HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Analyses were conducted yearly, although data analysis was documented as once a quarter. **Recommendation:** Document that analyses are conducted yearly and quarterly in data analysis cycle section.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	Rates for all measures were presented in a table in a concise and clear manner. HEDIS 2012 rates are not of relevance to the study; so, chi square analyses should not be conducted to compare HEDIS 2012 to HEDIS 2013 since HEDIs 2013 is considered the baseline. Comparison goal rates are not explained in documentation. **Recommendations**: Remove documentation of HEDIS 2012 values and omit chi square analyses of comparison between HEDIS 2012 and HEDIS 2013.

Component / Standard (Total Points)	Score	Comments
		Explain basis for comparison goal rates for each measure.
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**	Repeat measurements were presented.
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**	Conclusions were offered and revisions were made to increase success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Yes, general improvement was documented for all measures.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical tests were conducted and showed that some improvements were statistically supported and others were not. However, rates are increasing.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement was demonstrated through repeated measurements over annual time periods.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	0
3.2	1	1		8.2	10	5
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	5	5		9.2	1	1
5.2	10	10		9.3	5	5
5.3	5	5		9.4	1	1
Step 6				Step 10		
6.1	5	5		10.1	5	5
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	106
Project Possible Score	116
Validation Findings	91%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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 MS CAN**
Name of PIP:	**REDUCING ADULT, ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	MS is the most obese state in the country.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Data were analyzed yearly, whereas the data analysis plan indicates quarterly. **Recommendation:** Document that analyses are conducted yearly and quarterly in *Section C.4. Data Analysis Cycle*.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	Results for annual rates and quarterly rates are presented clearly. The comparison goal rates were not explained in the documentation. **Recommendation:** Add justification and sources for comparison goal rates to 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**	Repeat measurements are recorded.
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**	Conclusions were offered and follow-up plans were documented.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent starting in HEDIS 2013 measurement year.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement is occurring for Measure 1, Measure 2a, and Measure 2c. Measure 2b has remained the same for the past three years.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Improvement from year to year is statistically significant for a majority of the remeasurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Partial Met**	Improvement was sustained for Measure 1 and Measure 2c. Measures 2a and 2b have remained the same or decreased since last measure. **Recommendation:** Focus efforts on interventions that will impact on documentation of measuring BMI percentile rates as well as nutrition counseling.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	0
3.2	1	1		8.2	10	5
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	5	5		9.2	1	1
5.2	10	10		9.3	5	5
5.3	5	5		9.4	1	1
Step 6				Step 10		
6.1	5	5		10.1	5	2
6.2	1	1		Verify		
6.3	1	1				

Project Score	103
Project Possible Score	116
Validation Findings	89%

CONFIDENCE IN REPORTED RESULTS

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 MS CHIP**
Name of PIP:	**USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Asthma is the most common chronic disease among children under the age of 18. Prevalence in MS is 10.4% for children ages 0 - 17.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Partially Met**	Research question is not clearly stated. Adding more information on how medication management and appropriate use are measured would allow the reader to understand the question more readily. **Recommendation:** Re-write the research question to clarify how medication management and appropriate use are separately measured to allow for reader clarification on how both are being addressed in the PIP.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measure is related to health status.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.
STEP 5: Review Sampling Methods		
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**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage using HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Not Met**	Results are conducted for yearly data although the data plan indicates quarterly data analysis. **Recommendation**: Revise data analysis plan to reflect all analyses both quarterly and yearly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.

Component / Standard (Total Points)	Score	Comments
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**	There was an increase in rates over time.
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**	Conclusions were offered and revisions were made to increase success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Yes, improvement was documented.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Yes, improvements were shown over time.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	5		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	0
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	5	5
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	85
Project Possible Score	95
Validation Findings	90%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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 MS CHIP**
Name of PIP:	**ADOLESCENT WELL CARE**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	HEDIS rate for AWC is below the NCQA benchmark.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in Section B.
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**	Measure is related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in the Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Baseline data are the only data available at this time, and were presented for the year and for each quarter, as documented in the plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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)**	**NA**	Baseline data only.
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**	Conclusions were offered and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement in rates is occurring.
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**	Yes, improvement appears to be results of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Too early to judge.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge. Only one full year of data collected.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	NA	NA
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	5	5		9.2	1	1
5.2	10	10		9.3	5	5
5.3	5	5		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	NA	NA
6.2	1	1		Verify		
6.3	1	1				

Project Score	**109**
Project Possible Score	**109**
Validation Findings	**100%**

HIGH CONFIDENCE IN REPORTED RESULTS

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 MS CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	There is lack of performance improvement for Medicaid plans in mental health aftercare.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
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**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Baseline data are the only data available at this time; and were presented for the year and for each quarter as documented in the plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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**	Initial and repeat measurements are documented. Statistical analysis was conducted.
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**	Conclusions were offered and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement in rates is occurring, although the most recent measure for the 7 day follow-up decreased from the previous year.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Not Met**	The most recent comparisons for both measures were not

Component / Standard (Total Points)	Score	Comments
		significant from Remeasurement 3 to Remeasurement 4 as one measure had a decrease instead of increase. **Recommendation:** Implement plan of action to increase rates more substantially.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Not Met**	Rate increased steadily, but then declined from Remeasurement 3 to Remeasurement 4 for the 7 day follow-up measure. **Recommendation:** Continue to track data to ensure rates improve and revise interventions if necessary.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6	41	
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2	7			Step 7	52	
2.1	10	10		7.1	10	10
Step 3	17			Step 8	62	
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4	28			8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9	79	
Step 5	34			9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	1	0
Step 6				Step 10	91	
6.1	5	5		10.1	5	0
6.2	1	1		Verify	96	
6.3	1	1				

Project Score	90
Project Possible Score	96
Validation Findings	94%

HIGH CONFIDENCE IN REPORTED RESULTS

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 MS CHIP**
Name of PIP:	**REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	2015
Review Performed:	2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	MS is the most obese state in the country.
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**	The plan addresses a key aspect of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was the intended population.
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in data collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data sources were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that will be used to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Baseline data are the only data available at this time and were presented for the year and for each quarter, as documented in the plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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)**	**NA**	Baseline data only.
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**	Conclusions were offered and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement in rates is occurring.
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**	Yes, improvement appears to be the result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Too early to judge.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge. Only one full year of data collected.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				**Step 6**		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				**Step 7**		
2.1	10	10		7.1	10	10
Step 3				**Step 8**		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	NA	NA
4.1	5	5		8.4	1	1
4.2	1	1		**Step 9**		
Step 5				9.1	5	5
5.1	5	5		9.2	1	1
5.2	10	10		9.3	5	5
5.3	5	5		9.4	NA	NA
Step 6				**Step 10**		
6.1	5	5		10.1	NA	NA
6.2	1	1		**Verify**		
6.3	1	1				

Project Score	**109**
Project Possible Score	**109**
Validation Findings	**100%**

HIGH CONFIDENCE IN REPORTED RESULTS

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.*

D. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CAN**
Review Performed:	2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					UnitedHealthcare (UHC) has a comprehensive list of policies and procedures. *Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures*, describes the process used to adopt policies and conduct reviews on an annual basis. Policies can be local, United Behavioral Health policies, Optum policies, and national policies. Some include Mississippi addenda with state specific information. It is noted that some external policies adopted by UHC do not include the most recent review or revision dates or the line of business applicable (CHIP or CAN). Reference *UHC Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures*. ***Recommendation:*** *Ensure the date of the last review or revision and the business line impacted is documented on all policies and procedures.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						UHC has sufficient staff in place to ensure the provision of benefits and services to all enrollees.
1.1 *Full-Time Chief Executive Officer;	X					Jocelyn Chisholm Carter serves as Chief Executive Officer for United Healthcare Community Plan of Mississippi.
1.2 *Chief Operations Officer;	X					Mitch Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Sharon Sanger Estess is the CFO.
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					Mike Rogers is Manager of Information Technology. Most IT functions are conducted at the national level.
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					J. Michael Parnell is Director Network Strategies. Nicole Tucker is Director Provider Services Call Center and Morgan Jones is Provider Relations Manager.
1.6.1 *Provider credentialing and education;	X					The National Credentialing Center is responsible for credentialing providers. Provider education is conducted by Provider Relations in collaboration with other departments. UHC has developed a national model called PRISM to support provider relationships and analyze the root cause for provider disputes in order to attain complete and timely resolutions and prevent future problems.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 *Member Services Manager;	X					Royal Walker is the Member Services and Community Outreach Director.
1.7.1 Member services and education;	X					Community Outreach Specialists conduct member education and wellness events on a variety of subjects throughout the year.
1.8 Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals;	X					Rachel Clark oversees the grievance process and Dawn Stover addresses community and state appeals.
1.9 Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions;	X					Latrina McClenton is Utilization Management/Health Services Director.
1.9.1 *Medical/Care Management Staff;	X					Care management staff may include complex care managers, practice care managers, clinical social workers, RNs, LPCs, and Community Healthcare Workers.
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.
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 serves as Chair of the Credentialing Committee;	X					Dr. David Williams serves as Chief Medical Officer. He is supported by an Associate Medical Director, Behavioral Health Medical Director, pre-service, and inpatient review physicians. Dr. Williams is board certified in Internal Medicine and licensed in Mississippi. He sits on the National Credentialing Committee, Quality Management Committee, Provider Advisory Committee, and the Healthcare Quality and Utilization Management Committee. Other physicians include Behavioral Health Practitioners and Pediatricians. The UHC Plan of Mississippi organization chart and UHC Mississippi Medical Directors organization chart contain discrepancies with some names appearing on one chart but not the other.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: *Reconcile the organization charts with an accurate representation of medical directors making decisions for the Mississippi plan.*
1.13 Fraud and Abuse/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 serves as the Compliance Officer for UHC. He chairs the Compliance Committee and is the primary point of contact for the Division of Medicaid (DOM). The organization chart depicts the Compliance Officer reporting directly to the CEO. The Compliance Officer maintains open lines of communication with staff and tracks annual compliance training.
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*, encompasses how UHC ensures current job descriptions define qualifications and competencies required and any required licensure and certification in accordance with corporate policies, accreditation requirements and applicable laws.
4. A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week.	X					NurseLine[SM] Services are available via a toll-free number 24 hours a day, seven days a week and is staffed by experiences registered nurses. In the case of Behavioral Health services, members have access twenty-four (24) hours, seven (7) days per week to clinical personnel who act within the scope of their licensure to practice a Behavioral Health-related profession.
I. C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					UHC has implemented policies and procedures to meet the MS DOM requirements for claims processing, and regularly exceeds those requirements by processing 100% claims almost every month. Additionally, UHC's leadership team reviews monthly claims statistics to gauge current processing performance and to identify trends that may need investigating.
2. The CCO tracks enrollment and	X					UHC monitors member attributes throughout the IT systems used for the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
demographic data and links it to the provider base.						Mississippi Coordinated Access Network (CAN) program. The program considers the state provided 834 files as the primary source of member enrollment status and processes the files daily to ensure enrollment accuracy. As part of the ISCA, UHC provided documentation covering the data collection points, data processing systems, monitoring points, and reporting systems used to service the CAN program. The details within the provided documentation indicate that UHC's systems are capable of collecting, tracking, and monitoring the member demographics required by the *CAN Contract*.
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					UHC consolidates CAN member, enrollment, provider, provider specialty, claims, pharmacy, vision, dental, and lab data into a dedicated reporting system on a monthly basis. The program uses member data alongside National Committee for Quality Assurance (NCQA) certified software to generate HEDIS and other state required reports. The policies, procedures, and reports provided indicate that UHC is capable of meeting reporting and quality improvement requirements specified for the CAN program.
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 and Business Continuity Plan in place for the systems that service the CAN program. Table top testing disaster recovery exercises were last performed in March of 2016. The disaster recovery (DR) test results provided note that the test met UHC's DR requirements and no variances were identified. The results also state that any issues or enhancements will be recorded to an internal UHC SharePoint system. No issues or enhancements were reported as part of the ISCA. Disaster recovery test results state that recovery exercises were completed successfully and without issue, but there was not much documentation provided to validate these claims. CCME requested additional information from UHC; however, the request was declined. UHC stated the results of the testing are considered proprietary and confidential. ***Recommendation:*** *It is recommended that UHC develop a way to provide adequate information for evaluating the results of disaster recovery testing.*
I D. Compliance/Program Integrity						
1. The CCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard	X					A comprehensive Fraud and Abuse Compliance Plan is in place for UHC Mississippi that meets federal and state requirements. Fraud, waste and abuse and general compliance training is required for all UnitedHealth

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
against fraud and abuse.						Group and UHC Government Programs employees as well as contractors who perform services on behalf of Medicare and Community & State. The False Claims Act Compliance policy for UnitedHealth Group was submitted onsite. The UHC Fraud Plan, Mississippi Addendum, details state specific requirements for reporting and cooperating with DOM investigations of fraud, waste and abuse. The *Member Handbook*, page 49, gives a brief statement about fraud and abuse and provides a toll free number, 866-242-7727. The hotline informs callers that the call may be recorded and reports of fraud, waste, and abuse can remain anonymous. The 2015 Fall member newsletter listed the number to Member Services (877-743-8731) for members to report fraud and abuse which would not allow for anonymous reporting. The *Provider Administrative Guide*, pages 7 and 45, provides a number for providers to report fraud and abuse: 877-743-8734. The provider is not informed that reports can be made anonymously. Also, the provider is required to report their tax ID prior to speaking with anyone, which eliminates the possibility of anonymity. This number is listed throughout the *Provider Administrative Guide* as the number to call for Provider Services and does not appear to be a hotline to report fraud and abuse. See the *CAN Contract, Section 11 (B) (3),* and the *UHC Compliance Plan*. ***Recommendation:*** *Ensure the fraud, waste, and abuse hotline phone number in the CAN Provider Administrative Guide is accurate and allows for anonymous reporting if desired.*
2. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					UHC has developed a Compliance Committee and Charter that includes the following: the purpose of the committee, membership, the frequency of meetings, quorum; and requirements for attendance. A quorum is defined as 51 percent of the designated members present. Attendance at Compliance Committee meetings from July 2015 through March 2016 revealed that one member attended only two meetings and another member attended only one. The committee charter states a designated member may appoint a delegate to attend on their behalf; however this is not documented in the minutes and it appears UHC does not follow the process in the charter for replacing inactive members. ***Recommendation:*** *Note in the Compliance Committee meeting minutes if*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						an attendee is replacing a designated member for that meeting and follow the process outlined in the charter for replacing inactive members when possible.
I E. 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					UHC has a Code of Conduct within the Compliance Plan. It requires employees to sign an acknowledgement that attests to confidentiality and compliance with UHC's Code of Conduct upon hire and annually thereafter. UHG policy 3A, Personal Security, states a confidentiality agreement must be in place before a person is permitted access to confidential and/or protected information. Employees and providers are checked monthly for exclusion from participating in federal and state programs. Policies are in place that guide the release of member records and the Notice of Privacy Practices can be found in the Member Handbook.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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				The *UnitedHealthcare (UHC) Credentialing Plan 2015–2016* addresses the credentialing and recredentialing processes and guidelines for licensed independent practitioners and facilities. Specific credentialing criteria for Mississippi (MS) are detailed in a rider. Aperture conducts the primary source verification. The *Optum Physical Health Credentialing Risk Management Program 2016* and several policies address the credentialing/recredentialing requirements for the *Optum* behavioral health network. An addendum to the credentialing policies addresses MS specific criteria; however, this information is not addressed in the *Optum Physical Health Credentialing Risk Management Program 2016, page 32, Attachment B, State Specific Requirements.* ***Corrective Action:*** *Update the Optum Physical Health Credentialing Risk Management Program 2016 to address MS specific credentialing*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						requirements in Attachment B.
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 Advisory Committee (PAC) is chaired by Dr. David Williams, and voting members of the committee include ten network providers with various specialties of pediatrics, psychiatry, dentistry, OB/GYN, internal medicine, family medicine and emergency medicine. Additional staff attends the meetings as non-voting guests. The committee chair votes in case of a tie and a review of committee minutes show that a quorum of at least 51% of the voting committee members is established at the beginning of each meeting. A report of the providers credentialed by the National Credentialing Committee (NCC) is presented at each quarterly PAC meeting. Detailed reports by month are also provided. However, the PAC only reviews reconsiderations and is not involved in the initial credentialing or recredentialing decisions. The National Credentialing Committee performs credentialing/ recredentialing for all lines of business and is the decision-making committee for the MS credentialing process. Decisions made by the NCC are reported to the PAC on a quarterly basis. The NCC is chaired by two physicians that do not have voting privileges. The voting members include 15 licensed independent practitioners (LIPs) with specialties such as pediatrics, obstetrics & gynecology, internal medicine, cardiology, surgery, podiatry, and family practice that are located in various states. Additional non-voting members include the Market Medical Directors that attend meetings periodically. The following concerns were noted: • Only 7 to 8 voting LIPs of the NCC are invited to each NCC meeting and a quorum is determined from a majority of LIPs that attend the particular meeting. This process is in direct conflict with the *UHC Credentialing Plan 2015-2016* for determining a quorum at the NCC meetings. The plan states that a quorum requires at least 51% of the LIP NCC membership to be present. A review of NCC minutes indicated decisions were made at the following meetings with only six voting LIPs in attendance: 1/6/16, 9/16/15, 9/21/15, and 8/15/15. • NCC committee meeting minutes do not notate the absent voting members of the committee. A few committee meetings mentioned one or two names, but since all committee members are not invited to each

