CCME

2019 External Quality Review

UNITEDHEALTHCARE COMMUNITY PLAN MISSISSIPPI

Submitted: November 19, 2019

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 who contract with Managed Care Organizations (MCOs) to evaluate their compliance with 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 (United). This report contains a description of the process and results of the 2019 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi (MS) 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 include the following:

- Determine if United is in compliance with service delivery as mandated in the Coordinated Care Organization (CCO) contract with DOM.
- Provide feedback about potential areas of improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

The EQR process is based on Centers for Medicare & Medicaid Services (CMS)-developed protocols for EQRs of Medicaid MCOs. The review includes a desk review of documents; results from a one-day onsite visit; a compliance review; validation of performance improvement projects (PIPs) and performance measures, member satisfaction and provider satisfaction surveys; and an Information System Capabilities Assessment (ISCA) audit.

OVERVIEW

The 2019 CAN Program EQR shows United achieved "Met" scores for 91% of the standards reviewed. As the following chart indicates, 7% of the standards were scored as "Partially Met" with 2% scoring as "Not Met." For the CHIP Program, 91% of the standards were scored as "Met," 8% of the standards were scored as "Partially Met" with 1% scoring as "Not Met."

Figure 1: 2019 Annual EQR Review Results for CAN & CHIP

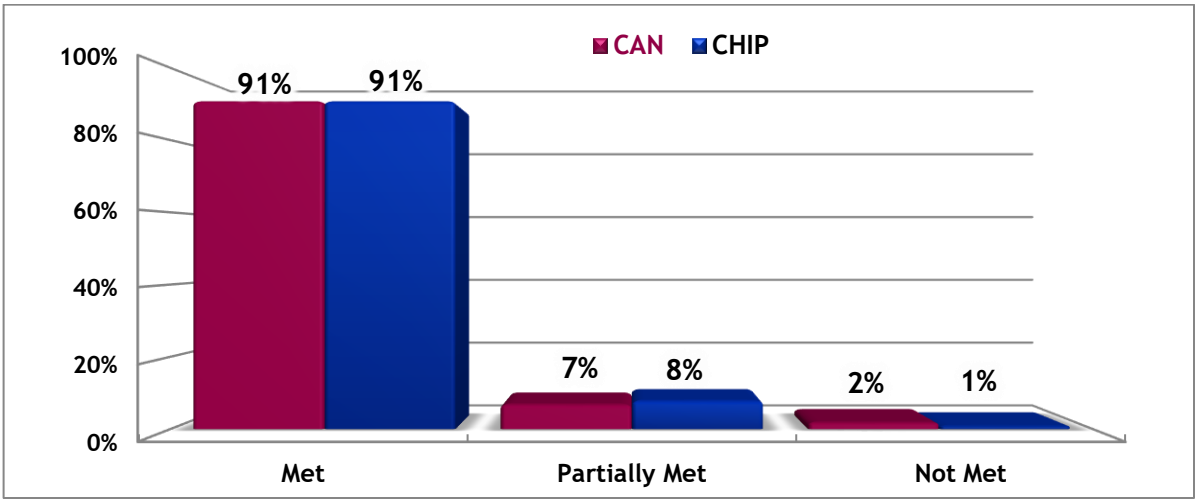


Table 1, Scoring Overview provides an overview of the scores for each review section for the CAN and the CHIP programs.

Table 1: Scoring Overview

2019	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
CAN	27	4	0	0	0	31
CHIP	27	4	0	0	0	31
Provider Services						
CAN	80	5	2	0	0	87
CHIP	77	6	2	0	0	85
Member Services						
CAN	30	1	2	0	0	33
CHIP	30	1	1	0	0	32
Quality Improvement						
CAN	19	0	0	0	0	19
CHIP	19	0	0	0	0	19
Utilization Management						
CAN	50	3	0	0	0	53
CHIP	49	4	0	0	0	53

2019	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Delegation						
CAN	1	1	0	0	0	2
CHIP	1	1	0	0	0	2

Overall Findings

An overview of the findings for each section is included in this Executive Summary. Details of the review, as well as specific strengths, weaknesses, and any applicable corrective action items and recommendations, are found in the respective sections and narrative of this report.

Administration

United's *Organizational Chart* does not reflect current staff in all positions. United does not meet DOM's requirement for a minimum of eight representatives to provide face-to-face provider services or the contractual requirement for two additional representatives designated for out-of-state providers.

Although United policy requires annual review of all policies, procedures, and standard operating procedures, some policies do not reflect an annual review. Also, some do not indicate the line(s) of business to which they apply.

United's ability to safely collect, store, and process Medicaid claims is well documented. However, United's estimate of claims completion after three months falls below the 90-day clean claims payment requirement. While not a contractual requirement, United reported an excellent claims payment accuracy average of 98.90% for a recent 12-month period. United provided business continuity plans that summarize approaches to keeping systems available during events that could cause interruptions and restoring operations if a disaster occurs. However, United conducted only limited testing on those processes.

Documentation of United's processes to guard against fraud, waste, and abuse (FWA) and to ensure employees comply with standards of ethical behavior are, overall, well done. However, documented processes for monitoring the exclusion status of any person with an ownership or control interest or who is an agent or managing employee of the CCO need to be strengthened. Current processes do not address the requirements to conduct routine checks of the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System.

While suitable processes are in place for training and educating staff and providers about compliance and FWA requirements, laws, and regulations, the CAN and CHIP *Member*

Handbooks contain scant information about FWA. Moreover, United staff reported that no additional information is provided to members. Suitable avenues are available for staff, members and providers to report potential compliance, FWA, and ethics concerns or violations. Anonymous reporting, as well as a no-retaliation policy, is ensured.

Provider Services

Dr. Amit Prasad, Chief Medical Officer, chairs the Provider Advisory Committee (PAC). Dr. Prasad took over as PAC chair in August 2019 from the Interim Chief Medical Director. Additional committee voting members include 10 participating network providers with specialties of pediatrics, psychiatry, dentistry, obstetrics (OB)/gynecology (GYN), internal medicine, family medicine, and emergency medicine. The PAC meets quarterly and acts as the health plan's Credentialing Committee.

The PAC also reviews the National Credentialing Committee (NCC) recommendations and has the authority to approve, deny, or suspend the recommendations made by the NCC related to the MS Medicaid network. Two Market Medical Directors chair the NCC. Voting members include 16 network providers from local health plans. George Russell, an orthopedic surgeon and committee member, represents MS. CCME noted that the previous Interim Chief Medical Director did not attend any of the 26 NCC meetings based on reviewed meeting minutes. Onsite discussion confirmed that Chief Medical Officer Dr. Prasad is now a committee member and will attend the meetings. The Market Medical Directors are non-voting committee members.

United uses the following credentialing plans to define processes for credentialing and recredentialing:

- *UnitedHealthcare Credentialing Plan 2019- 2021* for licensed independent practitioners and facilities
- *Optum Physical Health Credentialing Risk Management Plan 2019* for physical medicine providers, including chiropractic, physical therapy, occupational therapy, and speech therapy
- *United Behavioral Health Clinician and Facility Credentialing Plan 2019-2020* for behavioral health providers and facilities

Addendums address MS-specific criteria; however, several UBH/OPTUM policies did not address MS-specific credentialing criteria.

In the previous EQR, CCME identified that *Ownership Disclosure* forms showed signatures from people that did not have the authority to sign the document. This contradicted United's *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* document, which says "an individual must have the power to legally bind the entity." During the corrective action process, United presented an updated *Provider*

Entity Disclosure of Ownership form that contained a statement ensuring the signer had authority to legally bind the entity. The updated form was not implemented. Additional issues relating to the CAN and CHIP credentialing/recredentialing file review included the following:

- Outdated *Ownership Disclosure* forms
- Missing proof of query of the MS DOM *Sanctioned Provider List*
- Documentation of provider office site visits missing from nurse practitioner (NP) credentialing files when the NPs indicated on the application they would act as a primary care practitioner (PCP)

Onsite discussion confirmed United implemented a new Provider Orientation Training Program, which was not reflected in the training policy presented in the desk materials. While both the CAN and CHIP *Care Provider Manuals* are detailed, some issues need to be corrected.