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						meeting, the information is inaccurate. • In the 14 NCC meeting minutes reviewed, Dr. David Williams was listed as only attending three meetings (1/6/16, 9/16/15, & 10/21/15). • The NCC is the credentialing decision-making committee and there is no representation of MS LIPs on the committee. As mentioned in the previous *2015 EQR*, the process UHC follows for credentialing and recredentialing of MS providers is of concern. Credentialing and recredentialing decisions are not made by MS providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *CAN Contract, Section 1 L*. ***Corrective Action:*** *The NCC should invite all LIP voting committee members to meetings and follow the UHC Credentialing Plan 2015-2016 for determining a quorum. Committee minutes should notate absent voting members. Credentialing/recredentialing decisions need to be made by a MS Credentialing Committee made up of UHC MS network providers and chaired by the MS Medical Director as required by the CAN Contract, Section 1 L.*
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 for the most part contained appropriate information. The credentialing files included queries for the Social Security Death Master File (SSDMF), Medicare Opt Out, and the National Plan and Provider Enumeration System (NPPES). The section that follows contains recommendations made as a result of the file review. The overall condition of the credentialing/recredentialing files should be addressed as many of the screen shots in the files were hard to read or unreadable and some of the queries did not contain dates of when the query was conducted. In addition, in some cases the query date listed in the Aperture primary source verification section of the file did not match the date the query was performed as indicated in the screen shot of the query. ***Recommendation:*** *UHC should improve the overall condition of the credentialing/recredentialing files to ensure all information in the file is readable and dates in the Aperture primary source verification section of the files are consistent with the date the queries were performed.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					For one nurse practitioner file, the Aperture information stated “unable to obtain DEA and provider who prescribes’ drugs on his behalf,” and the application did not have the DEA section answered. UHC responded that verbal verification was given stating the provider that was covering for hospital admittance was also covering for the DEA, but this was not indicated in the file. Other files were appropriately documented. ***Recommendation:*** *Ensure information that is verbally verified is indicated in the file, i.e. verification of no DEA license for a nurse practitioner when the DEA license section was not completed on the application.*
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					For one file, the proof of malpractice insurance did not reflect the name of the provider as being insured; however, the other files reviewed were appropriately documented. ***Recommendation:*** *Ensure the proof of malpractice insurance reflects the name of the provider being credentialed.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					One credentialing file did not have proof of the CLIA but other files reviewed were appropriately documented. UHC stated verbal verification had been performed and that coaching had been provided to the processor to collect this information. ***Recommendation:*** *Ensure CLIA certificates and/or waivers are collected if the applicant indicates they provide laboratory services. If the application section for the CLIA has not been completed by the applicant, a verbal*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						verification to confirm no CLIA certificate or waiver is appropriate, but it must be indicated in the file.
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					Provider office site visits are conducted at initial credentialing for PCPs and OB/GYNs as defined in the *Credentialing Plan State and Federal Regulatory Addendum* for MS. Onsite visits are indicated as being conducted via a screen print in the files showing the date of the onsite visit. One credentialing file showed that a provider office site visit had not been conducted. UHC indicated this was an oversight and that another provider in that practice was in the process of being credentialed and the site visit would be performed. ***Recommendation:*** *Ensure provider office site visits are conducted at initial credentialing for PCPs and OB/GYNs.*
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. The recredentialing files included queries for the Social Security Death Master File (SSDMF), Medicare Opt Out, and the National Plan and Provider Enumeration System (NPPES). One issue is discussed in the section that follows.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
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					
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					
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				One recredentialing file indicated “no” for CLIA, but indicated “yes” for a CLIA waiver; however, there was no information in the file that it was collected or verified. UHC stated they misinterpreted the requirement related to the CLIA and that they were only collecting the CLIA if the provider indicated they had certification. Also, they were not collecting documentation to verify any other type of CLIA documentation. The “Partial Met” score is due to UHC not having the process in place to collect and verify CLIA waivers. ***Corrective Action:*** *Ensure that CLIA waivers are collected/verified if the provider indicates a CLIA waiver has been issued.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					UHC has a process in place to monitor complaints concerning participating physicians and facilities. *Policy Ongoing Monitoring of Office Site Quality* outlines the process for monitoring complaints and referrals concerning participating physician's office site and facilities. This process ensures the information is recorded, investigated, and the appropriate follow up is conducted to assure that members receive care in a safe, clean, accessible, and appropriate environment. *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 a participating physician's office sites and facilities. During the look back period of July 1, 2015 – May 30, 2016, 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*, states that UHC has systems and processes in place to monitor member utilization and the information is communicated using profiles for primary care physicians. Evidence of practitioner profiling reports were received in the desk materials for both CAN and CHIP primary care providers. The reports 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. The *UHC Credentialing Plan 2015-2016* states that during recredentialing, an applicant is subject to review of malpractice history and quality of care/quality of service concerns within the recredentialing cycle. If histories of malpractice claims exceed established thresholds and/or substantiated quality of care concerns are found, the Credentialing Committee will

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						conduct a thorough review of these findings and the applicant may be subject to a denial of recredentialing.
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,* identifies actions that may be taken to improve practitioner performance prior to termination by implementing an improvement action plan (IAP). It also outlines the procedures for suspending or terminating a practitioner's participation in the network and notifying the provider of these actions. Several other policies such as *Imminent Threat to Patient Safety*, *Quality of Care Appeal*, *Quality of Care Investigation*, *Improvement Action Plans*, and *Disciplinary Actions* define the processes for how UHC addresses serious quality of care issues and the process for a provider to appeal.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				The *UnitedHealthcare Credentialing Plan 2015–2016* addresses the credentialing and recredentialing of facilities in Section 7.0. This section does not address the need to collect ownership disclosure forms or the need to collect CLIA information if the facility is billing for laboratory services. A few areas of concern identified with the file review are addressed as follows: • One recredentialing file for a hospital did not have proof of CLIA, SAM or NPPES queries, and did not have proof of malpractice insurance (the Aperture source verification information for malpractice insurance stated the signed and dated application was the verification source). UHC's response stated the facility credentialing process was not line specific. Instead, the overarching process verifies organization exclusion and eligibility for programs during processing, but the same standards for practitioner/provider are not applied specifically to organization profiles. • One credentialing file for a Rural Health Center did not have an ownership disclosure form. UHC's response was that the file had been included incorrectly and that the organization had not responded to request for an ownership disclosure form. However, ownership disclosure forms should be collected for all credentialing/ recredentialing files. Facility credentialing and recredentialing processes should include proof of verification in the files; including proof of malpractice insurance. In addition,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the CLIA certificates/waivers should be collected for facilities that bill for laboratory services and ownership disclosure forms should be collected for all files. ***Corrective Action:*** *The UnitedHealthcare Credentialing Plan 2015 – 2016 or the MS Addendum needs to be updated to include requirements that proof of verification for facilities should be in the files, including proof of malpractice insurance; to collect the CLIA certificate/waiver if the facility bills for laboratory services; and the need to collect ownership disclosure forms for facilities. This information also needs to be reflected in the facility credentialing/recredentialing files.*
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*, defines the procedure for ensuring that UHC notifies PCPs of the enrollees assigned to them, including notification of panel changes, within 5 business days from the date UHC receives the *Member Listing Report* from DOM. UHC makes member panel details available to all participating PCPs via the secure portal. Within 5 days of receiving the *Member Panel Listing Report* from DOM, UHC identifies PCP changes in member panels and mails a post card notification regarding the changes to impacted PCPs.
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 all providers, including out-of-network providers, may call a telephone number on the member ID card to verify enrollment. Participating providers may access member enrollment via the secure online provider portal.
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*, defines the procedure for the management of the PCP membership panel. PCP panels are determined during initial credentialing and/or contracting setup and at that time the PCP can communicate desired restrictions to UHC. For closed panels, no members will be assigned to them. In the event that no restrictions are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						requested, it is understood that the PCP agrees to accept all members as assigned. 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. UHC makes member panel details available to all participating PCPs via the secure provider portal in order to notify providers of panel composition and keep them informed of any changes to their member panels. The online *Provider Directory* specifies whether the provider is accepting new patients.
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 the geographic access standards for the CAN and CHIP programs which complies with the contract guidelines for both of the MS programs. GEO access reports are run quarterly and evidence of the reports were received in the desk materials.
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					The criteria for evaluating specialists are defined in *Policy PS3, Geographic Access Standards,* and comply with contract guidelines. GEO access reports confirm compliance in evaluating the specialty networks. UHC also utilizes *Compass Reports* which include detailed network analysis to identify gaps in care.
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. The reports are delivered each quarter to DOM, as well as the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis purposes.
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					
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The *Compass Report* for the first quarter of 2016 shows that behavioral health is one of the biggest gaps in care for the CAN population due to the lack of providers in the areas of inpatient psychiatric hospitals, psychiatrists, psychologists. Other areas include social workers,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						dermatology, hematology, rheumatology, and 24-hour pharmacies. Onsite discussion confirmed that available providers in the state are constantly monitored and resources are utilized to provide the needed care, even if it is outside of the service area.
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 Standard – Appointment Availability Requirements*, defines the appointment availability requirements for providers contracted by UHC to provide services to members enrolled in the CAN and CHIP programs. The criteria defined in the policy complies with the *CAN Contract* guidelines. The policy states the standards are documented for reference in the *Provider Manual* and reinforced through provider education. Quarterly assessments are performed to gauge the level of compliance among PCPs, OBGYNs, and Behavioral Health providers. Annual assessments are performed to gauge the level of compliance among high-volume specialty providers. These results are submitted to DOM and the UHC Service Quality Improvement Subcommittee for monitoring, tracking, trending, as well as to support the identification of improvement opportunities and the development of corrective action initiatives. UHC utilizes Dial America to make calls to provider offices to assess appointment availability and after-hours access. Results of the first quarter 2016 report for appointment availability showed a large percentage (65.12%) of the behavioral health providers needed corrective action. Results of the other providers included the following results for corrective action: PCPs (19.15%), pediatrics (31.40%), and OB/GYNs (21.43%). The 4th quarter 2015 after hours survey showed that PCPs (45.32%) and behavioral health providers (55.56%) had the highest noncompliance. Onsite discussion revealed that providers receive a letter regarding their noncompliance and are resurveyed. UHC feels that provider staff turnover attributes to the issue of noncompliance. ***Recommendation:*** *Since the Dial America quarterly reports continue to show high percentages of noncompliance for appointment availability and after-hours access, UHC should investigate and implement interventions to address the issue.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 (41%). When compared to last year's results of 49%, this year's study proportion did fall from the previous measure, but statistically it was unchanged. So in both absolute terms and statistically, no improvement was seen. ***Corrective Action:*** *Implement more strategies to ensure provider files are updated in a timely and accurate manner.*
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 it is the policy of UHC to conduct timely outreach to all newly contracted providers in order to provide orientation. A Provider Advocate contacts 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. *The Standard Operating Procedure (SOP) PS11, Provider Orientation Plan Summary & Checklist*, provides checklists for the welcome call and on-site provider orientation.
2. Initial provider education includes:						
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				The following discrepancies were identified between the *CAN Member Handbook* and the *CAN Provider Administrative Guide*: •Page 31 of the *Member Handbook* states prior authorization is needed for durable medical equipment (DME) items over $500 for, but this is not mentioned in the *Provider Administrative Guide*. •Page 32 of the *Member Handbook* for hearing services states prior authorization is required for DME over $500. It also states no prior authorization is needed for testing; but these items are not mentioned in the *Provider Administrative Guide* on page 10. •Page 36 of the *Member Handbook* states a limitation of 58 days coverage per fiscal year for nursing facility services; however, this is not mentioned in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the *Provider Administrative Guide* on page 11. •Page 33 of *Member Handbook* for orthotics & prosthetics states prior authorization is required for DME over $500; however, this is not mentioned in the Provider Administrative Guide on page 11. •Page 12 of the *Provider Administrative Guide* for dental benefits for adults mentions coverage for preventive, diagnostic, and restorative care and orthodontia, which appears is incorrect as these only relate to the children's benefit. The *Member Handbook* for dental adults mentions palliative care on page 31, which is not mentioned in the *Provider Administrative Guide.* ***Corrective Action:*** *Correct benefit discrepancies between the CAN Member Handbook and the CAN Provider Administrative Guide.*
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					
2.7 Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 Prior authorization requirements including the definition of medically necessary;	X					During an onsite discussion, UHC stated that non-participating providers do not have access to the online prior authorization system. So when a non-participating provider needs to submit a request for prior authorization, they must use a participating provider to submit the request through the online prior authorization system. If this is UHC's practice, information should be included in the *Provider Administrative Guide* to educate participating providers that they need to work with non-participating providers in submitting online prior authorizations. ***Recommendation:*** *Include information in Provider Administrative Guide to educate participating providers that they need to work with non-participating providers in submitting online prior authorizations.*
2.12 A description of the role of a PCP and the reassignment of a Member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.		X				*Policy NQM-052, Web-based Network Provider Directory Usability Testing*, defines the procedure for ensuring the web-based *Provider Directory* provides information to members and prospective members that is easy to understand and navigate. It states that new information is updated within 30 days of being received; however, the *CAN Contract, Section 6 E*, states the web-based *Provider Directory* must be updated within five business days upon changes to the provider network. The *2015 QI Program Evaluation,* page 44, states the online *Provider Directory* is updated each night and a print version is produced weekly. A review of the printed *Provider Directory* showed the information is consistent with contract requirements. However, the sample chart at the front of the directory which shows the description of provider listings does not match the information that is displayed for each provider in the directory and needs to be updated. ***Corrective Action:*** *Update policy NQM-052 to reflect the correct timeframe for updating the data in the online Provider Directory. Also, update the paper Provider Directory sample chart (at the front of the directory) that shows the description of provider listings. This chart, should match the information that is displayed for each provider in the directory.*
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, Member benefits, standards, policies, and procedures.	X					The provider website portal provides resource information for daily administration of the plan such as claims information, bulletins, provider forms, clinical practice guidelines, pharmacy program and cultural competency library. The *Provider Administration Guides* are available on the website for both the CAN and CHIP programs and a physician newsletter, *Practice Matters*, is produced several times a year. Training webinars and forums are held periodically as well.
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 local Provider Advisory Committee (PAC) reviews and accepts preventive health practice guidelines that have been reviewed and accepted on a national level by the Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC). The preventive care guidelines and clinical practice guidelines were last updated on May 6, 2016.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO members to providers.	X					*Clinical and Preventive Health Guidelines* are made available to both members and practitioners. To encourage the use of appropriate preventive care, UHC promotes member focused educational programs. These programs are designed to identify at-risk members and involve members and practitioners in the decision-making process. Policy review of *Clinical and Preventive Guidelines* states that on an annual basis, practitioners are notified via mail, fax, or email of the availability of the guidelines on the website. Providers may also request that hard copies of the guidelines be sent to them by contacting the Provider Services Center. When new guidelines are added or current guidelines are revised, UHC notifies providers of the changes in the provider newsletter. The *Provider Administrative Guide* provides information regarding preventive and clinical practice guidelines and lists the website where the information can be found.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and Adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	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					
3.6 Recommendations specific to Member high-risk groups.	X					
3.7 Behavioral Health	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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				The clinical practice guidelines are adopted from nationally recognized, evidence-based clinical criteria and guidelines are integrated into UHC's clinical system. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive care 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 *2016 Clinical Practice Guidelines* document received in the desk materials included two guidelines that are not listed on the website: Dementia, and Violence and Abuse. ***Corrective Action:*** *Ensure the UHC website includes all clinical practice guidelines adopted by the Plan.*
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					The clinical practice guidelines are addressed in the *Provider Administrative Guide* and posted on the website. When new guidelines are added or current guidelines are revised, UHC notifies providers of these changes in the provider newsletter. When a provider demonstrates a pattern of noncompliance with the clinical practice guidelines, the medical director may contact the provider by phone or in person to review the guideline and identify any barriers that can be resolved.
II F. 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 for CAN and CHIP,* defines the process of medical record review to ensure both paper and electronic medical records (EMR) are current and organized to support effective patient care and quality review. Practitioners are informed of medical record standards in the *Provider Administrative Manual* and other ad hoc communication documents. The National Quality Oversight Committee (NQOC) annually reviews and approves medical record documentation standards. Individual health plans are responsible for adding additional medical record requirements, as well as approving the review tools. The record review will be completed annually, unless required more frequently. If standards are not met, improvement action plans will be implemented.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Medical record reviews were conducted in September and October of 2015 for 30 providers with a total of 90 records reviewed. The results showed that only 6 providers out of 30 scored below 100%, with the lowest score at 97%. Results were presented to the February 11, 2016 PAC Committee with comments. One item requiring corrective action was: "Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record." Results showed that 48% had an advance directive and 51% did not. The minutes stated this is an ongoing issue and the Clinical Practice Consultants would be reviewing this item with the providers during Q1 and Q2 visits. The *2016 MSCAN QI Work plan*, 1st Quarter, stated the annual medical record audit would begin around August/September for 2016.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.			X			UHC 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 and was found to not be valid. For the provider satisfaction survey, the low response rate could bias results and not provide reliable information on the population. The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report. It is recommended that UHC implements at least one of the strategies provided in the enclosed final report to increase response rate. ***Corrective Action:*** *Provide information regarding the survey's purpose/objective as well as reliability and validity measures for the survey.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Results were presented to the QMC committee in March 2016.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					*Policy NQM-051, Members Rights and Responsibilities, Attachment A*, and *Rider* to this policy includes: UHC review its *Rights and Responsibilities* information on annual basis, provides the information to new members and providers in respective manuals, and publishes the information annually via newsletters or manuals. UHC makes printed copies of its materials available upon request and offers to publish in another language upon request.
2. Member rights include, but are not limited to, the right:	X					The following rights are found in the *Member Handbook*, the *Provider Administrative Guide*, and the *Rider to Policy NQM-51, Member Rights and Responsibilities*. Additionally, the *Member Rights and Responsibilities* brochure includes these rights.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 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;						
2.7 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;						
2.8 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;						Free exercise of rights and the exercise of those rights do not adversely affect the way the contractor and its provider's treat the member is found in *Policy 4a, Notification of Rights* and the *CAN Member Handbook*.
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						The *Member Handbook* includes the provisions found in *42 CFR § 438.206 – 438.210. The Provider Administrative Guide* and *Policy NQM-051, Member Rights and Responsibilities*, states oral interpretation services available free of charge.
3. Member Responsibilities include the responsibility:	X					Member responsibilities are included in the *Member Handbook* and *Policy NQM-051, Member Rights and Responsibilities*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						
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				*Policy MBR 2a, Information Packets to Members* (Prior to the first day of the month of their enrollment). UHC ensures the information is provided no later than 14 days after the contractor receives notice of the beneficiary's enrollment. Onsite visit discussion confirmed envelopes include the statement "Return Service Requested" as required by the *CAN Contract, Section 4 (D).* Data submitted with the desk materials revealed that on average 1 in 5 members report <u>not</u> receiving New Member kits. Onsite discussion confirmed UHC is attempting several interventions to improve this. UHC makes multiple attempts to correct address errors, confirm addresses with members, and obtain updated information during Welcome calls. Unable to deliver data is tracked and reported. The issues found relating to member education are addressed in the individual standards below.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1 Full disclosure of benefits and services included and excluded in their coverage;						Page 36 of the *Member Handbook* includes a table of services covered and paid for by Medicaid. Hospital Care-Inpatient services are included in the table. Per the *CAN Contract, Section 12 (H), and Section 17*, beginning 12/1/2015, UHC is responsible for inpatient services provided to members. ***Recommendation:*** *Ensure the Member Handbook contains the updated information regarding UHCs responsibility for coverage of inpatient hospitalizations.*
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						Page 21 of the *Member Handbook* states members can get a second opinion from a network provider for any covered benefit. Page 27 states if a member cannot find another network provider for a second opinion, an out-of-network provider with prior authorization can be used at no charge. The information on page 21 is incorrect because it does not include obtaining a second opinion out-of-network or that second opinions are provided at no cost to the member. *Reference Federal Regulation § 438.206.* ***Corrective Action:*** *Update the Member Handbook by removing the misinformation on second opinions from page 21.*
1.2 Limits of coverage and maximum allowable benefits, 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;						The *Member Handbook* includes detailed information on the prior authorization process as well as which services require prior authorization.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						*Policy UCSMM 06.21, Out of Network Requests and Continuing Care,* includes the process of referring members to alternate sources for care and for obtaining out-of-network care.
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 *Member Handbook* explains how members can obtain prescription medications, the preferred drug list (PDL), and how to help the doctor request exceptions to the PDL. Members are directed to the UHC website or Member Services for additional information. Members are informed they can obtain a 3-day temporary supply of medication while awaiting an authorization decision. The *Member Handbook* states there is no copay for any service covered by UHCCP.
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;						Policies in place meet the contract requirements for notifying members in the case of provider termination, changes to the contract, or changes to covered services and benefits.
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;						
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;						The toll-free phone number and TTY access to Member Services is listed throughout the *Member Handbook*. Page 10 of the *Member Handbook* states Member Services is available 7 days a week; however, the hours listed indicate they are available 7 days a week for the first week in every month and 5 days per week thereafter. Nurseline^{SM} is available 24 hours a day, every day. Page 10 of the Member Handbook also lists the features available to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						members when they sign up for myuhc.com, the member portal. Members can print an ID card, complete a health assessment, and download the *Member Handbook* from the member portal. The website features health information for children, parents, and teens via KidsHealth. The website address is found on the Member ID card. UHC utilizes other electronic media such a text messages and is developing an app for members to connect to the UHC Health Plan. ***Recommendation:*** *Update the misleading statement in the Member Handbook regarding availability of Member Services 7 days per week.*
1.13 A description of the EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						Page 50 of the *Member Handbook* describes mandatory and optional enrollee status and the option to change or leave plan within the first 90 days of enrollment. No information is given to members in the *Member Handbook* about the right to request disenrollment for cause at any time and the process for doing this. Reference the *CAN Contract, Section 4 (G, H, I and M).* ***Corrective Action:*** *Update the Member Handbook with information on disenrollment for cause and other reasons for disenrollment as stated in the contract.*
1.15 Procedures for filing complaints/grievances and appeals, including the right to request a Fair Hearing through DOM;						The *Member Handbook* defines a grievance, an action, and an appeal. Members must give written consent for someone to file a grievance or appeal on their behalf. State Fair Hearings and the continuation of benefits are addressed in the *Member Handbook*. Additionally, the *Member Handbook* includes a form members can use to file a grievance or an appeal.
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* states members can obtain information about network doctors such as professional qualifications, medical schools and residency completion, name, address, telephone number, and languages they speak at myuhc.com/CommunityPlan, or by calling Member Services. The website listings and search features are very thorough, meet contract specifications, and include the ability to search by non-English languages