The *Telephonic Provider Access Study* CCME conducted shows improvement from the previous study's results. A modified review was conducted in 2018, so the most recent *Telephonic Provider Access Study* was conducted in 2016 and had a success rate of 40%. Since that review, CCME adjusted the definition of a successful call. Now, the success rate is based on an adjusted denominator instead of the total calls made. The denominator is the total calls made minus those answered with voicemail messages, which is now standard for many provider offices. Given the new formula, the success rate for the CAN 2019 *Telephonic Provider Access Study* was 63% and the success rate for CHIP was 61%.

CCME performed a *Provider Satisfaction Survey* validation using a validation worksheet based on the *CMS Survey Validation Protocol*. CCME identified the response rate as an area needing improvement. The *Provider Satisfaction Survey* had a low response rate (3%), which is well below the National Committee for Quality Assurance (NCQA) target response rate of 40% for surveys. The low response rate may impact the generalizability of the survey.

Member Services

United's policies and procedures define and describe member rights and responsibilities and methods used to notify members of their rights and responsibilities. Information is included in the *Member Handbook*, *Care Provider Manual*, on United's website, and in member newsletters. However, CCME identified incomplete or omitted requirements for member rights and responsibilities.

United encourages CAN and CHIP members to obtain recommended preventive services (including well-child services) via the website, at community events, through reminder phone calls, and through mailings.

CCME's review of United's documentation of grievance processes and requirements revealed several issues related to definitions of grievance terminology and grievance filing processes. The issues also related to requirements. These issues were previously identified during the 2018 EQR and contributed to scores of "Not Met" for the applicable review standards. The CAN and CHIP grievance files review revealed some acknowledgement letters were untimely, and one CHIP grievance file contained an improper resolution. Another issue involves the Service Quality Improvement Committee (SQIC). Although the CAN and CHIP *2019 Quality Improvement Program Descriptions* indicate the SQIC monitors member complaint and grievance trends, this was not evident in the SQIC meeting minutes.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys continue to be conducted annually via a third-party vendor. *Member Satisfaction Survey* validation, for both CAN and CHIP, was performed based on the CMS Survey Validation Protocol. Generalizability of the survey results is difficult to discern due to low response rate.

Quality Improvement

United implemented a Quality Improvement (QI) Program that is described in the *2019 Quality Improvement Program Description* for the MississippiCAN Program and in the *2019 Quality Improvement Program Description* for the CHIP Program. The purpose of the QI Program is to monitor, evaluate, and improve the quality of clinical care and services provided to United's members. Program descriptions are updated annually and submitted to the Board of Directors, Quality Management Committee, and to DOM for review and approval.

United's Standard Operating Procedure titled *EPSDT Services – Tracking Process* and the Standard Operating Procedure titled *Well Child Services – Tracking Process* indicates any problems identified during the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) and Well-Child exams that required referrals are tracked quarterly. United provided a sample of the results of these tracking reports. However, the reports did not contain EPSDT or Well-Child visits. The reports appeared to include encounters not related to a diagnosis found on the EPSDT or Well-Child exams such as emergency room visits or unspecified effects of drowning and nonfatal submersion. CCME recommends tracking reports only include the problems or diagnoses identified during the EPSDT or Well-Child exams that required referrals.

The CAN and CHIP performance measures and PIPs met the CMS validation requirements. The CAN Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures comparison from the 2016 measurement year to the 2018 measurement year revealed a substantial improvement (>10%) in human papillomavirus (HPV) and Combination #2 Vaccinations for Adolescents, and Comprehensive Diabetes Care HbA1c Control. The measures with a substantial decrease in rate were Comprehensive Diabetes Care hemoglobin A1c (HbA1c) Poor Control, Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5-year olds, and Alcohol Abuse or Dependence: Initiation of AOD Treatment: Total. *Table 2: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from 2016 to 2018.