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						spoken by provider's office. *Policy NQM-052, Web-Based Network Provider Directory Usability Testing* states updates occur within 30 days of receiving new information and the online *Provider Directory* is evaluated for accuracy at least once a year.
1.17 Instructions on reporting suspected cases of Fraud and Abuse;						The *Member Handbook* includes a brief paragraph about fraud and abuse and a toll-free hotline phone number for members to report any suspicion of fraud. The UHC website did not appear to have any additional information or the hotline number for reporting fraud. ***Corrective Action:*** *Add a visible link on the UHC website informing members how to report fraud or abuse using the hotline and provide the hotline phone number.*
1.18 Information regarding the Care Management Program and how to contact the Care Management Team;						
1.19 Information about advance directives;						The information in the *Member Handbook* on *Advance Directives* does not include a description of all aspects of advanced care planning including living wills, durable power of attorney for health care, and the process for establishing an advance care plan. *Policy MBR15a, Advanced Directives*, states members are informed of the opportunity for advance care planning *in the Evidence of Coverage (Member Handbook)* and other member documents. Onsite discussion revealed no other document is provided to members on advance directives, except what is found in the *Member Handbook*. This policy also states that UHC informs members that complaints concerning non-compliance with an advanced directive may be filed with the State Survey and Certification Division of the State Department of Health; however, this information is not found in the *Member Handbook*. See the *CAN Contract, Section 5 (K).* ***Corrective Action:*** *Update the Member Handbook and Policy MBR15a, Advanced Directives, to include all aspects of advance directives and the process for obtaining them. Inform members that complaints concerning non-compliance with advance directives may be filed with State Survey and Certification Division of the State Department of Health.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.20 Additional information as required by the contract and by federal regulation.						Per onsite discussion, UHC makes available *Provider Directories* in State Medicaid Regional Offices, the CCO's offices, WIC offices, and upon a member's request. The *Member Handbook* does not include information about the WIC program or include it in a discussion of care management or coordination with other health or social programs. ***Recommendation:*** *Update the Member Handbook to include coordination with community resources such as WIC, IDEA, and Head Start. Reference the CAN Contract, Section 8 (2) (f).*
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					
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					*Policy MBR 7 Member Materials/Sixth Grade Level of Reading Comprehension*, states all written materials provided to members, should not exceed sixth grade level of reading comprehension. UHC utilizes the Flesch-Kincaid Readability Scale. *Policy NCM 011, Cultural Proficiency*, defines prevalent as the predominant language spoken by more than 5 % of members or potential member base. Core marketing and health information materials are translated into that language. *Policy MBR 1a, DOM's Limited English Proficiency* policy states all written information needs to be made available in prevalent non-English languages in the State of Mississippi in a manner that can be easily understood. The *Member Handbook* is written in easy to understand language, and is available in Spanish. Per onsite discussion the *Member Handbook* is available in audio, braille, and electronic versions and informs members about interpreter and translation services available.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5. Member complaints/grievances, denials, and appeals are reviewed to identify potential Member misunderstanding of the CCO program, with reeducation occurring as needed.	X					The *2016 MSCAN QI Program Description* states the review and analysis of complaint, grievance, and appeal data is conducted to: • Monitor, evaluate, and effectively resolve member concerns in a timely manner. • Identify opportunities for improvement in the quality of care or service provided to members. • Identify opportunities for improvement in the appeal and grievance process. • In addition, the action plans to address opportunities for improvement are identified and reported to the National Quality of Care Committee.
6. Materials used in marketing to potential Members are consistent with the state and federal requirements applicable to Members.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					UHC maintains separate toll-free call center lines for Member and Provider services. In the case of Behavioral Health services, members have access 24 hours a day, 7 days a week to clinical personnel who act within their scope of licensure to practice a Behavioral Health related profession. Hours for the Member Services Call Center are 8:00 a.m. until 5:00 p.m. on Monday, Tuesday, Thursday, Friday; and 8:00 a.m. until 5:00 pm Saturday and Sunday the first weekend of the month. Wednesday hours are 8:00 a.m. until 8:00 p.m. Provider Services Call Center hours are 8:00 a.m. until 5:00 p.m. Monday through Friday.
2. Call Center scripts are in-place and staff receives training as required by the contract.	X					*Policy ADM6a, Call Center Scripts*, defines the purpose of scripts are to ensure that customers and providers receive consistent information. Scripts and welcome call content is found in this policy. During the onsite visit, CCME and DOM were provided the opportunity to listen to recorded Member and Provider Call Center calls. Observation confirmed consistent application of the call scripts and courteous interaction with callers. Members are informed that the call may be recorded and have the option to self-identify through a series of questions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						This process enables call center staff to quickly identify the issue and provide assistance. Call scripts are in place for a number of scenarios, including handling crisis and emergency situations. All call scripts are approved by DOM prior to use. According to the *CAN Contract, Section 6 (a) (4),* Member Services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, MississippiCAN, guidelines for transferring calls to care managements, and customer service. UHC submitted a narrative found in folder #19 of the desk materials that states refresher and ongoing training to member services staff is performed on an as needed basis. No policy was found that included the requirement for quarterly trainings or the quarterly submission to DOM detailing the trainings conducted. ***Recommendation:*** *Include in a policy the quarterly training required for Member Services call center staff and the contract requirement to submit information on the trainings conducted.*
3. Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call center activity is monitored for performance by measuring metrics and by the supervisor and the director auditing phone calls on a daily basis. UHC consistently meets *CAN Contract* requirements and internal benchmarks for call metrics on speed of answer and abandonment rates. Onsite discussion confirmed that UHC monitors no less than 3% of calls for compliance with customer care guidelines.
III D. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. 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 within 24 hours of receipt from the State, if a PCP is not provided in the 834 file. Customer service will assist members with a request to change PCPs, make the initial appointment, and arrange for the transfer of medical records to the new PCP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 UHC *Member Handbook* includes abundant information on preventive health services that is very well done. Preventive health care guidelines are provided for men, women, women of childbearing age, and children. Member newsletters sent quarterly stress the importance of preventive care and encourage members to use these services.
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					The *Member Handbook* describes UHC's Healthy First Steps program available to all expectant mothers. Pregnant women are identified during enrollment, through claims data, and case management contacts. Perinatal high risk management services are listed as a benefit in the *Member Handbook*. Case management has the responsibility to inform pregnant members about services available such as WIC. Participation in pre-natal care is monitored through claims and the Department of Health.
4. The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages Members to utilize these benefits.	X					The annual *Quality Improvement (QI) Evaluation* states EPSDT outreach is made to members and their parents/guardians to encourage members to make and keep screening appointments. Outreach includes outbound phone calls, brochures, calendar stickers, and bookmarks, to name a few. Onsite discussion revealed that UHC makes follow-up phone calls for missed appointments and tracks member compliance.
5. The CCO provides educational opportunities to Members regarding health risk factors and wellness promotion.	X					Page 44 of the *Member Handbook* states UHC has many health education programs including: classes to help quit smoking, classes about pregnancy and parenting, and nutrition. Wellness activities are also found in member newsletters and brochures.
III F. 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					The low response rate is a common issue, and in effort to increase the response rate for the *Member Satisfaction Survey*, several strategies have been recommended in the narrative of this report. ***Recommendation:*** *Implement at least 1 of the strategies listed in the report for next year's CAN survey. UHC must submit all incentive award packages to the Division for approval prior to implementation.*
2. The CCO analyzes data obtained from the Member satisfaction survey to identify quality problems.	X					Results were presented to the QMC committee in March 2016.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The CCO reports the results of the Member satisfaction survey to providers.	X					Results were communicated to providers in *MS Summer 2016 Practice Matters*.
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 were presented to the QMC committee in March 2016 and action plans as per the CAHPS Task Force were documented.
III G. 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 processes for handling complaints and grievances.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;	X					UHC maintains a log of member and provider complaints and grievances. Complaints can be received orally or in writing and are of a less serious or formal nature. The log documents date and time of receipt. These complaints resolved within 1 business day to the satisfaction of the complainant do not require a formal written response or notice. If not resolved within 1 business day, it is considered a grievance. *Policy AG-01 and United Behavioral Health Complaints and Grievances* policy defines a grievance as an expression of dissatisfaction about any matter or aspect involving the contractor or its operation, other than a contractor action. The *Member Handbook a*nd *Provider Directory* use the same definition for a grievance. The policy, *Member Handbook* and *Provider Administrative Guide* meet contract requirements. All documents include who may file a grievances and that written consent is needed from the member for anyone to file a grievance on their behalf.
1.2 The procedure for filing and handling a complaint/grievance;		X				Grievances may be filed orally or in writing. The *Member Handbook* contains a toll-free number as well as a form for members to submit a grievance. UHC will assist members as needed and provide interpretation service as required. This information is also found in the policy and the *Provider Administrative Guide*. Regarding the acknowledgement of grievances, the contractor is required

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						to acknowledge or confirm receipt of the grievance and provide the expected date of resolution within 5 business days of receipt of the grievance per the *CAN Contract, Section 5 (J).* The following inconsistencies for this process were identified: •The *Member Handbook* does not list a timeframe for acknowledgement. •The *Provider Administrative Guide*, pages 35 and 37, lists the timeframe as 10 working days. • *Policy AG-01 Complaint, Grievance and Appeal Procedures,* states oral grievances can be acknowledged orally; however, the *Member Handbook* states UHC will send the grievant a letter confirming receipt of the grievance. ***Corrective Action**: Update the Member Handbook and Provider Administrative Guide with the correct timeframe for acknowledging grievances and the Member Handbook with the method of acknowledging grievances received orally.*
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 grievances will be resolved within 30 calendar days of receipt and expedited requests within 72 hours. Both timeframes may be extended 14 calendar days. If UHC extends the timeframe-written notice will be sent within 2 working days. The timeframes meet contract requirements and are correct as found in the policy, the *Member Handbook*, and the *Provider Administrative Guide*. Grievance acknowledgement and resolution letters submitted with the desk materials included those letters still in use and those waiting for DOM approval. Letter templates in draft form and awaiting approval have been corrected following the previous EQR and will be put into use by UHC following DOM approval.
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, Complaints, Grievances and Appeals Procedures*, states for grievances involving clinical issues, a health care professional will review and investigate the clinical aspect of the grievance. UHC Services, Quality of Care Investigation, *Improvement Action Plans*, and *Disciplinary Actions Policy and Procedures* state if an urgent risk to patient health or serious quality of care issues is present, the issue will be referred to the Medical Director or a designee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Policy AG-01 and Behavioral Health Complaints and Grievances policy do not address *Federal Regulation § 438.406 (b) (2)* which includes: • Ensuring individuals deciding grievances or appeals are individuals who were not involved in any previous level of review, nor are a subordinate of any such individual. • Who, if deciding any of the following, are individuals with the appropriate clinical expertise in treating the enrollee's condition or disease, as determined by the State? o An appeal of a denial based on a lack of medical necessity. o A grievance regarding the denial of the expedited resolution of an appeal. o A grievance that involves clinical issues. ***Corrective Action:*** *Include in policy AG-01 Complaints, Grievances and Appeals Procedures and the Behavioral Health Complaints and Grievances policy all the requirements from Federal Regulation § 438.406 (b) (2) as noted above.*
1.5 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					*Policy AG-01, Complaints, Grievances and Appeals Procedures,* states UHC maintains logs for complaints, grievances and appeals in the local office for the term of the contract and for a period of 5 years thereafter unless an audit, litigation, or other legal action is in progress.
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					Review of grievance files for CAN members demonstrated UHC sends written acknowledgment and resolution letters in a timely fashion within UHC policy and the *CAN Contract* requirements. In one case an extension was requested by UHC and the appropriate notification was provided to the member. In another case the person handling the grievance at UHC responded to a member by saying, "There is no process for an expedited or an urgent grievance;" however, UHC does have a process to address this need and the employee was apparently not aware of this process. Several grievances related to quality of care or service was sent to the Clinical Services Team to investigate and impose plans of correction as needed. It was not immediately clear who served on this committee; however, onsite discussion confirmed the committee membership consists of medical directors, other physicians and clinicians. ***Recommendation:*** *Ensure employees handling grievances are educated*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						on all aspects of the grievance process.
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Onsite discussions confirm UHC does tally and trend grievances by category, volume, and resolution timeframes looking for trends and outliers. Minutes of the Service Quality Improvement Subcommittee (SQIS), Healthcare Quality and Utilization Management (HQUM), and the Quality Management (QMC) committees reflect tallying and discussion about opportunities for improvement. Aggregate data is also found in the QI Program Evaluation. This process is not defined in any policy or document. ***Recommendation:*** *Include your process for tracking, trending, and evaluation of grievance data in a new or existing policy or document.*
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					UHC employees sign a code of conduct acknowledgement annually that includes maintaining confidentiality and data security for all physician, provider, or member specific data or information. The *Provider Administrative Guide* states UHC's grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies.
III H. Practitioner Changes						
1. The CCO investigates all Member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					A request by a member to change PCPs is handled by customer services and then the file is forwarded to the QI area to determine the reason for the request.
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					Per onsite discussion, requests for change of PCPs due to dissatisfaction are forwarded to QI to be tracked as grievances. This information is also forwarded to Provider Networking for use during the re-credentialing process.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					UHC's *2016 Quality Improvement (QI) Program Description* of the MississippiCAN programs outlines the program in-place for measuring and improving the care and services received by members and their providers. The program description discusses the objectives and the goals for the program, which are included in the QI work plan.
2. The scope of the QI program includes monitoring of services furnished to Members with special health care needs and health care disparities.	X					
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					*Policy NQM005, Provider Profiling and Monitoring Over and Under-Utilization,* discusses the process used for monitoring utilization data.
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					UHC has a very comprehensive work plan for their CAN program.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					UHC has a number of National Committees listed in the *2016 Quality Improvement Program Description*. Oversight of the health plan's QI activities has been delegated to the National Quality Oversight Committee. This committee's membership includes health plan staff throughout the organization. However, there are no voting members from Mississippi (MS) represented on this committee. This committee interfaces with other national and regional committees as applicable. Locally, the Quality Management Committee has been established and is responsible for the implementation and coordination of all QI activities throughout the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						organization in MS. The monitoring of QI activities is the responsibility of the Provider Advisory Committee. ***Recommendation:*** *Consider adding a voting member to the National Quality Oversight Committee from Mississippi.*
2. The composition of the QI Committee reflects the membership required by the contract.	X					There are no voting members from MS included on the National Quality Improvement Committee. The MS plan is only represented by one non-voting member. Membership for the Quality Management Committee includes senior executives and directors and staff from each area of the health plan. A variety of network providers are included on the Provider Advisory Committee.
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Separate meetings were not held for the CAN and the CHIP programs. However, the minutes clearly indicated which program was being discussed.
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					All of the HEDIS measures met the protocol guidelines and were considered fully compliant. For non-HEDIS measures, 3 of the 4 measures were found to be *"Fully Compliant"* and one measure was *"Substantially Compliant."* The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.*
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					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating		X				UHC submitted four projects for review. Three of the projects received a score of *"High Confidence"* in Reported Results and one received a score

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
Performance Improvement Projects."						of *"Confidence"* in Reported Results. Some of the errors identified included presenting the findings clearly and accurately, as well as ensuring the planned data analysis is consistent with performed data analysis. The projects should be reviewed closely before submission to ensure mistakes and ambiguities are clarified, which will assist with results interpretation. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.* ***Corrective Action:*** *Correct the errors identified in the performance improvement project documents.*
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					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			The *CAN Contract, Section 5 D,* requires the health plan to establish a tracking system for reporting all screening results; and diagnosis and/or treatment for members. UHC has systems in place for tracking initial visits for newborns, and EPSDT screenings. However, the health plan does not track any diagnoses identified during the assessments, treatments, or referrals provided as a result of the assessments. ***Corrective Action:*** *Develop a system for tracking any diagnoses identified during an EPSDT screening and the treatment and/or referrals provided.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					
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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 UHC 2016 UM Program Description* and the *2016 MS Addendum* describe UHC's utilization management (UM) program for the CAN program. Departmental policies and procedures guide staff in performance of UM functions. Monitoring of over- and underutilization are briefly mentioned, but more detail is provided in *Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization.*
1.1 Structure of the program;	X					The *2016 UM Program Description* defines the UM program structure, including the various committees charged with oversight and input into the UM program.
1.2 Lines of responsibility and accountability;	X					The *2016 UM Program Description* and the *CAN Addendum to the 2016 UM Program Description* define departmental roles and responsibilities for the national and local UM programs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Guidelines/standards to be used in making utilization management decisions;	X					It is unclear in policies and the *UM Program Description/CAN Addendum* which criteria are used for medical necessity determinations for the CAN population. Onsite discussion confirmed that UHC uses *MCG™ Care Guidelines* for medical determinations and internal policies for behavioral health determinations. • *Policy UCSMM.06.10, Clinical Review Criteria*, page 1, states, "External clinical review criteria are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as *MCG Care Guidelines* or I*nterQual*." • The *UHC 2016 UM Program Description* states evidence based *MCG™ Care Guidelines* and *InterQual® Guidelines*, UHC Medical Technology Assessments, peer-reviewed medical literature, standardized coverage determination policies, evidence-based national guidelines, CMS national coverage determinations and local coverage determinations are used for clinical reviews. • The *CAN Addendum to the 2016 UM Program Description* does not specify the criteria set used by UHC. ***Recommendation:*** *Revise the CAN Addendum to the 2016 UM Program Description and Policy UCSMM.06.10 to mention MCG™ Care Guidelines are used for medical necessity determinations for the CAN population.*
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					*Policy UCSMM.06.15, Peer Clinical Review*, states peer review is performed for cases that were not approved by an initial screening or initial clinical review process (i.e., 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). Onsite discussion confirmed all cases for which there are no criteria are reviewed by a Medical Director. New medical policies are developed in response to emerging technology or new treatments and are based on scientific evidence - when such evidence

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						exists. Medical policy updates are communicated to all staff through various means of communication.
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. David Williams, UHC's Chief Medical Officer (CMO), is board certified in internal medicine and actively practicing in Jackson, MS. Dr. Williams chairs the Quality Management Committee (QMC), Healthcare Quality Utilization Management (HQUM) Committee, and Provider Advisory Committee (PAC). In addition, he is a member of the National Credentialing Committee (NCC). The *2016 CAN UM Program Description Addendum* defines the CMO's roles and responsibilities for oversight of the UM Program.
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					The National Medical Care Management Committee (NMCMC) reviews and approves the *UM Program Description* on an ongoing basis and at least annually. The NMCMC also reviews and approves clinical policies, criteria, and guidelines recommended by the Medical Technology Assessment Committee (MTAC). The MTAC membership includes diverse medical and surgical specialists and subspecialists. Internal clinical criteria are developed with review and input from the appropriate providers and are based on current clinical principles, processes, and evidence-based practices. The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates by the Medical Policy Committee. At the local level, the HQUM Committee reviews and approves the *UM Program Description*. An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the NMCMC, the Community and State National Quality Management Oversight Committee (NQMOC), and the HQUM for approval.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					UM approval files for CAN members reflected attempts to obtain additional clinical information when needed to render a determination and the use of appropriate criteria to render the determinations.
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					The *2016 UM Program Description* states UHC performs inter-rater reliability (IRR) assessments and Medical Directors responsible for benefit coverage determinations also participate. IRR studies are performed no less than annually and results are monitored and tracked for coaching opportunities. The *UCS Annual MCG Care Guidelines Interrater Reliability Standard Operating Procedure (SOP)* describes the processes employed for annual IRR testing. The SOP addresses when remediation will be required, but does not describe the remediation process. Onsite discussion indicated that remediation includes further training, mentoring, and development of an action plan for improvement. HQUM minutes from 5/31/16 state IRR scores for 2015 were: • RNs—four scores of 100% and one score of 90% • MDs—five scores of 100% and two scores of 10% Onsite discussion confirmed the MD scores of 10% are incorrect and that the correct scores were 90%. ***Recommendation:*** *Revise the UCS Annual MCG Care Guidelines Interrater Reliability SOP to include the process for remediation for IRR scores below the benchmark. Ensure HQUM Committee minutes reflect accurate information regarding IRR scores.*
5. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The *2015 Pharmacy Program Evaluation* states the pharmacy benefit became aligned with the Medicaid PDL beginning in January 2015. The UHC CAN website directs users to the DOM website for the most current formulary.
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					Per *Policy RX-012, Pharmacy Coverage Reviews*, describes the pharmacy prior authorization (PA) process. Drugs which require PA include non-formulary drugs, certain formulary drugs that may have precursor therapies or very specific indications, and drugs that are not routinely covered due to plan benefit limitations or exclusions. *Policy RX-01, MS Pharmacy Benefit*, indicates UHC covers a minimum of a 3 day emergency supply of drugs to allow the PA time to be completed.
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Requirements for emergency and post-stabilization care are addressed in *Policy UCSMM.04.11, Consumer Safety*. The *CAN Member Handbook*, page 25, defines post-stabilization services and informs members that post-stabilization services are covered and can be provided without prior authorization. The *CAN Provider Administrative Guide* does not address post-stabilization services. ***Recommendation:*** *Include information on post-stabilization requirements and processes in the CAN Provider Administrative Guide.*
7. Utilization management standards/criteria are available to providers.	X					*Policy UCSMM.06.10, Clinical Review Criteria*, confirms that providers have access to clinical review criteria upon request. Providers are informed of the availability of the criteria in the *Provider Administrative Guide* and in the notice of adverse action letter templates. The *CAN Addendum to the 2016 UM Program Description*, page 21, states, "UnitedHealthcare shall distribute its criteria for approval or denial of outside services to all outside providers to whom members are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities providing Emergency Medical Services known to UnitedHealthcare and located within a thirty (30) mile radius." Onsite discussion confirmed that this statement should not be included in the *CAN Addendum to the 2016 UM Program Description* and will be removed. ***Recommendation:*** *Remove the statement above from the CAN*

STANDARD	SCORE					COMMENTS
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						Addendum to the 2016 UM Program Description.
8. Utilization management decisions are made by appropriately trained reviewers.	X					Staff members who conduct the initial review are MS-licensed healthcare professionals, including RNs, LPN/LVNs, and other appropriately licensed health professionals. Staff members who conduct peer clinical review are qualified health professionals with a current MS license to practice.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					UM approval files for CAN members reflected attempts to obtain additional clinical information when needed to render a determination, timely determinations, and timely notifications.
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					UM denial files for CAN members reflected attempts to obtain additional clinical information when needed to render a determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					UM denial files for CAN members reflected appropriate peer reviewers issued the denial 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					UM denial files for CAN members reflected timely determinations and notifications of the denial determinations. Denial letters contained appropriate information, including the rationale for the denial as well as the criteria on which the denial was based.
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					Appeals processes are defined in *Policies AG-01, Complaint, Grievance and Appeal Procedures*, and *AG-02, Expedited Review Process*.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				The term “appeal” is appropriately defined in *Policy AG-01 and AG-02* as well as the *Member Handbook*. It is not defined in the *Provider Administrative Guide*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The term "action" is appropriately defined in *Policies AG-01 and AG-02*, and the *Member Handbook*. The *Provider Administrative Guide* includes as part of the definition, "denial of a member's request to exercise his or her rights under federal law to obtain services outside the network", and the *UBH Appeals of Adverse Actions* policy includes, "For a resident of a rural area with only one contractor, the denial of a member's request to exercise his or her right to obtain services outside the network." These are not found in *Policies AG-01 and AG-02* or the *Member Handbook*. Information regarding who may file an appeal is appropriately documented in *Policy AG-01* and the *Member Handbook*. The *Provider Administrative Guide*, page 33, states the member, member's representative acting on behalf of the member, or the provider may appeal an adverse action. It does not include that the provider needs written consent from the member to file the appeal on the member's behalf. ***Corrective Action**: Remove the unnecessary part of the definition of the term "action" from the Provider Administrative Guide and the UBH Appeals of Adverse Actions policy. Revise the Provider Administrative Guide to include that a provider needs written consent from the member to file an appeal on the member's behalf.*
1.2 The procedure for filing an appeal;		X				The procedure for filing an appeal is appropriately documented in *Policy AG-01*, the *Member Handbook*, the *Provider Administrative Guide*, the *UBH Appeals of Adverse Actions* policy, and the *CAN Denial Letter*. The process for acknowledgement of an expedited appeal is not addressed in *Policy AG-02*. Onsite discussion confirmed that expedited appeals are acknowledged verbally ***Corrective Action:** Revise Policy AG-02 to include the process for acknowledgement of an expedited appeal request.*
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					*Policy AG-01* states decision makers on appeals should not be involved in previous levels of review or decision making for the case and that all decision makers are health care professionals with related clinical expertise in treating the member's condition when deciding appeals based on the lack of medical necessity or appeals involving clinical issues. Appeals are to be reviewed by at least 1 person who was not involved in the initial decision and who is not the subordinate of any person involved in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the initial decision. *Policy UCSMM.06.15, Peer Clinical Review*, page 1, states, "The peer clinical reviewer will be available to provide peer-to-peer discussion. Only peer clinical reviewers will render adverse determinations for clinical review outcomes. In the case of clinical adverse determination, the peer clinical reviewer or their alternate will be available within 1 business day to discuss determinations with requesting providers." Onsite discussion confirmed that after an initial denial has been formally issued, the original reviewer can change the initial denial decision based on a peer-to-peer conversation. However, this is prohibited by *Federal Regulation § 438.406 (a) (3) (i)*. Any changes to the original determinations must be issued by a reviewer who was not involved with the original decision. In addition, *NCQA 2016 UM Standards, UM 7: Denial Notices, Element A: Discussing a Denial With a Reviewer*, and *Element D: Discussing a Behavioral Healthcare Denial With a Reviewer*, agree with this position by stating, "Although federal regulations may define an overturned denial based on the (peer to peer) discussion as an appeal, such an approval does not fall under the scope of NCQA's appeal standards; however, the case is considered a denial because a denial notice was issued." ***Recommendation:*** *Update UHC's peer-to-peer processes to ensure peer-to-peer reviews either occur before a denial determination has been issued or that a different reviewer changes the initial denial determination.*
1.4 A mechanism for expedited appeal where the life or health of the Member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				The standard appeal resolution and notification timeframe of 30 calendar days is appropriately documented in *Policy AG-01*, the *Member Handbook*, and the *CAN Denial Letter* template. The *UBH Appeals of Adverse Actions* policy states UBH follows a more restrictive resolution timeframe of 15 calendar days from the receipt of an appeal for standard appeals. The expedited appeal resolution and notification timeframe of 72 hours is appropriately documented in *Policy AG-02, the UBH Appeals of Adverse Actions* policy, the *Member Handbook*, and the *CAN Denial Letter*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						template. *Policy AG-01*, page 14, states, "Expedited Appeals must be resolved within three 72 hours of receipt of the request for an Expedited Appeal." ***Corrective Action:*** *Correct the timeframe for resolution of expedited appeals in Policy AG-01.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.		X				The *CAN Contract, Exhibit D, Section C*, states timely filing for requesting a benefit continuation is within 10 days of the notice of action for an appeal, or within 30 calendar days from the date on the notice of action for a State Fair Hearing. *Policy AG-01* states benefits will continue if the appeal is filed timely, within 10 days of UHC's notice of action. The *Provider Administrative Guide*, page 34, states benefits will continue if the appeal is filed within 10 days of UHC's notice of action or if the member asks for a State Fair Hearing within 30 calendar days from the date on UHC's notice of action. The following documents state the timeframe to request continuation of benefits is within 10 days of receiving the notice of action: • The *Member Handbook*, page 57; • The appeal uphold letter for UHC • The appeal uphold letter for UBH • The *Your Appeal Rights* attachment to the initial denial and reduction in service letters ***Corrective Action:*** *Correct the timeframe to request continuation of benefits in the above documents.*
2. The CCO applies the appeal policies and procedures as formulated.	X					Appeal files for CAN members reflect the appropriate processes are generally followed, the appropriate reviewers issue the determinations, and the determination letters contain the appropriate information.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Provider Advisory Committee reviews summary appeals data, identifies trends, conducts barrier analyses, and recommends corrective actions as needed. The Service Quality Improvement Subcommittee monitors trends related to appeal activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 *2016 UHC Community and State Person Centered Care Model (PCCM) Program Description* defines the care management (CM) program's overall purpose, scope, data sources for member identification, program components, staff qualifications, etc. In addition to the program description, various CM policies and procedures address CM functions and processes. The *PCCM Program Description* and CM policies and procedures are all national documents and do not address the MS-specific requirements found in the *CAN Contract, Section 8.* No riders or policy addenda were found to address specific MS requirements. In addition, policies address only high-risk CM. ***Corrective Action:*** *Develop an addendum to the PCCM Program Description. Develop and implement policies or riders/ addenda to care management policies that address MS-specific CM requirements. Refer to the CAN Contract, Section 8.*
2. The CCO uses varying sources to identify and evaluate Members' needs for care management.	X					*Policy NCM 001, Identification of High Risk Members for Case Management*, defines the process by which all new members are screened for CM and defines the sources used to identify members for CM. All new UHC CAN members are screened for CM programs using the health risk assessment (HRA) screening tool. The policy states members identified as high-risk are further stratified into two groups, those receiving long-term services and support (LTSS) and those not receiving LTSS. Members identified as high-risk or those who are receiving LTSS will be referred to CM. Members identified as high-risk and not receiving LTSS will be referred to high risk CM. Onsite discussion with UHC staff confirmed this is not applicable to CAN; however, there is no indication within the policy to indicate that this does not apply to CAN membership. Per onsite discussion, members are stratified into low, medium, and high-risk categories. Members determined to be in the medium and high-risk

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						categories are referred to CM for assessment. In addition, CM services are available, if needed, for members in the low-risk category. ***Recommendation:*** *Update policy NCM 001 to indicate that LTSS services are not applicable to the CAN membership.*
3. A health risk assessment is completed within 30 calendar days for Members newly assigned to the high or medium risk level.		X				*Policy NCM 002, High-Risk Case Management Process*, states the initial comprehensive assessment is completed as expeditiously as the member's condition requires, but no later than 30 calendar days from identification as appropriate for high-risk CM. The assessment is completed telephonically or face-to-face based on the member's condition and regulatory guidance. Onsite discussion confirmed the timeframe for completion of the comprehensive assessment for members initially stratified into the medium-risk level is not addressed in policy and the timeframe is within 30 calendar days from the initial identification. ***Corrective Action****: Include in the related policy, the timeframe for completing comprehensive assessments for members initially stratified into the medium-risk category. Refer to the CAN Contract, Section 8 (A) (1).*
4. The detailed health risk assessment includes:						*Policy NCM 002, High Risk Case Management Process*, includes the requirements for comprehensive assessments for the high-risk member population. As noted above, there is no policy that addresses assessment requirements for members in the medium and low-risk populations.
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					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion		X				The *CAN Contract, Section 8 (A) (1)* requires the member's treatment plan to be completed within 30 days of a detailed health risk assessment. *Policy NCM 002* states the individual care plan is developed in concert with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
of the health risk assessments.						the member, caregiver/family (with member's consent) and a PCP. If the member is engaged in behavioral health services, the BH provider is also engaged in the POC development. The policy does not specify the timeframe for completion of the individual care plan; however, onsite discussion revealed the care plan is completed within 30 days from completion of the comprehensive assessment. ***Corrective Action:*** *Revise policy NCM 002 to include the timeframe for completion of the individual care plan. Refer to the CAN Contract, Section 8 (A) (1).*
6. The risk level assignment is periodically updated as the Member's health status or needs change.	X					*Policy NCM 002* states member contact frequency for follow-up is based on the member's acuity level, medical/psychosocial status, and their preference for level of engagement. The care plan and goals are re-evaluated and modified based on member accomplishments and progress. Reassessments are completed annually and with significant changes in condition.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all Members through the following minimum functions:	X					The *PCCM Program Description* summarizes the philosophy and structure for ensuring the member's medical, behavioral and social/environmental needs are addressed through the engagement of members, hospitals, and physicians. Interventions are focused on the member's social, medical, and behavioral needs. The ultimate goals are to create a better quality of life for members, improve access to healthcare, and reduce expenses. The PCCM program assesses the member, provides an integrated team for CM/care coordination, provides resources to fill gaps in care, and develops individualized goals for a common outcome.
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 contact their assigned team;						Per onsite discussion, all members in CM are assigned to a specific care manager. Assignments are based on the member's zip code unless the member's specific circumstances require assignment to a more specialized care manager.
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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
otherwise;						
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;						
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						UHC has developed an integrated care model for discharge planning involving case rounds with the medical and inpatient (hospital) care managers. Medication reconciliation is performed as part of discharge planning and follow-up.
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;						UHC care managers assist members in obtaining authorizations for needed services.
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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;						The *PCCM Program Description* states CM staff ensures that each member is assigned a PCP. Each member is strongly encouraged and instructed on the optimal use of the PCP as their medical home for community-based health and preventive services. The PCP is involved in the plan of care development process and CM staff reinforces PCP's in the treatment plan process.
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;						*Policy UCSMM.06.21, Out-of-Network Requests and Continuing Care*, defines the processes for providing out-of-network care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;						Members are involved in all stages of the assessment and care plan development, monitoring, and revision. Community health workers make home visits to the member with frequent check-ins and education is provided. The care plan is reviewed with the member at development and any time there are revisions to the care plan.
7.15 Monitor and follow-up with Members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						Per the *PCCM Program Description*, the care manager reviews the member's compliance with the plan of care, and the physician's treatment plan, and it is conducted at least monthly for high-risk members.
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				Onsite discussion confirmed UHC has no policy that addresses CM for CAN members assigned to the medium and low-risk levels. ***Corrective Action:*** *Develop a policy, or add to an existing policy, the CM services provided to CAN members in the medium and low-risk levels.*
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					UHC's Disease Management (DM) program includes the required diagnoses and members are informed of the availability of the DM program in the *Member Handbook*, and the *Provider Administrative Guide, which* includes brief information on the DM program.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and	X					UHC's Transitional Care Management program is a component of the Care Management Program. The *PCCM Program Description* states the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
other service providers.						Community Care Team is accountable for end-to-end integrated person centered CM of all members to whom they are assigned. Members who experience a trigger event such as an inpatient admission or emergency department visit are assigned to a Community Health Worker to complete an *Access to Care* questionnaire and individuals with more complex medical or behavioral needs are assigned to a Community Care Team clinician for interventions. Each care team is responsible for managing transitions in care, high-risk CM (including behavioral and medical), social determinant needs, and pregnancy needs.
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					A component of the CM program is to effectively manage transitions of care from hospital to home during the 30 days post-acute hospital discharge and ensure the member is connecting regularly with their provider. The goal is to improve care transitions and reduce unnecessary readmissions by providing members with the tools and support to promote knowledge and self-management skills. The four conceptual areas are medication self-management, primary care and specialist follow-up, knowledge of red flags (indications that their condition is worsening and when to notify their physician to get help), and education of the member on the use of a *Personal Health Record* to facilitate communication and ensure the continuity of care plan across provider and settings. This is accomplished through pre-hospital discharge introduction to the program, establishment and member education of the post discharge contact plan, post-hospital discharge assessment within 72 hours to determine needs and reconcile medications, and follow-up calls to reinforce the value and importance of a PCP visit within 7 days of discharge.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					The interdisciplinary care team includes providers, registered nurses, behavioral health advocates, and community health workers. The team meets weekly and holds ad hoc meetings.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the	X					An evaluation of the overall effectiveness of the UM Program is conducted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
effectiveness of the UM program is prepared annually.						annually and presented to the NMCMC, the Community and State National Quality Management Oversight Committee (NQMOC), and the HQUM for approval. The *UM Evaluation for 2015* cited data for many UM metrics and included the goals, barriers, and interventions. A summary of the information was provided and included recommendations for 2016. The evaluation was reviewed and approved by the HQUM and QMC on 8/1/16.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the NMCMC, the Community and State National Quality Management Oversight Committee (NQMOC), and the HQUM for approval.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 agreements with: • OptumHealth—Behavioral health services • Dental Benefit Providers—Dental network services and 3rd party dental administrator • MTM, Inc.—Non-Emergency Transportation (NET) benefit services • eviCore National—Radiology and Cardiology management services and prior authorizations • Vision Service Providers (VSP)—Vision and eye care services • MHG and Physician Corporation—credentialing • Hattiesburg Clinic—credentialing • River Region—credentialing • HubHealth—credentialing • University Physicians—credentialing *UHC's Master Services Agreement* specifies tasks to be performed,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						compensation arrangements, and agreement termination for breach of contract.
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					Onsite discussion revealed Mitch Morris, Chief Operating Officer, is responsible for delegation oversight. The monitoring of delegated activities is accomplished through a combination of several activities including regular and recurring vendor reporting of operational trends/issues and performance improvement initiatives; standing joint operating committee meetings to review performance and discuss of needed remediation; email communications; and ad hoc meetings. The *UHC Credentialing Plan, Section 11,* and *policy 102, Delegated Credentialing and Oversight Procedures,* address delegated credentialing requirements and oversight. The documentation of monitoring and oversight activities for all delegated entities was provided. Issues discovered in review of delegation oversight documentation included: •Oversight documentation for OptumHealth contains no evidence that authorization turn-around times are monitored. •Oversight documentation for Dental Benefit Providers documented the average resolution time for appeals, but it was unclear if this included only standard appeals or if expedited appeals resolution timeframes were included in this average. •Oversight documentation for MTM, Inc. does not indicate that MTM is monitored for compliance with the contractual requirement that transportation requests are authorized and scheduled within three (3) business days after receipt of the request. ***Recommendation:*** *Ensure that delegated entity oversight documentation includes all standards for which the health plan is held accountable.*