Table 2: CAN HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescents (ima)			
HPV	6.81%	18.98%	12.17%
Combination #2	6.08%	17.27%	11.19%
Comprehensive Diabetes Care (cdc)			
HbA1c Control (<8.0%)	35.04%	46.23%	11.19%
Substantial Decrease in Rate (>10% decrease)			
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	56.93%	45.50%	-11.43%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	35.42%	23.91%	-11.51%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.89%	34.37%	-11.52%

All relevant CHIP HEDIS performance measures were compared with the current review year (MY 2018) to the previous year (2016). No measures had substantial improvements of greater than 10%, although many rates improved. The measures of Antidepressant Medication Management and Follow-Up After Hospitalization for Mental Illness declined substantially. *Table 3: CHIP HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial decreases in rate from 2016 to 2018.

Table 3: CHIP HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2016	Measure Year 2018	Change from 2016 to 2018
Substantial Decrease in Rate (>10% decrease)			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	47.62%	32.35%	-15.27%
Effective Continuation Phase Treatment	33.33%	17.65%	-15.68%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total-30-day Follow-Up	76.97%	61.39%	-15.58%
Total-7-day Follow-Up	53.95%	35.15%	-18.80%

As of July 1, 2019, there are four new topics required for the CAN PIPs. The required topics are: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). United submitted four PIPs for the required topics. *Table 4: CAN Performance Improvement Project Validation Scores* provides an overview of the validation scores for the CAN PIPs.

Table 4: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Behavioral Health Readmissions	N/A	78/78=100% High Confidence in Reported Results
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	N/A	62/62=100% High Confidence in Reported Results
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	N/A	57/62=92% High Confidence in Reported Results
Respiratory Illness: COPD/Asthma	N/A	62/62=100% High Confidence in Reported Results

As shown, four of the projects (4/4=100%) received a score of "High Confidence in Reported Results."

United submitted four projects for CHIP. As per the Contract, the topic of obesity should be selected annually for study, providing continuous evaluation. The following table displays the submitted projects and their current and previous validation scores. For the

2018 review, each PIP scored in the "High Confidence in Reported Results" validation range. For the current review, each PIP also scored in the "High Confidence in Reported Results" range, although there are several recommendations that apply to the most recent submitted reports. *Table 5: CHIP Performance Improvement Project Validation Scores* provides an overview of the scores for the CHIP PIPs.

Table 5: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Adolescent Well Child Visits	111/111=100% High Confidence in Reported Results	104/105=99% High Confidence in Reported Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-formerly called Reducing Adolescent and Childhood Obesity	111/111=100% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Getting Needed Care CAHPS	92/98=94% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	95/95=100% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results

Utilization Management

CCME's utilization management (UM) assessment includes CAN and CHIP reviews of program descriptions and evaluations; policies; the *Member Handbooks; the Care Provider Manuals*; approval, denial, appeal and case management files; and United's website. Policies and procedures define how care management (CM) services are operationalized and provided to members.

The *UM Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. CCME identified minor issues with obtaining Preferred Drug List information in the *Member Handbook* and from the website. Review of approval and denial files met criteria and timeframe requirements.

The CAN and CHIP CM program descriptions and policies correctly document CM processes and service provided. CM files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels. However, member risk levels were difficult to determine or not found in reviewed files. During the onsite visit, United confirmed documentation of risk levels for the files reviewed and explained how they document CM risk levels.

United uses an established policy that defines how to handle CAN and CHIP appeals of adverse benefit determinations. CCME's review of information related to appeals

processes and requirements revealed issues with documentation of terminology definitions, the appeal filing timeframe, members' ability to present evidence or review the case file, expedited appeal resolution timeframe, and continuation of benefits pending the resolution of an initial member appeal.