CCME CHIP Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CHIP**
Review Performed:	2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					UnitedHealthcare (UHC) has a comprehensive list of policies and procedures. Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, describes the process used to adopt policies and conduct annual reviews. Policies may be local, United Behavioral Health policies, Optum policies, or national policies and, some may have Mississippi addenda that include state specific information. It is noted that some external policies adopted by UHC do not include the most recent review or revision dates or the line of business they apply to CHIP or CAN. Reference *UHC Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures*. ***Recommendation:*** *Ensure the date of the last review or revision and the business line impacted is documented on all policies and procedures.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						United Healthcare has sufficient staff in place to ensure the provision of benefits and services for CHIP enrollees. Employees are trained to address CHIP requirements and are updated when changes are made to contracts or services.
1.1 *Full-Time Chief Executive Officer;	X					Jocelyn Chisholm Carter serves as Chief Executive Officer for United Healthcare Community Plan of Mississippi.
1.2 *Chief Operations Officer;	X					Mitch Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Sharon Sanger Estess is the CFO.
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					Mike Rogers is Manager of Information Technology. Most IT functions are conducted at the national level.
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					J. Michael Parnell is Director Network Strategies. Nicole Tucker is Director Provider Services Call Center and Morgan Jones is Provider Relations Manager.
1.6.1 *Provider credentialing and education;	X					The National Credentialing Center is responsible for credentialing providers. Provider education is conducted by Provider Relations in collaboration with other departments. UHC has developed a national model called PRISM to support provider relationships and analyze the root cause for provider disputes in order to attain complete and timely resolutions and prevent future problems.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.7 *Member Services Manager;	X					Royal Walker is the Member Services and Community Outreach Director.
1.7.1 Member services and education;	X					Community Outreach Specialists conduct member education and wellness events on a variety of subjects throughout the year.
1.8 Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals;	X					Rachel Clark oversees the grievance process and Dawn Stover addresses community and state appeals.
1.9 Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions;	X					Latrina McClenton is Utilization Management/Health Services Director.
1.9.1 *Medical/Care Management Staff;	X					UHC appears to have sufficient medical management and care management staff to perform all necessary medical assessments and to meet all CHIP Members' Care Management needs.
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.
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 serves as Chair of the Credentialing Committee;	X					Dr. David Williams is the Chief Medical Officer and per onsite discussion pediatricians are available to render authorization decisions for the CHIP population. Dr. Williams is board certified in Internal Medicine and licensed in Mississippi. He sits on the National Credentialing Committee, Quality Management Committee, Provider Advisory Committee, and the Healthcare Quality and Utilization Management Committee. The UHC Plan of Mississippi organization chart and UHC Mississippi Medical Directors organization chart contain discrepancies with some names appearing on one chart, but not the other. ***Recommendation:*** *Reconcile the organization charts with an accurate*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						representation of medical directors making decisions for the Mississippi plan.
1.13 *Fraud and Abuse/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 serves as the Compliance Officer for UHC. He chairs the Compliance Committee and is the primary point of contact for the Division of Medicaid (DOM). The organization chart depicts the Compliance Officer reporting directly to the CEO. The Compliance Officer maintains open lines of communication with the staff and tracks annual compliance training.
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*, encompasses how UHC ensures current job descriptions define qualifications and competencies required and any required licensure and certification in accordance with corporate policies, accreditation requirements, and applicable laws.
4. A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week.	X					The *CHIP Member Handbook* provides a toll-free number for members or parents to access the 24 hour Nurseline[SM]. In the case of Behavioral Health services, members have access twenty-four (24) hours, seven (7) days per week to clinical personnel who are licensed Behavioral Health professionals.
I. C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					The policies and procedures UHC has implemented meet the MS DOM requirements and regularly exceed those requirements by processing 100% claims almost every month. Additionally, UHC's leadership team reviews monthly claims statistics to gauge current processing performance and to identify trends that may need further investigation.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					UHC monitors member attributes throughout the IT systems used for the Mississippi Children's Health Insurance Program (CHIP) program. UHC processes 834 files as the primary sources of member enrollment status and processes the files daily to ensure enrollment accuracy. As part of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						ISCA, UHC provided documentation covering the data collection points, data processing systems, monitoring points, and reporting systems used to service the CHIP program. The documentation indicated that UHC's systems are capable of collecting, tracking, and monitoring the member demographics as required by the contract.
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					UHC consolidates CHIP member, enrollment, provider, provider specialty, claims, pharmacy, vision, dental, and lab data into dedicated reporting system on a monthly basis. The program uses that member data alongside the National Committee for Quality Assurance (NCQA) certified software to generate HEDIS and other state required reports. The policies, procedures, and reports provided indicate that UHC is capable of meeting reporting and quality improvement requirements as specified for the CHIP program.
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 and Business Continuity Plan in place for the systems that service the CHIP program. Table top testing disaster recover exercises were last performed in March of 2016. The disaster recovery (DR) test results provided note that the test met UHC's DR requirements and no variances were identified. The results also state that any issues or enhancements will be recorded to an internal UHC SharePoint system. No issues or enhancements were reported as part of the ISCA. Disaster recovery test results state that recovery exercises were completed successfully and without issue, but there was not much documentation provided to validate these claims. CCME requested additional information from UHC; however, the request was declined. UHC stated the results of the testing are considered proprietary and confidential. ***Recommendation:*** *It is recommended that UHC develop a way to provide adequate information for evaluating the results of disaster recovery testing.*
I D. Compliance/Program Integrity						
1. The CCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					A comprehensive Fraud and Abuse Compliance Plan is in place for UHC Mississippi which meets federal and state requirements. Fraud, waste and abuse and general compliance training is required for all UnitedHealth Group and UHC Government Programs employees as well as contractors who perform services on behalf of Medicare, the Community & State. The False Claims Act Compliance policy for UnitedHealth Group was submitted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						onsite. The UHC Fraud Plan, Mississippi Addendum, details state specific requirements for reporting and cooperating with DOM investigations of fraud, waste or abuse. The *CHIP Member Handbook* gives a brief description of fraud and provides a toll-free hotline 866-242-7727 for members to report fraud anonymously. The *CHIP Provider Administrative Guide* page 49, lists a number for reporting fraud 800-557-9933. This is different from the number found in the *CAN Provider Administrative Guide*; however, calling this number leads to the provider being required to report their tax ID prior to speaking with anyone, which eliminates the possibility of anonymity. It does not appear to be a hotline to report fraud and abuse. ***Recommendation:*** *Ensure the fraud, waste, and abuse hotline phone number in the CHIP Provider Administrative Guide is accurate and allows for anonymous reporting if desired.*
2. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					UHC has developed a Compliance Committee and Charter that includes the following: the purpose of the committee, membership, the frequency of meetings, quorum, and requirements for attendance. A quorum is defined as 51 percent of the designated members present. Attendance at Compliance Committee meetings from July 2015 through March 2016 revealed that one member attended only two meetings and another member attended only one. The committee charter states a designated member may appoint a delegate to attend on their behalf; however this is not documented in the minutes and it appears UHC does not follow the process in the charter for replacing inactive members. ***Recommendation:*** *Note in the Compliance Committee meeting minutes if an attendee is replacing a designated member for that meeting and follow the process outlined in the charter for replacing inactive members when possible.*
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations	X					UHC has a Code of Conduct within the Compliance Plan. It requires employees to sign an acknowledgement of confidentiality and compliance with UHC's Code of Conduct upon hire and annually thereafter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
regarding health information privacy.						UHG policy 3A, Personal Security, states a confidentiality agreement must be in place before a person is permitted access to confidential and/or protected information. Employees and providers are checked monthly for exclusion from participating in federal and state programs. Policies are in place that guide the release of member records and the Notice of Privacy Practices can be found in the *CHIP Member Handbook*.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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				The *UnitedHealthcare Credentialing Plan 2015–2016* addresses the credentialing and recredentialing processes and guidelines for licensed independent practitioners and facilities. Specific credentialing criteria for Mississippi (MS) are detailed in a rider. The primary source verification is conducted by Aperture. The *Optum Physical Health Credentialing Risk Management Program 2016* and several policies address the credentialing/recredentialing requirements for the Optum behavioral health network. An addendum to the credentialing policies addresses MS specific criteria; however, this information is not addressed in the *Optum Physical Health Credentialing Risk Management Program 2016, page 32, Attachment B, State Specific Requirements.* ***Corrective Action:*** *Update the Optum Physical Health Credentialing Risk Management Program 2016 to address MS specific credentialing requirements in Attachment B.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including			X			The Provider Advisory Committee (PAC) is chaired by Dr. David Williams and voting members of the committee include ten network providers with various specialties of pediatrics, psychiatry, dentistry, OB/GYN, internal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.						medicine, family medicine and emergency medicine. Additional staff attend the meetings as non-voting guests. The committee chair votes in case of a tie and a review of committee minutes show that a quorum of at least 51% of the voting committee members is established at the beginning of each meeting. A report of the providers credentialed by the National Credentialing Committee (NCC) is presented at each quarterly PAC meeting. Detailed reports by month are also provided. However, the PAC only reviews reconsiderations and is not involved in the initial credentialing or recredentialing decisions. The NCC performs credentialing/recredentialing for all lines of business and is the decision-making committee for the MS credentialing process. Decisions made by the NCC are reported to the PAC on a quarterly basis. The NCC is chaired by two physicians that do not have voting privileges. The voting members include 15 licensed independent practitioners (LIPs) with specialties such as pediatrics, obstetrics & gynecology, internal medicine, cardiology, surgery, podiatry, and family practice that are located in various states. Additional non-voting members include the Market Medical Directors that attend meetings periodically. The following concerns were noted: •Only 7 to 8 voting LIPs of the NCC are invited to each NCC meeting and a majority of these attendees is used to determine a quorum. This process is in direct conflict with the *UHC Credentialing Plan 2015-2016* for determining a quorum at the NCC meetings. The plan states that a quorum requires at least 51% of the LIP NCC membership to be present. A review of NCC minutes showed where decisions were made at the following meetings with only six voting LIPs in attendance: 1/6/16, 9/16/15, 9/21/15, and 8/15/15. •NCC committee meeting minutes do not notate the absent voting members of the committee. A few committee meetings mentioned one or two names, but since all committee members are not invited to each meeting, the information is inaccurate. •In the 14 NCC meeting minutes reviewed, Dr. David Williams was listed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						as only attending three meetings (1/6/16, 9/16/15, & 10/21/15). •The NCC is the credentialing decision-making committee and there is no representation of MSLIPs on the committee. As mentioned in the previous *2015 EQR*, the process UHC follows for credentialing and recredentialing of MS providers is of concern. Credentialing and recredentialing decisions are not made by MS providers and Dr. Williams does not chair or oversee the functions of the credentialing committee as required by the *CAN Contract, Section 1 L.* This requirement is also listed in the *CHIP Contract, Section 1 L*. ***Corrective Action:*** *The NCC should invite all LIP voting committee members to meetings and follow the UHC Credentialing Plan 2015-2016 for determining a quorum. Committee minutes should notate absent voting members in the meeting minutes. Credentialing/recredentialing decisions need to be made by a MS Credentialing Committee made up of UHC MS network providers and chaired by the MS Medical Director as required by the CHIP Contract, Section 1 L.*
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 for the most part contained appropriate information. The credentialing files included queries for the Social Security Death Master File (SSDMF), Medicare Opt Out, and the National Plan and Provider Enumeration System (NPPES). The section that follows contains some recommendations made as a result of the file review. UHC should address the overall condition of the credentialing/recredentialing files as many of the screen shots in the files were hard to read or unreadable and some of the queries did not contain dates of when the query was conducted. In addition, in some cases the query date listed in the Aperture primary source verification section of the file did not match the date the query was performed as indicated in the screen shot of the query. ***Recommendation:*** *UHC should improve the overall condition of the credentialing/recredentialing files to ensure all information in the file is readable and dates in the Aperture primary source verification section of*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the files are consistent with the date the queries were performed.
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					One credentialing file did not have the verification of board certification in the file; however, other files reviewed were appropriately documented. ***Recommendation:*** *Ensure verification for board certification is included in the file when board certification is claimed by the provider.*
3.1.4 Work history;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Provider office site visits are conducted for the initial credentialing of PCPs and OB/GYNs as defined in the *Credentialing Plan State and Federal Regulatory Addendum for MS*. Onsite visits are indicated as being conducted via a screen print in the files that shows the date of the onsite visit. One file reviewed showed that a provider office site visit had not been conducted. UHC indicated this was an oversight and that another provider in that practice was in the process of conducting a site visit for the credentialing process. ***Recommendation:*** *Ensure provider office site visits are conducted at initial credentialing for PCPs and OB/GYNs.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. The recredentialing files included queries for the Social Security Death Master File (SSDMF), Medicare Opt Out, and the National Plan and Provider Enumeration System (NPPES). One recredentialing file did not include the CLIA certification as discussed below.
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					One recredentialing file indicated a CLIA certification but it was not collected or verified. ***Recommendation:*** *Ensure that CLIA information is collected/verified if the provider indicates a CLIA certification/waiver has been issued.*
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					UHC has a process in place to monitor complaints concerning participating physicians and facilities. *Policy Ongoing Monitoring of Office Site Quality* outlines the process for monitoring complaints and referrals concerning participating physician's office site and facilities. This process ensures the information is recorded, investigated, and appropriate follow up is conducted to ensure members will receive care in a safe, clean, and accessible environment. *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 a participating physician's office sites and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						facilities. During the look back period of July 1, 2015 – May 30, 2016, 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*, states that UHC has systems and processes in place to monitor member utilization and the information is communicated using profiles of primary care physicians. Evidence of practitioner profiling reports was received in the desk materials for both CAN and CHIP primary care providers. The reports 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. The *UHC Credentialing Plan 2015 – 2016* states that during recredentialing, applicants are subjected to a malpractice history review and a review of quality of care/quality of service concerns within that recredentialing cycle. If histories of malpractice claims exceed the established thresholds and/or substantiated quality of care concerns are found, the Credentialing Committee will conduct a thorough review of these findings and the applicant may be subject to a denial of recredentialing.
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, identifies actions that may be taken to improve practitioner performance prior to termination by implementing an improvement action plan (IAP) and also outlines the procedures for suspending or terminating a practitioner's participation in the network and notifying the provider of these actions. Several other policies such as Imminent Threat to Patient Safety, Quality of Care Appeal, Quality of Care Investigation, Improvement Action Plans, and Disciplinary Actions define the UHC processes for how to address serious quality of care issues and the process for provider appeal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				The *UnitedHealthcare Credentialing Plan 2015–2016* addresses the credentialing and recredentialing of facilities in Section 7.0. This section does not address the need to collect CLIA information if the facility is billing for laboratory services. A few areas of concern identified with the file review are addressed as follows: •Two recredentialing files for hospitals did not have proof of CLIA, SAM or NPPES queries •One recredentialing hospital file did not have proof of malpractice insurance (the Aperture source verification information for malpractice insurance stated the signed and dated application was the verification source) UHC's response stated the facility credentialing process was not line specific; however, the overarching process verifies organization exclusion and eligibility for programs during processing, but the same standards for practitioner/provider are not applied specifically to organization profiles. Facility credentialing and recredentialing processes should include proof of verification in the files. In addition, the CLIA certificates/waivers should be collected for facilities that bill for laboratory services. ***Corrective Action:*** *UHC needs to update the UnitedHealthcare Credentialing Plan 2015–2016 or the MS Addendum to include requirements that proof of verification for facilities should be in the files and to collect the CLIA certificate/waiver if the facility bills for laboratory services.*
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*, defines the procedure for ensuring that UHC notifies PCPs of the enrollees assigned to them, including the notification of panel changes, within five business days from the date UHC

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						receives the *Member Listing Report* from DOM. UHC makes member panel details available to all participating PCPs via the secure portal. Within five days of receiving the *Member Panel Listing Report* from DOM, UHC identifies PCP changes in member panels and mails a post card notification regarding the changes to impacted PCPs.
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 all providers, including out-of-network providers, may call a telephone number on the member ID card to verify enrollment. Participating providers may access member enrollment via the secure online provider portal.
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*, defines the procedure for the management of the PCP membership panel. PCP panels are determined during initial credentialing and/or contracting setup and at that time the PCP can communicate desired restrictions to UHC. For closed panels, no members will be assigned to them. In the event that no restrictions are requested, it is understood that the PCP agrees to accept all members as assigned. 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. UHC makes member panel details available to all participating PCPs via the secure provider portal in order to notify providers of panel composition and keep them informed of any changes to their member panels. The online *Provider Directory* gives the ability to indicate whether the provider is accepting new patients.
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 the geographic access standards for the CAN and CHIP programs which comply with contract guidelines for both the MS programs. GEO access reports are run quarterly and evidence of the reports were included in the desk materials.
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					The criteria for evaluating specialists are defined in *policy PS3, Geographic Access Standards*, and comply with contract guidelines. GEO access reports confirm compliance in evaluating the specialty network. UHC also utilizes *Compass Reports* which include detailed network analysis to identify gaps in care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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. The reports are delivered each quarter to DOM, as well as the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis purposes.
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					
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting member demand.	X					The *Compass Report* for the first quarter of 2016 shows that lack of social workers and behavioral health providers are some of the biggest gaps in care for the CHIP population. The lack of providers in the areas of community mental health centers, inpatient psychiatric hospitals, and psychology are the behavioral health weaknesses. There are other gaps with hospitals, dermatology, dialysis, endocrinology, hematology, rheumatology, 24-hour pharmacies and thoracic surgery. Onsite discussion confirmed that available providers in the state are constantly monitored and resources are utilized to provide the needed care, even if it is outside of the service area.
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 Standard – Appointment Availability Requirements*, defines the appointment availability requirements for providers contracted by UHC to provide services to CAN and CHIP program members. The criteria defined in the policy comply with the *CHIP Contract* guidelines. The policy states the standards are documented for reference in the *Provider Manual* and reinforced through provider education. Quarterly assessments are performed to gauge the level of compliance among PCPs, OBGYNs, and Behavioral Health providers. Annual assessments are performed to gauge the level of compliance among high-volume specialty providers. These results are submitted to DOM and the UHC Service Quality Improvement Subcommittee for monitoring, tracking, trending, as well as for identifying improvement opportunities and developing corrective action