CCME's review of appeal files confirmed timely acknowledgement, resolution, and notification of resolution. Appropriate physicians rendered appeal determinations. However, CCME noted CAN and CHIP appeal resolution letters could result in confusion for the reader since they sometimes document two different physicians as reviewing the appeal. CCME recommended clarification of this in the resolution letters. Several CHIP appeal resolution letters used the word "upheld" when referencing the initial denial of services. This also could result in confusion for the reader. Although the CAN and CHIP *2019 Quality Improvement Program Descriptions* indicate the SQIC monitors member appeal data and activities, this was not evident in the SQIC meeting minutes.

Delegation

United ensures all delegation arrangements are governed by written agreements between the delegate and the health plan. United delegates the following services:

- Behavioral health
- Pharmacy benefit administration
- Dental network services and third party dental administration
- Radiology and cardiology management services and prior authorizations
- Vision and eye care
- Non-emergency transportation benefit
- Credentialing

CCME received proof of annual oversight for all delegated entities. For credentialing and recredentialing oversight, annual audits were conducted to assess compliance with defined standards. The tool is comprehensive and included file review. However, the delegated credentialing and recredentialing tools omitted the requirement for ensuring the entities collect *Ownership Disclosure* forms and query the Social Security Administration's Death Master File.

METHODOLOGY

On July 9, 2019 CCME sent notification to United 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 Standards for the CAN and CHIP Programs.

Further, CCME invited the health plan to participate in a pre-onsite conference call with CCME and DOM to offer United an opportunity to seek clarification on the review process and ask questions about desk materials CCME requested.

The review consisted of two segments. The first was a desk review of materials and documents received from United on August 8, 2019 for review at the CCME offices (see *Attachment 1*).

The second segment was a two-day onsite review conducted October 7, 2019 and October 8, 2019 at United's office in Ridgeland, Mississippi. CCME's onsite visit focused on areas not covered by the desk review and areas needing clarification (see *Attachment 2*). CCME's onsite activities included the following:

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

The EQR process follows CMS's protocols for EQRs of MCOs. This review focused on the three federally mandated EQR activities: compliance determination, validation of performance measures, and validation of PIPs. In addition, the review included the optional activities of *Member Satisfaction Survey* and *Provider Satisfaction Survey* validations and a Telephonic Provider Access Study.

FINDINGS

EQR findings 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 United and DOM. Strengths, weaknesses, corrective actions, and recommendations are identified where applicable.

Areas of review are recorded in a tabular spreadsheet (*Attachment 4*) and identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated." Separate tabular spreadsheets for the respective CAN and CHIP programs are included in *Attachment 4*.

A. Administration

CCME conducted an Administration Section review of UnitedHealthcare Community Plan - Mississippi (United). The review focused on the following areas of the Mississippi

Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP) lines of business:

- Policies and procedures
- Staffing
- Information systems
- Compliance and confidentiality

Jeff Wedin is the Chief Executive Officer and Mitch Morris is the Chief Operating Officer. CCME's review of United's *Organizational Chart* and associated onsite discussion revealed the *Organizational Chart* does not reflect current staff in all positions. In addition, the Mississippi (MS) Division of Medicaid's (DOM's) requirement for a minimum of eight representatives to provide face-to-face provider services, along with the contractual requirement for two additional representatives designated for out-of-state providers, is not met.

Policies are organized by department or functional area within the organization. Staff can access policies through a SharePoint site. United staff reported that policies are reviewed annually. However, many policies do not show an annual review, as required by United's *Development and Maintenance of Policies and Procedures and Standard Operating Procedures* policy. Also, some policies do not show the line(s) of business to which they apply.

United's documentation shows it can safely collect, store, and process Medicaid claims. United reported an estimated claims payment rate of 85% to 90% completion after three months. This estimated average falls below the *CAN Contract* requirement that 99% of clean claim payments be completed within 90 days and shows a need for United to improve its clean claim payment rate. While not a *CAN Contract* requirement, United reported an excellent claim payment accuracy average of 98.90% for a recent 12-month period.

United provided business continuity plans that summarize its approach to keeping its systems available during events that could cause interruptions. The plans also reviewed the steps United would take to restore operations if a disaster does occur. Business continuity and disaster recovery documentation shows United has reasonable processes to maintain service and data availability. The documentation, however, reveals those processes have only been tested in a limited way. Failover testing results for a single application (ICUE - Integrated Clinical User Experience) was provided along with a summary of a recent disaster recovery tabletop simulation.

The *UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2018-2019* and the *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019* define

ways to guard against fraud, waste, and abuse (FWA). A comprehensive document titled *UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity* defines standards of ethical behavior for all employees. United uses suitable processes for training and educating staff and providers about compliance and FWA requirements, laws, and regulations. CCME noted the CAN and CHIP *Member Handbooks* contain scant information about FWA. CCME recommends that United provide a more comprehensive explanation of FWA in the *Member Handbooks*. Many avenues for reporting potential compliance, FWA, and ethics concerns or violations are available to staff, members, and providers. Anonymous reporting, as well as a no-retaliation policy, is ensured. Documented processes for monitoring the exclusion status of any person with an ownership or control interest or who is an agent or managing employee of the Coordinated Care Organization (CCO) need to be strengthened. They do not address the requirements to conduct routine checks of the Social Security Administration's Death Master File (SSDMF) and the National Plan and Provider Enumeration System (NPPES).

United received "Met" scores for 87.1% of the standards reviewed for both CAN and CHIP in the Administration section of the review. This represents a decrease in the percentages of "Met" scores for both lines of business.

Figure 2: CAN Administration Findings

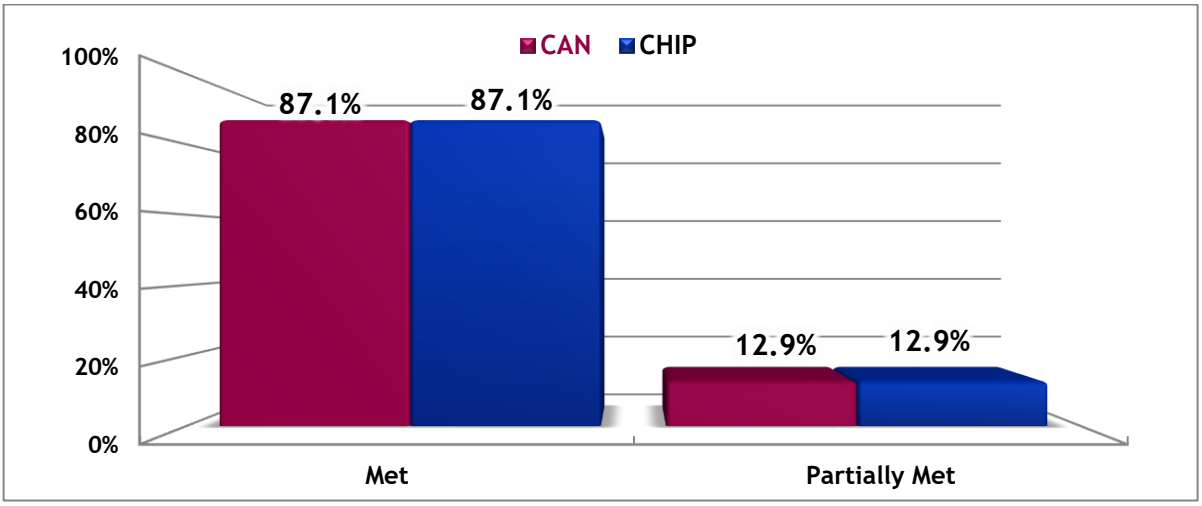


Table 6: Administration

Section	Standard	CAN 2019 Review	CHIP 2019 Review
General Approach to Policies and Procedures	The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Partially Met	Partially Met

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Organizational Chart / Staffing	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: *Provider credentialing and education	Partially Met	Partially Met
Management Information Systems	The CCO processes provider claims in an accurate and timely fashion	Partially Met	Partially Met
Compliance / Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including: Exclusion status monitoring	Partially Met	Partially Met

Strengths

- United reported excellent claims processing accuracy of 98.90% over 12 months.
- The *Code of Conduct: Our Principles of Ethics & Integrity* is organized into precise topics such as integrity, accountability, and government interactions. Each topic concludes with scenarios related to the topic and directs the reader to related resources and policies.