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						initiatives. UHC utilizes Dial America to make calls to provider offices to assess appointment availability and after-hours access. Results of the first quarter 2016 report for appointment availability showed a large percentage (65.12%) of the behavioral health providers needed corrective action. Results of the other providers included the following results for corrective action: PCPs (19.15%), pediatrics (31.40%), and OB/GYNs (21.43%). The 4th quarter 2015 after hours' survey showed that PCPs (45.32%) and behavioral health providers (55.56%) had the highest noncompliance. Onsite discussion revealed that providers receive a letter regarding their noncompliance and are resurveyed. UHC feels that provider staff turnover attributes to the issue of noncompliance. ***Recommendation:*** *Since the Dial America quarterly reports continue to show high percentages of noncompliance for appointment availability and after-hours access, UHC should investigate and implement interventions to address the issue.* A review of the *CHIP Provider Administrative Guide*, page 62, shows incorrect information for the primary care appointment access standards as follows: •It states that urgent cases shall be seen within 48 hours of PCP notification when the *CHIP Contract, Section 7 (B) (Table 5),* states not to exceed 24 hours. •It states that routine cases shall be seen within 10 days of PCP notification when the *CHIP Contract* states not to exceed 7 calendar days. •It states that well-care visits shall be scheduled within 6 weeks of PCP notification when the *CHIP Contract* states not to exceed 30 calendar days. In addition, the *CHIP Contract* lists appointment standards for routine and urgent dental care that is not addressed on page 63 of the *CHIP Provider Administrative Guide*. ***Corrective Action****: Update the CHIP Provider Administrative Guide to properly address appointment standards for primary care and dental care.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.				X		This standard is "Not Applicable" due to this year being the first evaluation of provider access in the CHIP program. Calls were successfully answered by personnel at the correct practice for 77 out of 189 calls (40.7%), which equates to between 34 and 48% for the entire population, based on a 95% confidence interval.
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 it is the policy of UHC to conduct timely outreach to all newly contracted providers in order to provide orientation into Community Plan networks. A Provider Advocate contacts 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. The *Standard Operating Procedure (SOP) PS11, Provider Orientation Plan Summary & Checklist*, provides checklists for the welcome call and on-site provider orientation.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;		X				The following discrepancy was identified between the *CHIP Member Handbook* and the *CHIP Provider Administrative Guide:* •Page 27 of the *Member Handbook* states the yearly maximum benefit for dental care is $2000 and the Provider Administrative Guide lists routine dental as a $1500 calendar year benefit maximum. ***Corrective Action:*** *Correct the dental maximum out of pocket to be consistent between the CHIP Member Handbook and the CHIP Provider Administrative Guide.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;			X			Page 60 of the *CHIP Provider Administrative Guide* states the PCP responsibility to provide all Well-Baby and Well-Child services; however, detailed information is not addressed anywhere in the guide. The table of contents (page 1) shows that preventive health care standards and recommended childhood immunization schedules are addressed in the Medical Management section; however, this information is not listed in the document. ***Corrective Action:*** *Update the CHIP Provider Administrative Guide to include the recommended standards of care for Well-Baby and Well-Child screenings and services.*
2.7 Responsibility to follow-up with Members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					Page 60 states it is the responsibility of the PCP to make use of any member lists supplied by the Health Plan that indicate which members are due for preventive health procedures or testing. However, it does not state it is the PCP's responsibility to follow-up with non-compliant members for Well-Baby and Well-Child screenings and services. ***Recommendation:*** *Clarify that it is the PCP's responsibility to follow-up with non-compliant members for Well-Baby and Well-Child 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.11 Prior authorization requirements including the definition of medically necessary;	X					During an onsite discussion, UHC stated that non-participating providers do not have access to the online prior authorization system. So when a non-participating provider needs to submit a request for prior authorization, they must use a participating provider to submit the request through the online prior authorization system. If this is UHC's practice, information should be included in the *Provider Administrative Guide* to educate participating providers that they need to work with non-participating providers in submitting online prior authorizations. ***Recommendation:*** *Include information in the Provider Administrative Guide to educate participating providers that they need to work with non-participating providers in submitting online prior authorizations.*
2.12 A description of the role of a PCP and the reassignment of a Member to another PCP;		X				Page 60 addresses the role of the PCP; however, information regarding the reassignment of a member to another PCP could not be found. Reference the *CHIP Contract, Section 7 H (2) (r)*. ***Corrective Action:*** *Update the CHIP Provider Administrative Guide to include information regarding 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			Information regarding the process for communicating the provider's limitations on panel size to the CCO could not be found in the *CHIP Provider Administrative Guide*. Reference the *CHIP Contract, Section 7 H (2) (q)*. ***Corrective Action:*** *Update the CHIP Provider Administrative Guide to include information regarding the process for communicating the provider's limitations on panel size to the CCO.*
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;		X				Page 45 states the following regarding member rights, "Get interpretation services if they do not speak English or have a hearing impairment, to help them get the medical services they need." But there is no information to explaining who provides the translation services or how a provider would access those services for the member. ***Corrective Action:*** *Update the CHIP Provider Administrative Guide to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						include information regarding translation services and how to access those services for the member.
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 *CHIP Provider Administrative Guide* as required in the *CHIP Contract, Section 7 H (2) (s)*. ***Corrective Action:*** *Update the CHIP 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				*Policy NQM-052, Web-based Network Provider Directory Usability Testing*, defines the procedure for ensuring the web-based *Provider Directory* contains information for members and prospective members that is easy to understand and navigate. It states that new information is updated within 30 days of being received; however, the *CHIP Contract, Section 6 E*, states the web-based Provider Directory must be updated within five business days upon changes to the provider network. The *2015 QI Program Evaluation*, page 44, states the online *Provider Directory* is updated each night and a print version is produced weekly. A review of the printed *Provider Directory* showed the information is consistent with contract requirements; however, the sample chart at the front of the directory that shows the description of provider listings, does not match the information that is displayed for each provider in the directory and needs to be updated. ***Corrective Action:*** *Update policy NQM-052 to reflect the correct timeframe for updating the data in the online Provider Directory. Also, update the paper Provider Directory sample chart (at the front of the directory) that shows the description of provider listings. This chart, should match the information that is displayed for each provider in the directory.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, Member benefits, standards, policies, and procedures.	X					The provider website portal provides resource information for daily administration of the plan, such as claims information, bulletins, provider forms, clinical practice guidelines, pharmacy program, and cultural competency library. The *Provider Administration Guides* are available on the website for both the CAN and CHIP programs. Physician newsletters, *Practice Matters,* are produced several times a year. Training webinars and forums are held periodically as well.
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				Policy*, Review of Clinical and Preventive Guidelines,* states the Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive guidelines. This information is also stated in the narrative received in the desk materials for the guidelines. The narrative also states the guidelines are approved locally by the Provider Advisory Committee (PAC). However, the *CHIP Provider Administrative Guide*, page 27, incorrectly states, "The UnitedHealthcare Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized clinical practice guidelines. The guidelines are then distributed to the National Quality Management Oversight Committee (NQMOC) and the Health Plan Quality Management Committee." ***Corrective Action:*** *Correct the CHIP Provider Administrative Guide to reflect the correct committees that review and approve the clinical practice and preventive guidelines.*
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO members to providers.	X					*Clinical and Preventive Health Guidelines* are made available to both members and practitioners. To encourage the use of appropriate preventive care, UHC promotes member focused educational programs. These programs are designed to identify at-risk members and involve members and practitioners in the decision-making process. UHC policy, Review of *Clinical and Preventive Guidelines,* states that on an annual basis practitioners are notified via mail, fax or email of the availability of the guidelines on the website. Providers may also request hard copies of the guidelines by contacting the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Provider Services Center. When new guidelines are added or current guidelines are revised, UHC notifies providers of these changes in the *Provider Newsletter*.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and Adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to Member high-risk groups.	X					
3.5 Behavioral Health	X					
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				The clinical practice guidelines are adopted from nationally recognized, evidence-based clinical criteria and guidelines are integrated into UHC's clinical system. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive care guidelines for use by UHC's Community Plan. The maintenance of the guidelines is completed by the Medical Policy Development Team. These guidelines are approved locally by the Provider Advisory Committee (PAC). The *2016 Clinical Practice Guidelines* document received in the desk materials included two guidelines that are not listed on the website: Dementia, and Violence and Abuse. In addition, the *CHIP Provider Administrative Guide* contains an outdated list of clinical practice guidelines beginning on page 28. A small note to the provider suggests they refer to the website for the most updated list, but this statement could be missed by the provider. Consider removing the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						outdated list of practice guidelines and referring the provider to the website to obtain the information. ***Corrective Action:*** *Ensure the UHC website includes all clinical practice guidelines adopted by the Plan and either update the list of practice guidelines in the CHIP Provider Administrative Guide or remove the information and refer the provider to website.*
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO Members.	X					The clinical practice guidelines are addressed in the *CHIP Provider Administrative Guide* and have been posted on the website. UHC policy, *Review of Clinical and Preventive Guidelines,* states that on an annual basis practitioners are notified via mail, fax or email of the availability of the guidelines on the website. Providers may also request that hard copies of the guidelines be sent to them 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.
II F. 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*, defines the process of medical record review to ensure both paper and electronic medical records (EMR) are current and organized to support effective patient care and quality review. Practitioners are informed of medical record standards in the *Provider Administrative Manual* and other ad hoc communication documents. The National Quality Oversight Committee (NQOC) annually reviews and approves medical record documentation standards. Individual health plans are responsible for adding additional medical record requirements, as well as approving the review tools. The record review will be completed annually, unless required more frequently. If standards are not met, improvement action plans are implemented. While policy NQM-025 states it applies to the CAN and CHIP programs, the policy addresses Early and Periodic Screening, Diagnostic and Treatment (EPSDT) which is specific to CAN; but does not address Well-Baby and Well-Child care which is the language used in the *CHIP Contract*. In addition, the *EPSDT Medical Record Review* tool and manual received in the desk materials does not include Well-Baby and Well-Child care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						language, and does not include dental and oral assessment which is required in the *CHIP Contract, Section 5 D*. ***Corrective Action:*** *Update policy NQM-025, Ambulatory Medical Record Review Process to address Well-Baby and Well-Child care. In addition, update the EPSDT Medical Record Review tool and manual to address Well-Baby and Well-Child care and include dental and oral assessment.*
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.			X			It does not appear that UHC has conducted a provider medical record review to ensure EPSDT/Well-Baby and Well-Child services are being properly documented. ***Corrective Action:*** *UHC needs to conduct a medical record review for EPSDT/Well-Baby and Well-Child care services.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey performed and meets all requirements of the CMS Survey Validation Protocol.			X			UHC 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 and was found to not be valid. For the provider satisfaction survey, the low response rate could bias results and not provide reliable information for the represented population. The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report. It is recommended that UHC implements at least one of the strategies provided in the enclosed final report to increase the response rate. ***Corrective Action:*** *Provide information regarding the survey's purpose/objective as well as reliability and validity measures for the survey.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QMC committee in March 2016.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					*Policy NQM-051, Members Rights and Responsibilities*, Attachment A, and *Rider* to this policy includes: UHC reviews member *Rights and Responsibilities* on annual basis, provides the information to new members and providers in respective manuals, and publishes the information annually via newsletters and manuals. Upon request, printed versions of materials are available in English, Spanish or other languages.
2. Member rights include, but are not limited to, the right:		X				The following rights, with one exception, are found in the *CHIP Member Handbook*, the *Provider Administrative Guide*, and the *Rider to Policy NQM-51, Member Rights and Responsibilities*. Additionally, the *Member Rights and Responsibilities* brochure includes these rights. Issues related to member rights are detailed in the 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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 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;						
2.7 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;						
2.8 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;						Free exercise of member rights and the exercise of those rights should not adversely affect the way the contractor and its provider's treat the member can be found in *Policy 4a, Notification of Rights*. The *CHIP Member Handbook* and the *CHIP Provider Administrative Guide* do not include this standard. See the *CHIP Contract, Section 6 (I) (g).* ***Corrective Action:*** *Include in the CHIP Member Handbook and CHIP Provider Administrative Guide a statement that members/parents or guardians can exercise their rights and the exercise of those rights will not adversely affect the treatment received from the CCO and its providers.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member Responsibilities include the responsibility:	X					Member responsibilities are included in the *Member Handbook* and *Policy NQM-051, Member Rights and Responsibilities*.
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 *CHIP Member Handbook* includes notifying DOM if you move and have a new address. It does not address changes in family size or obtaining other health care coverage. See the *CHIP Contract, Section 6 (D) (16).* ***Recommendation:*** *Update the CHIP Member Handbook to include the responsibility of members to report family size changes, any address change, if they move out of state, or obtain other health care coverage.*
III B. Member 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		X				*Policy MBR 2a, Information Packets* to Members (Prior to the first day of the month of their enrollment) addresses this standard. UHC ensures the information is provided no later than 14 days after the contractor receives notice of the beneficiary's enrollment. Onsite visit discussion confirmed envelopes state "Return Service Requested" as required by the *CHIP*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
entitled, including:						*Contract, Section 4 (D).* Issues related to CHIP 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 family planning and direct access for female Members to a women's health specialist in addition to a PCP;						The UHC *CHIP Member Handbook* informs members that family planning is included in their coverage and that they may choose from a variety of types of providers to serve as PCP including obstetricians and gynecologists. Page 29 provides a detailed description of family planning services. The *CHIP Member Handbook* does not inform members that they can obtain family planning services from non-contracted providers. See the *CHIP Contract, Section 6 (D).* ***Recommendation:*** *Update the CHIP Member Handbook to include how members may obtain family planning services from non-contracted providers.*
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						Page 19 of the *CHIP Member Handbook* states members may receive a second opinion from a network provider for any covered benefit. The right to receive a second opinion is found in the listing of member rights on page 43. Both locations fail to include, "Upon request, the contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain a second opinion outside the network from a Non-Contracted Provider, at no cost to the member." See the *CHIP Contract, Section 7 (B) (4).* This contract reference also states the contractor shall have policies and procedures for rendering second opinions by providers within the network, or by non-participating providers. No policy was found that addressed second opinions. ***Corrective Action:*** *Update the CHIP Member Handbook with the information regarding second opinions required by the contract. Develop a policy or add to an existing policy the process UHC uses to provide second opinions to in-network and non-participating providers.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						*Policy MBR4c, Member Financial Liability* and onsite discussion confirmed that UHC does track copayments made by members. A letter is sent to the member if the out-of-pocket maximum is reached during the coverage period. UHC stated that to date the maximum has not been reached by any member. A letter template was submitted with the desk materials.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The *CHIP Member Handbook* includes information on the prior authorization process.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						*Policy UCSMM 06.21, Out of Network Requests and Continuing Care*, includes the process of referring members to alternate sources for care and obtaining out-of-network care.
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;						Page 19 of the *CHIP Member Handbook* informs members to see their PCP or call Member Services to obtain a referral for specialty care.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *CHIP Member Handbook* informs members/parents that the plan covers prescription drugs without copayment. It discusses the Preferred Drug List and mentions how their physician may request an exception. Members are informed that a temporary 3 day supply of medication can be provided while waiting for authorization.
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;						See *Policy MBR 8a, Proper Notice to Members on Written Notices in Material Changes*. It includes notifying CHIP members of changes to benefits and provider terminations, and complies with contract requirements.
1.9 A description of the Member's identification card and how to use the card;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The *CHIP Member Handbook* contains good information about the role and responsibilities of a primary care provider.
1.11 Procedure for making appointments and information regarding provider access standards;						The *CHIP Contract, Section 7 (B) (2),* lists appointment scheduling timeframes required of CHIP providers. Page 17 of the *CHIP Member Handbook* also includes expected timeframes for scheduling appointments; however, it only includes the timeframe for PCP visits. It fails to include the following timeframes: • Specialists not to exceed 45 days; • Routine dental care not to exceed 45 days; • Urgent dental care not to exceed 48 hours; • Behavioral Health routine visit not to exceed 21 calendar days; • Behavioral Health urgent visit not to exceed 24 hours; • Behavioral Health post discharge from an acute psychiatric hospital not to exceed 7 days; ***Corrective Action:*** *Update the CHIP Member Handbook to include all appointment scheduling timeframes members can expect from providers, including specialists, dentists, and behavioral health providers.*
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the Member portal;						The toll-free phone number and TTY access to Member Services is found throughout the *CHIP Member Handbook*. NurseLine[SM] services are described on page 18. Functions of the Member Services department are included throughout the *CHIP Member Handbook*.
1.13 A description of the Well-Baby and Well-Child services that includes;						The *CHIP Member Handbook* describes the Well-Baby, Well-Child services including the immunizations that children are likely to receive. Preventive health screenings for children are detailed on pages 32-33. All the requirements for Well-Baby, Well-Child visits are included in this table.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/Education and referral for identified problems.						
1.14 Procedures for disenrolling from the CCO;						Policies define the provision of continuity of care by the contractor when a member disenrolls from the contractor. The *CHIP Member Handbook* explains that children who are eligible for CHIP must be enrolled in a CCO and members may change CCOs within the first 90 days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *CHIP Member Handbook* does not include the reasons a member may disenroll for cause as found in the *CHIP Contract, Section 4 (F).* ***Corrective Action:*** *Include the reasons a member could request disenrollment for cause at any time during their enrollment.*
1.15 Procedures for filing complaints/grievances and appeals, including the right to request an independent external review;						The *CHIP Member Handbook* defines a grievance, an action, and an appeal; however, it does not include a form members can use to file a grievance or appeal. ***Recommendation:*** *Include a form for members to file a grievance or appeal in the CHIP Member Handbook.*
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;						Members are directed to myuhc.com/CommunityPlan or to Member Services for network provider information. Page 15 of the *CHIP Member Handbook* informs members they can obtain provider information such as their qualifications and languages they speak via the search menu on the website or by calling Member Services.
1.17 Instructions on reporting suspected cases of Fraud and Abuse;						The *CHIP Member Handbook* includes a brief paragraph about fraud and abuse and a toll-free hotline phone number for members to report any suspicion of fraud.
1.18 Information regarding the Care Management Program and how to contact the Care Management Team;						
1.19 Information about advance directives;						UHC has developed a policy, *MBR15a, Advance Directives*, which meet the *CHIP Contract* requirements. The *CHIP Member Handbook* lists the right to make an advance directive in the member rights area. No other information is provided in the *CHIP Member Handbook* regarding advance directives. See the *CHIP Contract, Section 6 (B) (16).* ***Corrective Action:*** *Update the CHIP Member Handbook with information about advance directives such as living wills or durable power of attorney.*
1.20 Additional information as required by the contract and by federal regulation.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					
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					*Policy MBR 7 Member Materials/Sixth Grade Level of Reading Comprehension*, states all written materials provided to members should not exceed a sixth grade level of reading comprehension. UHC utilizes the Flesch-Kincaid Readability Scale. The *CHIP Member Handbook* is written in easy to understand language and is also available in Spanish. Per onsite discussion the *Member Handbook* is available in audio, braille, and electronic versions and informs members about interpreter and translation services available.
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, the availability of free oral translation services for all languages.	X					The Nurseline[SM], a nurse advice line, is available 24 hours a day. The *CHIP Member Handbook* informs members of the availability of interpreter and translation services and how to obtain them.
5. Member complaints/grievances, denials, and appeals are reviewed to identify potential Member misunderstanding of the CCO program, with reeducation occurring as needed.	X					The *2016 MS CHIP QI Program Description* states the review and analysis of complaint, grievance, and appeal data is conducted to: • Monitor, evaluate, and effectively resolve member concerns in a timely manner. • Identify opportunities for improvement in the quality of care or service provided to members. • Identify opportunities for improvement in the appeal and grievance process. Action plans to address opportunities for improvement are identified and reported to the National Quality of Care Committee.
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					UHC maintains separate toll-free call center lines for CHIP Member and Provider services. In the case of Behavioral Health services, members have access 24 hours a day, 7 days a week to clinical personnel who act within their scope of licensure to practice a Behavioral Health related profession. The same call center staff is trained to handle both CAN and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						CHIP member service questions. Page 10 of the CHIP Member Handbook lists the hours for the CHIP Member Services Call Center are 8:00 a.m. until 5:00 p.m. on Monday, Tuesday, Thursday, Friday; and 8:00 a.m. until 5:00 pm Saturday and Sunday the first weekend of the month. Wednesday hours are 8:00 a.m. until 8:00 p.m. It states they are available 7 days a week; however this is true for the first week of the month and all other times they are available only 5 days per week. Provider Services call center hours are 8:00 a.m. until 5:00 p.m. Monday through Friday. ***Recommendation:*** *Remove the misinformation about member services being available 7 days per week from page 10 of the CHIP Member Handbook.*
2. Call Center scripts are in-place and staff receives training as required by the contract.	X					*Policy ADM6a, Call Center Scripts*, defines the purpose of call scripts are to ensure that customers and providers receive consistent information. Scripts and welcome call content is found in this policy. During the onsite visit, CCME and DOM were provided the opportunity to listen to recorded member and provider call center calls. Observation confirmed consistent application of the call scripts and courteous interaction with callers. Members are informed that the call may be recorded and have the option to self-identify through a series of questions. This process enables call center to staff to quickly identify the issue and provide assistance. Call scripts are in place for a number of scenarios, including handling crisis and emergency situations. All call scripts are approved by DOM prior to use. According to the *CHIP Contract, Section 6 (A) (4),* Member Services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, MississippiCAN, guidelines for transferring calls to care managements, and customer service. UHC submitted a narrative found in folder #19 of the desk materials that states refresher and ongoing training to member services staff is performed on an as needed basis. Onsite discussion confirmed that training is ongoing. No policy was found that included the requirement for quarterly trainings or the quarterly submission to DOM detailing the trainings conducted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: *Include in a policy or other document that quarterly training will be conducted for Member Services call center staff. See the contract reference above for more information.*
3. Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call center activity is monitored for performance by measuring metrics and by the supervisor and the director auditing phone calls on a daily basis. UHC consistently meets the *CHIP Contract* requirements and internal benchmarks for call metrics on the speed of answer and the abandonment rates. Onsite discussion confirmed that UHC monitors no less than 3% of calls for compliance with customer care guidelines.
III D. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. 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 within 24 hours of receipt from the State, if a PCP is not provided in the 834 file. Customer service will assist members with a request to change PCPs, make the initial appointment, and arrange for the transfer of medical records 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 UHC *CHIP Member Handbook* includes information on preventive health services for children through age 20. Member Newsletters sent quarterly stress the importance of preventive care and encourage members to use these services.
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		X				The *CHIP Member Handbook* includes information on pregnancy and prenatal care. It directs members to find additional information by enrolling in the Healthy First Steps program, which includes pregnancy care and parenting classes as part of the wellness program. Members are tracked for prenatal care through claims and the Department of Health. No policy was found that addressed the contract requirement for UHC to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
program.						notify DOM within 7 calendar days of CHIP members identified with a diagnosis of pregnancy as found in the *CHIP Contract*, *Section 4 (F)*. No information on the WIC program is included in the *CHIP Member Handbook*. ***Corrective Action:*** *Include in a policy the process UHC will use to meet the requirement to notify DOM of a CHIP member with a diagnosis of pregnancy. Update the CHIP Member Handbook to include information on the WIC program.*
4. The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages Members to utilize these benefits.	X					The annual QI evaluation states EPSDT outreach is extended to members and their parents/guardians to encourage screening appointments. Outreach includes outbound phone calls, brochures, calendar stickers, bookmarks, etc. Onsite discussion revealed that UHC makes follow-up phone calls for missed appointments and tracks member compliance.
5. The CCO provides educational opportunities to Members regarding health risk factors and wellness promotion.	X					The *CHIP Member Handbook* states UHC has many educational health programs including: classes to help quit smoking, classes about pregnancy and parenting, and nutrition. Wellness activities are also found in member newsletters and brochures. Members may also be notified about upcoming events through digital media and text messaging.
III F. 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					The low response rate to the *CHIP Member Satisfaction Survey* is a common issue. In an effort to increase the response, several strategies are recommended in the narrative portion of this report. ***Recommendation:*** *Implement at least 1 of the strategies listed in the narrative of this report for next year's survey.*
2. The CCO analyzes data obtained from the Member satisfaction survey to identify quality problems.	X					Results were presented to the QMC committee in March 2016.
3. The CCO reports the results of the Member satisfaction survey to providers.	X					Results were communicated to providers in *MS Summer 2016 Practice Matters*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 were presented to the QMC committee in March 2016 and action plans as per the CAHPS Task Force were documented.
III G. 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					*UHC CHIP Policy AG-03, Complaint, Grievance and Appeal Procedures*, and *CHIP Behavioral Health Complaints and Grievances* policy define the process used to address complaints, grievances and appeals.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;	X					The *CHIP Member Handbook*, page 45 defines a complaint or a grievance as when you are not happy with UHC benefits, services, policies, or providers. The member, provider, or someone representing the member may file a grievance. *Policy AG-03* and the Behavioral Health policy, *Complaints and Grievances* defines a complaint made by a member or provider that is received orally and is of a less serious or formal nature. A grievance as an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than an action. It includes a member or member representative may file a grievance and complaints not resolved in 1 day are treated as grievances. The *CHIP Provider Administrative Guide* does not include the definition of a complaint or grievance. ***Recommendation:*** *Include a definition of a complaint/grievance in the CHIP Provider Administrative Guide.*
1.2 The procedure for filing and handling a complaint/grievance;		X				Regarding how grievances may be filed the following documents include the contract requirement that grievances may be filed either orally or in writing: • The *CHIP Provider Administrative Guide* • *Policy AG-03, Complaint, Grievance and Appeal Procedures* • The *CHIP Member Handbook*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• *Behavioral Health Complaints and Grievances* policy The *CHIP Member Handbook* does not list a toll-free number for members to file grievances as required by the C*HIP Contract, Section 5 (D).* *Federal Regulation § 438.406* requires the health plan acknowledge the receipt of each grievance or appeal. No timeframe for acknowledgement is defined in this regulation or the *CHIP Contract*. Inconsistencies in the timeframes defined by UHC for acknowledgement are found in the following documents: • The *CHIP Member Handbook* does not include acknowledgment. • The *CHIP Provider Administrative Guide* states grievances are acknowledged not later than 5 days from receipt. • *Policy AG-03* states within 10 calendar days of receipt. • Behavioral Health policy *Complaints and Grievances* states within 10 calendar days of receipt. Regarding the plan providing assistance to file: • Behavioral Health policy *Complaints and Grievances* does not include providing assistance to file a grievance. • The *CHIP Member Handbook* does not include assisting members to file a grievance. ***Corrective Action:*** *Include in the CHIP Member Handbook a toll-free number for members to file a grievance and that they can receive filing assistance if necessary. Clarify the timeframe for acknowledging grievances across all documents. Include in the Behavioral Health policy that assistance to file a grievance is provided.*
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;	X					*Policy AG-03* states the timeframe to resolve expedited grievances is 72 hours, standard grievances within 30 calendar days, and both timeframes may be extended by 14 days. Issues noted with timeframes include: • The *CHIP Member Handbook* states UHC will respond to a grievance within 30 days from receipt; however, the expedited 72 hour timeframe and possible 14 day extension are not found. • *Behavioral Health Complaints and Grievances* policy does not include a 14 day extension.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• The *CHIP Provider Administrative Guide* does not include the timeframe for grievance resolution or timeframe extension. *Federal Regulation § 438.408* addresses timeframe extensions. ***Recommendation:*** *Clarify the timeframe for grievance and expedited grievance resolution across all documentation. Include that the timeframe may be extended by 14 days as defined in the Federal Regulation noted above.*
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-03, Complaints, Grievances and Appeals Procedures*, does not address *Federal Regulation § 438.406 (b) (2*) which includes: • Ensure individuals deciding grievances or appeals are individuals who were not involved in any previous level of review or a subordinate of any such individual. • Who, if deciding any of the following, are individuals with appropriate clinical expertise in treating the enrollee's condition or disease as determined by the State? • An appeal of a denial based on the lack of medical necessity. • A grievance regarding the denial of an expedited resolution of an appeal. • A grievance that involves clinical issues. ***Corrective Action:*** *Include in Policy AG-03 Complaints, Grievances and Appeals Procedures all the requirements from Federal Regulation as noted above.*
1.5 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					*Policy AG-03 Complaints, Grievances and Appeals Procedures* states UHC maintains logs for complaints, grievances and appeals in the local office the term of the contract and for a period of 5 years thereafter unless an audit, litigation or other legal action is in progress.
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					Review of grievance files for CHIP members confirmed timely resolution in all cases. It did not appear that written acknowledgement was sent for any of the files reviewed; however, onsite discussion confirmed this is done verbally. 1 file included a request for second opinion; however, a second opinion was not offered or arranged according to the resolution letter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Letters that included the language provided to UHC by an external vendor was not easy to understand language nor did not contain an explanation of resolution. Onsite discussions confirmed UHC has recognized this issue. ***Recommendation:*** *Review language added to resolution letters to ensure it is appropriate and easy for members to understand. Ensure that employees handling grievances are aware of the contract requirement to provide second opinions when requested as well as the process to do so.*
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Onsite discussions confirm UHC does tally and trend grievances by category, volume, and resolution timeframes looking for trends and outliers. Minutes of the Service Quality Improvement Subcommittee (SQIS), Healthcare Quality and Utilization Management (HQUM), and the Quality Management (QMC) committees reflect tallying and discussion about opportunities for improvement. Aggregate data is also found in the *Quality Improvement Program Evaluation.* This process is not defined in any policy. ***Recommendation:*** *Include your process for tracking, trending, and evaluation of grievance data in a new or existing policy or document.*
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					UHC employees sign a code of conduct acknowledgement annually that includes maintaining confidentiality and data security for all physician, provider, or member specific data or information. The *Provider Administrative Guide* states UHC's grievance and appeals system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies.
III H. Practitioner Changes						
1. The CCO investigates all Member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					A request by a member to change PCPs is handled by customer services and then the file is forwarded to the QI area to investigate the reason for the request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					Per onsite discussion, requests for change of PCPs due to dissatisfaction are forwarded to QI to be tracked as grievances. This information is also forwarded to Provider Networking for use during the re-credentialing process.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The *2016 Quality Improvement Program Description* for the CHIP program was presented for review. This program description describes the goals and objectives the health plan has adopted for 2106. The program description discusses the objectives and the goals for the CHIP program, which are included in the Quality Improvement work plan for CHIP.
2. The scope of the QI program includes monitoring of services furnished to Members with special health care needs and health care disparities.	X					
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					The committee meeting minutes documented reports and addressed various aspects of utilization such as same-day patient follow-up after inpatient hospitalization, length of stay, ESPDT growth trends, routine authorization rates, expedited authorization rates, wellness screening for infants, pharmacy utilization, homecare, and ER utilization. Action plans for rates that were not meeting Benchmarks or have decreased were documented. There was ample documentation of over and underutilization topics that were discussed and addressed often.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up	X					UHC maintains a separate work plan for their CHIP program. This work plan is very comprehensive and contained all the planned QI activities

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).						for the program.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Oversight of the health plan's QI activities has been delegated to the National Quality Oversight Committee. This committee's membership includes health plan staff throughout the organization. However, there are no voting members from MS represented on this committee. This committee interfaces with other national and regional committees as applicable. Locally, the Quality Management Committee has been established and is responsible for the implementation and coordination of all QI activities throughout the organization in MS. Monitoring of QI activities is the responsibility of the Provider Advisory Committee. ***Recommendation:*** *Consider adding a voting member to the National Quality Oversight Committee from Mississippi.*
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership for the Quality Management Committee includes senior leadership and other health plan staff. Network providers serve on the Provider Advisory Committee.
3. The QI Committee meets at regular quarterly intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					Meeting minutes clearly document the business being discussed by the committee and the decisions made.
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					All of the HEDIS measures met the protocol guidelines and were considered fully compliant. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet.* For non-HEDIS measures, UHC reported they were having software issues and were not able to report the measures at this time. ***Recommendation:*** *Work with the appropriate department to fix*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						software issues related to data being abstracted to ensure accuracy and reporting on the non-HEDIS performance measure rates.
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					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					
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					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 Well-Baby and Well-Child screenings and results;	X					
4.3 Diagnosis and/or treatment for children.			X			The *CHIP Contract, Section 5 D,* requires the health plan to establish a tracking system for reporting all screening results; and diagnosis and/or treatment for members. UHC has systems in place for tracking initial visits for newborns, and Well-Baby and Well-Care screenings. However, the health plan does not track any diagnoses identified during the assessments and treatments, or the referrals provided as a result of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the assessments. ***Corrective Action:*** *Develop a system for tracking any diagnoses identified during a Well-Baby and Well-Child screening and the treatment and/or referrals provided.*
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					
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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. The Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to:	X					The *UHC 2016 UM Program Description and the 2016 MS CHIP Addendum* describe UHC's utilization management (UM) program for the CHIP program. Departmental policies and procedures guide staff in the performance of UM functions. Monitoring of over- and under-utilization are briefly mentioned, but more detail is provided in *Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization*.
1.1 Structure of the program;	X					The *2016 UM Program Description* defines the UM program structure, including the various committees charged with oversight and input for the UM program.
1.2 Lines of responsibility and accountability;	X					The *2016 UM Program Description and the CHIP Addendum to the 2016 UM Program Description* define departmental roles and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						responsibilities for the national and local UM programs.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					It is unclear in the policies and the *UM Program Description/CHIP Addendum*, which criteria are used for medical necessity determinations for the CHIP population. Onsite discussion confirmed UHC uses *MCG™ Care Guidelines* for medical determinations and internal policies for behavioral health determinations. • *Policy UCSMM.06.10, Clinical Review Criteria*, page 1, states, "External clinical review criteria are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as *MCG™ Care Guidelines or InterQual*." • The *UHC 2016 UM Program Description* states evidence based *MCG™ Care Guidelines and InterQual® Guidelines, UHC Medical Technology Assessments*, peer-reviewed medical literature, standardized coverage determination policies, evidence-based national guidelines, CMS national coverage determinations and local coverage determinations are used for clinical reviews. • The *CHIP Addendum to the 2016 UM Program Description* does not specify the criteria set used by UHC. ***Recommendation:*** *Revise the CHIP Addendum to the 2016 UM Program Description and Policy UCSMM.06.10 to include that the MCG™ Care Guidelines are used for medical necessity determinations for the CHIP population.*
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					*Policy UCSMM.06.15, Peer Clinical Review*, states peer review is performed for cases that were not approved by an initial screening or an initial clinical review process (i.e., 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). Onsite discussion confirmed all cases for which there are no criteria are reviewed by a Medical Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						New medical policies are developed in response to emerging technology or new treatments and are based on scientific evidence, where such evidence exists. Medical policy updates are communicated to all staff.
1.6 The appeal process, including a mechanism for expedited appeal;	X					The *CHIP Addendum to the UM Program Description*, provides an overview of provider appeals, but does not address the member appeals process. Onsite discussion confirmed this is an oversight. ***Recommendation:*** *Revise CHIP Addendum to the UM Program Description to address member appeals. This is a requirement of the CHIP Contract, Section 9 (M) (2).*
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. David Williams, UHC's Chief Medical Officer (CMO), is board certified in internal medicine and actively practicing in Jackson, MS. Dr. Williams chairs the Quality Management Committee (QMC), Healthcare Quality Utilization Management (HQUM) Committee, and the Provider Advisory Committee (PAC). In addition, he is a member of the National Credentialing Committee (NCC). The *2016 CHIP Addendum to the UM Program Description* defines the CMO's roles and responsibilities for oversight of the UM Program.
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					The National Medical Care Management Committee (NMCMC) reviews and approves the *UM Program Description* on an ongoing basis and no less than annually. Also, the NMCMC reviews and approves clinical policies, criteria and guidelines recommended by the Medical Technology Assessment Committee (MTAC). Membership of the MTAC includes medical and surgical specialists and subspecialists representing diverse medical specialties. Internal clinical criteria are developed with review and input from the appropriate providers and are based on current clinical principles, processes, and evidence based practices. The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates by the Medical Policy Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						At the local level, the HQUM Committee reviews and approves the *UM Program Description*. An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the NMCMC, the Community and State National Quality Management Oversight Committee (NQMOC), and the HQUM for approval.
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					UM approval files for CHIP members reflect attempts to obtain additional clinical information when needed and the use of the appropriate criteria to render determinations.
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					The *2016 UM Program Description* states UHC performs *inter-rater reliability (IRR) assessments* and Medical Directors responsible for benefit coverage determinations also participate. IRR studies are performed no less than annually and results are monitored and tracked for coaching opportunities. The *UCS Annual MCG™ Care Guidelines Interrater Reliability Standard Operating Procedure (SOP*) describes the processes employed for annual IRR testing. The SOP provides notification for when remediation will be required, but does not describe the remediation process. Onsite discussion indicated that remediation includes further training, mentoring, and development of an action plan for improvement. HQUM minutes from 5/31/16 state IRR scores for 2015 were: • RNs—four scores of 100% and one score of 90% • MDs—five scores of 100% and two scores of 10% Onsite discussion confirmed the MD scores of 10% are incorrect and the correct scores were 90%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: *Revise the UCS Annual MCG™ Care Guidelines Interrater Reliability SOP to include the process for remediation for IRR scores below the benchmark. Ensure HQUM Committee minutes reflect accurate information regarding IRR scores.*
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The *2015 Pharmacy Program Evaluation* states, "Beginning in January 2015, the pharmacy benefit became aligned with the Medicaid PDL." The UHC CHIP website directs users to the DOM website for the most current formulary.
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					*Policy RX-012, Pharmacy Coverage Reviews*, describes the pharmacy prior authorization (PA) process. Drugs which require PA include non-formulary drugs, certain formulary drugs that may have precursor therapies or very specific indications, and drugs that are not routinely covered due to plan benefit limitations or exclusions. *Policy RX-01, MS Pharmacy Benefit*, indicates UHC covers a minimum of a 3 day emergency supply of drugs to allow the PA time to be completed.
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Requirements for emergency and post-stabilization care are addressed in *Policy UCSMM.04.11, Consumer Safety*. The *CHIP Member Handbook*, page 25, defines post-stabilization services and informs members that post-stabilization services are covered and can be provided without prior authorization. The *CHIP Provider Administrative Guide* does not address post-stabilization services. ***Recommendation:*** *Include information on post-stabilization requirements and processes in the CHIP Provider Administrative Guide.*
7. Utilization management standards/criteria are available to providers.	X					*Policy UCSMM.06.10, Clinical Review Criteria*, states providers have access to clinical review criteria upon request and will be advised in writing how to obtain the criteria. Providers are informed of the availability of criteria in the *Provider Administrative Guide* and in notice of adverse action letter templates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *CHIP Addendum to the 2016 UM Program Description*, page 15, states, "UnitedHealthcare shall distribute its criteria for approval or denial of outside services to all outside providers to whom members are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities providing Emergency Medical Services known to UnitedHealthcare and located within a thirty (30) mile radius." Onsite discussion confirmed that this statement should not be included in the *CHIP Addendum to the 2016 UM Program Description*, and will be removed. ***Recommendation:*** *Remove the statement above from the CHIP Addendum to the 2016 UM Program Description.*
8. Utilization management decisions are made by appropriately trained reviewers.	X					Staff members who conduct initial reviews are MS-licensed healthcare professionals, including RNs, LPN/LVNs, or other appropriate licensed health professionals. Staff members who conduct peer clinical reviews are qualified health professionals with a current MS license to practice.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					UM approval files for CHIP members reflect attempts to obtain additional clinical information when needed to render a determination, timely determinations, and timely notifications.
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					UM denial files for CHIP members reflect attempts to obtain additional clinical information when needed to render a determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					UM denial files for CHIP members reflected that the appropriate peer reviewers issued the denial 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					UM denial files for CHIP members reflected timely determinations and notifications of the denial determinations. Denial letters contained the appropriate information, including the rationale for the denial as well as the criteria on which the denial was based.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					*Policies AG-03, Complaint, Grievance and Appeal Procedures, and AG-04, Expedited Review Process*, define the appeals processes for the CHIP population.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				The terms "action" and "appeal" are appropriately defined in *Policy AG-03 and AG-04* as well as the *Member Handbook*; however, these are not defined in the *Provider Administrative Guide*. Pages 4 and 6 of *Policy AG-03, Complaint, Grievance and Appeal Procedures*, define who may file an appeal, but fail to include the legal representative of a deceased member's estate. ***Corrective Action:*** *Revise the CHIP Provider Administrative Guide to include definitions of the terms "action" and "appeal." Update Policy AG-03 to include the legal representative of a deceased member's estate may also file an appeal. Refer to the CHIP Contract, Exhibit E, Sections A and D.*
1.2 The procedure for filing an appeal;		X				Per onsite discussion, UHC allows an appeal to be filed up to 45 calendar days from the date on the notice of action (denial) letter. Discrepancies were noted in the following: • *Policy AG-03, Complaint, Grievance and Appeal Procedures*, page 6, states an appeal may be filed within forty-five calendar days of the date of the event causing the dissatisfaction. • The *Member Handbook*, page 44, states 45 calendar days from the date of the incident to file appeal. • The *Provider Administrative Guide*, page 35, states appeals may be filed 45 days from the date of the Notice of Action. *Federal Regulation §438.406 (b) (1)* requires acknowledgement of each appeal. *Policies AG-03, Complaint, Grievance and Appeal Procedures*, and *AG-04, Expedited Review Process*, do not address the acknowledgement of appeals and onsite discussion revealed that UHC