Weaknesses

- Some policies omit an annual review, as required by *Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures.*
- Some policies do not show the line(s) of business to which they apply.
- United's *Organizational Chart* does not show the current staff members holding the positions of Chief Financial Officer (CFO) and Provider Services Manager.
- DOM's requirement for a minimum of eight representatives to provide face-to-face provider services, along with the contractual requirement for two additional representatives designated for out-of-state providers, is not met.
- United did not provide exact claim completeness statistics, claims processing goals, or benchmarks. *Information Systems Capabilities Assessment* (ISCA) documentation United provided states, "In general, claims are 85% to 90% complete after 3 months." This general estimate does not meet the claims processing rate required by the *CAN Contract, Section 18 (A)* and the *CHIP Contract, Section 7 (J) (1).*
- United failed to provide detailed information about its business continuity and disaster recovery plans or tests. Instead, United submitted business continuity plans that

summarize approaches to keeping systems available during events that could cause interruptions. The plans also reviewed the steps United would take to restore operations if a disaster occurs. United conducted tabletop disaster recovery exercises in May 2019 to assess its ability to recover from a disaster. The results show there were no problems found during the exercise.

- The *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019* omits information about the local Compliance Oversight Committee.
- The *UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2018-2019* shows United issues educational materials about FWA detection to members through written communications designed to raise awareness of how to identify and report potential FWA. CCME could not find member educational materials about FWA in the submitted desk materials. Onsite discussion confirmed there are no materials provided other than the information in the *Member Handbook*. The information in the *Member Handbook* is minimal and does not provide members with a full explanation of FWA, nor does it explain how to recognize FWA.
- The *CAN Contract*, Section 17 (E) and *42 CFR §438.602* require CCOs to monitor the exclusion status of subcontractors and any persons with an ownership or control interest or who is an agent or managing employee of the CCO through routine checks of Federal databases, including the SSDMF and the NPPES. *Policy ID-5881, New Hire and Periodic Employee Sanction Review* and the *Government Sanctions Policy-U.S.* omit the requirements to monitor the SSDMF or the NPPES.

Corrective Actions

- Ensure compliance with the requirement documented in *Policy CE-01* that all policies, procedures, and standard operating procedures are reviewed at least annually.
- Recruit two additional Provider Advocates to provide field-based services for provider inquiries/issues. In addition, recruit two additional Representatives to be designated for out-of-state providers.
- Improve clean claims completion rate. This may require claims completion data to be reanalyzed so accurate clean claims completion statistics can be reported. If bottlenecks are limiting the claim completion rate, audit and upgrade those systems.
- Revise *Policy ID-5881, New Hire and Periodic Employee Sanction Review* and the *Government Sanctions Policy-U.S.* (or other applicable document) to include requirements to monitor the SSDMF and the NPPES for subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the CCO. Refer to *42 CFR §438.610*, the *CAN Contract, Section 1 (I)*, and *CHIP Contract, Section 1 (I)*.

Recommendations

- Ensure all policies and procedures clearly indicate the line(s) of business to which they apply.
- Update the *Organizational Chart* to reflect the current CFO and Provider Services Manager.
- Actual disaster recovery tests are always preferable to simulated tabletop or desktop tests. If tests are conducted that restore critical systems and their supporting infrastructure, results should be documented (and redacted as needed) so they can be reviewed.
- Revise the *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019* to include information about the local Compliance Oversight Committee.
- Revise the CAN and CHIP *Member Handbooks* to include full information about FWA, such as definitions of terminology, examples of FWA, all ways of reporting suspected or actual FWA, etc.