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						does not provide acknowledgement of receipt of CHIP appeals. *Policy AG-03, Policy AG-04*, and the *Provider Administrative Guide* do not address the requirement that in the appeals process the enrollee is provided a reasonable opportunity to present evidence and testimony and make legal and factual arguments. Refer to *Federal Regulation §438.406 (b) (4).* The *Member Handbook* does not inform members they can review the appeal case file and related documentation. Refer to *Federal Regulation §438.406 (b) (5)*. ***Corrective Action:*** *Revise policy AG-03, the Member Handbook, and the Provider Administrative Guide to state appeals may be filed 45 calendar days from the date on the notice of action letter. Implement a process to ensure that CHIP appeals are acknowledged. Include information in Policy AG-03, Policy AG-04, and the Provider Administrative Guide regarding the member's ability to present evidence and testimony and make legal and factual arguments regarding the appeal. Revise the Member Handbook to inform members that they can review the appeal case file and all related documentation.*
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					*Policy AG-04, Expedited Review Process*, page 4, states UHC ensures that the decision makers who review the appeal were neither involved in previous levels of review or decision-making, a subordinate of such an individual, and are health care professionals with clinical expertise in treating the member's condition or disease when deciding an appeal of a denial based on lack of medical necessity or an appeal involving clinical issues. *Policy AG-03, Complaint, Grievance and Appeal Procedures*, page 10, states, "The individuals reviewing the reconsideration shall not be the same individuals utilized in the initial determination when the Appeal was denied." There is no statement regarding the review of any appeal involving medical necessity or clinical issues must be performed by a practitioner with the appropriate medical expertise. *Policy UCSMM.06.15, Peer Clinical Review*, page 1, states, "The peer clinical reviewer will be available to provide peer-to-peer discussion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Only peer clinical reviewers will render adverse determinations for clinical review outcomes. In the case of clinical adverse determination, the peer clinical reviewer or their alternate will be available within one business day to discuss determinations with requesting providers." Onsite discussion confirmed that after an initial denial has been formally issued, the original reviewer can change the initial denial decision based on a peer-to-peer conversation. However, this is prohibited by *Federal Regulation § 438.406 (a) (3) (i)*. Any changes to the original determinations must be issued by a reviewer who was not involved with the original decision. In addition, *NCQA 2016 UM Standards, UM 7: Denial Notices, Element A: Discussing a Denial With a Reviewer*, and *Element D: Discussing a Behavioral Healthcare Denial With a Reviewer*, agree with this position by stating, "Although federal regulations may define an overturned denial based on the (peer to peer) discussion as an appeal, such an approval does not fall under the scope of NCQA's appeal standards; however, the case is considered a denial because a denial notice was issued." ***Recommendation:*** *Revise policy AG-03 to include a statement that the review of any appeal involving medical necessity or clinical issues is performed by a practitioner with the appropriate medical expertise. Update UHC's peer-to-peer processes to ensure peer-to-peer reviews either occur before a denial determination has been issued or that a different reviewer changes the initial denial determination.*
1.4 A mechanism for expedited appeal where the life or health of the Member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Timeliness requirements for first level and second level appeals are appropriately documented in *Policy AG-03 Complaint, Grievance and Appeal Procedures*, the *CHIP Member Handbook*, and the *CHIP Provider Administrative Guide*. Timeliness requirements for third level appeals are appropriately documented in *Policy AG-03 Complaint, Grievance and Appeal Procedures*, and the *Member Handbook*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The *CHIP Provider Administrative Guide*, page 37, states the notice of decision for third level appeals will be sent within 30 calendar days of receipt of the third level appeal request. All other documents state a 15 calendar day timeframe. ***Corrective Action:*** *Revise the CHIP Provider Administrative Guide to include the correct timeframe for third level appeal resolution and notification. Refer to the CHIP Contract, Exhibit E.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				A review of the CHIP appeal files revealed the following issues: • Appeals reviewed by the dental vendor do not include a reference to the benefit or the criteria used in the review in the appeal resolution letter for upheld appeals. • Although expedited appeals do contain evidence/notes of verbal acknowledgement being provided, standard appeal files do not contain evidence of written acknowledgement of the appeal. • Per onsite discussion, for one appeal file reviewed by the dental vendor, the initial denial was upheld for medical necessity due to the type of provider rendering the service; however, the notice of action letter incorrectly stated the service was not covered under the member's benefit package. • One appeal requested as expedited contained no evidence that the request to expedite the appeal was denied. The determination was not timely for an expedited appeal request. ***Corrective Action:*** *Ensure appeal resolution letters contain a reference to the benefit or criteria used in the review when the decision is to uphold the denial. Develop a process to send written acknowledgement of receipt of standard appeal requests. Ensure that appeal resolution letters contain an appropriate rationale for upholding the initial denial.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Provider Advisory Committee reviews summary appeals data, identifies trends, conducts barrier analyses, and recommends corrective actions as needed. The Service Quality Improvement Subcommittee monitors trends related to appeal activities.
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 2016 UHC Community and State Person Centered Care Model (PCCM) Program Description* is used for both the CAN and CHIP lines of business. It defines the CM program's overall purpose, scope, data sources for member identification, components, staff qualifications, etc. In addition to the program description, various CM policies and procedures address CM functions and processes. The *PCCM Program Description* and CM policies and procedures are all national documents and do not address the MS-specific requirements found in the *CHIP Contract, Section 8*. No riders or policy addenda were found to address specific MS requirements. In addition, policies address only high-risk CM. ***Corrective Action:*** *Develop an addendum to the PCCM Program Description. Develop and implement policies or riders/ addenda to CM policies that address MS-specific CM requirements. Refer to the CHIP Contract, Section 8.*
2. The CCO uses varying sources to identify and evaluate Members' needs for care management.	X					*Policy NCM 001, Identification of High-Risk Members for Case Management*, defines the process by which all new members are screened for CM and defines the sources used to identify members for CM. All new UHC members are screened for CM programs via a health risk assessment (HRA) screening tool to identify and refer members to CM and other specialized programs. The policy also states members identified as high-risk are further stratified into two groups: those receiving long-term services and support (LTSS) and those not receiving LTSS. Member's identified as high-risk who receive LTSS (community or facility based) will be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						referred for CM. Members identified as high-risk, not receiving LTSS, will be referred to high-risk CM (HRCM). Onsite discussion with UHC staff confirmed this is not applicable to CHIP; however, there is no indication within the policy to indicate that this does not apply to CHIP membership. Per onsite discussion, members are stratified into low-, medium-, and high-risk categories and members determined to be in the medium- and high-risk categories are referred to CM for assessment. CM services are available, if needed, to members in the low-risk category. ***Recommendation:*** *Update Policy NCM 001 to indicate that LTSS services are not applicable to the CHIP membership.*
3. A health risk assessment is completed within 30 calendar days for Members newly assigned to the high or medium risk level.		X				*Policy NCM 002, High-Risk Case Management Process*, states the initial comprehensive assessment is completed as expeditiously as the member's condition requires, but no later than 30 calendar days from when the member was identified as appropriate for high-risk CM. The assessment is completed telephonically or face-to-face based on the member's condition and regulatory guidance. Onsite discussion confirmed there is no policy that addresses when the comprehensive assessment is to be completed for members initially stratified into the medium-risk category. Onsite discussion revealed that this is done within 30 calendar days from initial identification. ***Corrective Action:*** *Include in policy the timeframe for completing comprehensive assessments for members initially stratified into the medium-risk category. Refer to the CHIP Contract, Section 8 (A) (1).*
4. The detailed health risk assessment includes:						*Policy NCM 002, High-Risk Case Management Process*, includes the requirements for comprehensive assessments for the high-risk member population. As noted above, there is no policy that addresses assessment requirements for members in the medium- and low-risk populations.
4.1 Identification of the severity of the Member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
complex health care conditions;						
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					
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				The *CHIP Contract, Section 8 (A) (1),* requires the treatment plan for the member to be completed within 30 days of the completion of the detailed health risk assessment. *Policy NCM 002* states the individual care plan is developed jointly with the member, caregiver/family (with member's consent) and PCP. If the member is engaged in behavioral health services, the BH provider is also engaged in the POC development. The policy does not specify the timeframe for completion of the individual care plan; however, onsite discussion revealed the care plan is completed within 30 days from the completion of the comprehensive assessment. ***Corrective Action:*** *Revise policy NCM 002 to include the timeframe for the completion of the individual care plan. Refer to the CHIP Contract, Section 8 (A) (1).*
6. The risk level assignment is periodically updated as the Member's health status or needs change.	X					*Policy NCM 002* states member contact frequency for follow-up is based on the member's acuity level, medical/psychosocial status, and their preference for level of engagement. The care plan and goals will be re-evaluated and modified based on member accomplishments and progress. Reassessments will be completed annually and with significant changes in condition.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all Members through the following minimum functions:	X					*The PCCM Program Description* summarizes the philosophy and structure for ensuring the member's medical, behavioral, and social/environmental needs are addressed through the engagement of members, hospitals, and physicians. Interventions are focused on the member's social, medical, and behavioral needs, with an ultimate goal of a better quality of life, improved access to healthcare, and reduced expenses. The PCCM program assesses the member, provides an integrated team for member CM/care coordination, provides resources to fill gaps in care, and develops individualized goals toward a common outcome.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 contact their assigned team;						Per onsite discussion, all members in CM are assigned to a specific CM. Assignments are based on the member's zip code; unless the member's specific circumstances require being assigned to a more specialized care manager.
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;						
7.3 Appropriate referral and scheduling assistance for Members needing specialty health care services, including behavioral health, and those identified through Well-Baby and Well-Child screening;						
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;						
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						UHC has developed an integrated care model for discharge planning involving case rounds with the medical and inpatient (hospital) care managers. Medication reconciliation is performed as part of discharge.
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;						UHC care managers assist members in obtaining authorizations for needed services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7.9 Coordination with other health and social programs such as, 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;						The *PCCM Program Description* states CM staff ensures each member is assigned a PCP. Each member is strongly encouraged and instructed on the optimal use of their PCP as the medical home for community-based health and preventive services. The PCP is involved in the plan of care development process and CM staff reinforces the PCP's treatment plan.
7.12 The CCO 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						*Policy UCSMM.06.21, Out-of-Network Requests and Continuing Care,* defines the processes for providing out-of-network care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						
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;						Members are involved in all stages of assessment, care plan development, monitoring, and revision. Community health workers make home visits to the member with frequent check-ins and education is provided. The care plan is reviewed with the member during the development and any time there are revisions to the care plan.
7.15 Monitor and follow-up with Members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						Per the *PCCM Program Description*, the Care Manager reviews the member's compliance with the plan of care and the physician's treatment plan occurs monthly at a minimum for high-risk members.
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				Per onsite discussion, this standard is met. However, there is no policy that addresses CM for members assigned to the medium- or low-risk levels. ***Corrective Action:*** *Develop a policy or add to an existing policy the CM services provided to CHIP members in the medium- and low-risk levels.*
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, obesity, attention	X					UHC's Disease Management program includes the required diagnoses and members are informed of the availability of the Disease Management program in the *Member Handbook*, and the *Provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
deficit hyperactivity disorder, and organ transplants.						*Administrative Guide, which* includes brief information on the program.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					UHC's Transitional Care Management program is a component of the CM program. Per the *PCCM Program Description*, the Community Care Team is accountable for end-to-end integrated person centered CM of all members to whom they are assigned. Members who experience a trigger event, such as an inpatient admission or emergency department visit, are assigned to a Community Health Worker to complete an access to care questionnaire. Individuals with more complex medical or behavioral needs are assigned to a clinician (registered nurse or behavioral health advocate) from the Community Care Team for interventions. Each care team will be responsible for managing transitions in care, high-risk CM (including behavioral and medical), social determinant needs, and pregnant members.
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					A component of the CM program is to effectively manage transitions of care from hospital to home during the 30 days post-acute hospital discharge and ensure that the member is connecting regularly with their provider. The goal is to improve care transitions and reduce unnecessary readmissions by providing members with the tools and support to promote knowledge and self-management skills. The four conceptual areas are: medication self-management, primary care and specialist follow-up, knowledge of red flags (indications that their condition is worsening and when to notify their physician and get help), and education of the member on the use of a *Personal Health Record* to facilitate communication and ensure continuity of care plan across provider and settings. This is accomplished through pre-hospital discharge education to introduce the program, a post discharge contact plan, a post-hospital discharge assessment (within 72 hours to determine needs and medication reconciliation), and follow-up calls to reinforce the value and importance of a PCP visit within 7 days of discharge.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements,	X					The interdisciplinary care team includes providers, registered nurses, behavioral health advocates, and community health workers. The team

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
designs and implements the transition of care plan, and provides oversight to the transition process.						meets weekly and holds ad hoc meetings.
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					An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the NMCMC, the Community and State National Quality Management Oversight Committee (NQMOC), and the HQUM for approval. The *UM Evaluation for 2015* cited data for many UM metrics and included the goals, barriers, and interventions. A summary of the information was provided and included recommendations for 2016. The evaluation was reviewed and approved by the HQUM and QMC on 8/1/16.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the NMCMC, the Community and State National Quality Management Oversight Committee (NQMOC), and the HQUM for approval.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 agreements with: • OptumHealth—Behavioral health services • Dental Benefit Providers—Dental network services and 3rd party dental administrator • eviCore National—Radiology and Cardiology management services and prior authorizations • Vision Service Providers (VSP)—Vision and eye care services

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						• MHG and Physician Corporation—credentialing • Hattiesburg Clinic—credentialing • River Region—credentialing • HubHealth—credentialing • University Physicians—credentialing *UHC's Master Services Agreement* specifies tasks to be performed, compensation arrangements, and informs that for breach of contract, the agreement may be terminated.
2. The CCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					Onsite discussion revealed Mitch Morris, Chief Operating Officer, is responsible for delegation oversight. The monitoring of delegated activities is accomplished through a combination of several activities, including regular and recurring vendor reporting of operational trends/issues and performance improvement initiatives; standing joint operating committee meetings to review performance and discuss any needed remediation; email communications; and ad hoc meetings. The *UHC Credentialing Plan, Section 11,* and *policy 102, Delegated Credentialing and Oversight Procedures,* address delegated credentialing requirements and oversight. Documentation of monitoring and oversight activities for all delegated entities was provided. Issues discovered in review of delegation oversight documentation include: • Oversight documentation for OptumHealth contains no evidence that authorization turn-around times are monitored. • Oversight documentation for Dental Benefit Providers documented the average resolution time for appeals, but it was unclear if this included only standard appeals or if expedited appeals resolution timeframes were included in this average. ***Recommendation:*** *Ensure that delegated entity oversight documentation includes all standards for which the health plan is held accountable.*