B. Provider Services

CCME conducted a Provider Services review focused on following areas of the CAN and CHIP lines of business:

- Policies and procedures
- Provider training and educational materials
- Provider network information
- Credentialing and recredentialing files
- Practice guidelines
- *Provider Satisfaction Survey*

Dr. Amit Prasad, Chief Medical Officer (CMO) chairs the Provider Advisory Committee (PAC). Dr. Prasad took over as PAC Committee Chair in August 2019 from an Interim Chief Medical Director (CMD). Voting members of the committee include 10 participating network providers with specialties including pediatrics, psychiatry, dentistry, obstetrics (OB)/gynecology (GYN), internal medicine, family medicine, and emergency medicine. A quorum of at least 51% of voting members in attendance is established at each meeting. The Committee Chair votes only to break a tie. The PAC meets quarterly and acts as the health plan's Credentialing Committee.

The PAC reviews all National Credentialing Committee (NCC) recommendations. The PAC can approve, deny, or suspend NCC recommendations related to the MS Medicaid network. Onsite discussion confirmed that clean files, unclean files, and credentialing reconsiderations are promptly communicated to the CMO and PAC.

Two Market Medical Directors chair the NCC. Voting members include 16 network providers from local plans. Dr. George Russell, an orthopedic surgeon and committee member, represents MS. The NCC reviews all credentialing/recredentialing decisions. Fifty-one percent of the voting members in attendance constitutes a quorum. CCME's review of meeting minutes showed very few meetings documented absent voting members. Also, the previous Interim CMD did not attend any meetings. Onsite discussion confirmed that Dr. Prasad is now a committee member and will attend the meetings. The Market Medical Directors are non-voting committee members.

The *UnitedHealthcare Credentialing Plan 2019- 2021* explains how United credentials and recredentials licensed independent practitioners and facilities. The plan addresses MS-specific credentialing standards in the *Additional State and Federal Credentialing Requirements Addendum*. The *Optum Physical Health Credentialing Risk Management Plan 2019* applies to physical medicine providers, including chiropractors, physical therapists, occupational therapists, and speech therapists. It also addresses MS-specific credentialing standards. The *United Behavioral Health Clinician and Facility Credentialing Plan 2019-2020* explains how United credentials and recredentials clinicians and facilities who provide behavioral health (BH) care and services to enrollees. The *Mississippi Addendum to Credentialing Policies* defines state credentialing standards. Other UBH/OPTUM policies support the credentialing plans. Some policies omit MS-specific credentialing standards. This is discussed in the Weaknesses section.

The CAN and CHIP credentialing and recredentialing file review revealed the following issues:

- An updated *Provider Entity Disclosure of Ownership* form that contained a statement ensuring the signer had authority to legally bind the entity was not implemented. This was noted as a corrective action in United's previous EQR.
- *Ownership Disclosure* forms received in many of the CAN and CHIP credentialing and recredentialing files were outdated.
- Two organizational files were missing proof of query of the MS DOM Sanctioned Provider List.
- Documentation for Nurse Practitioner (NP) provider office site visits were not in credentialing files when the application showed that the NP would act as a Primary Care Practitioner (PCP).

United runs GeoAccess Reports quarterly to assess network availability. Policies define availability and access standards that comply with contract guidelines. The *CAN 2018 Quality Improvement Program Evaluation* showed full monitoring for access and availability through questions from the *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey*, member complaints and appeals, assessing claims data for

behavioral health, and conducting *Practitioner Telephonic Surveys* for PCPs and high volume/high impact specialists.

Onsite discussion confirmed United implemented a new Provider Orientation Training Program. The program was not included in the *Training Policy* provided with the desk materials. While both the *CAN* and CHIP *Care Provider Manuals* are detailed, CCME found some issues. These are discussed in the Weaknesses section.

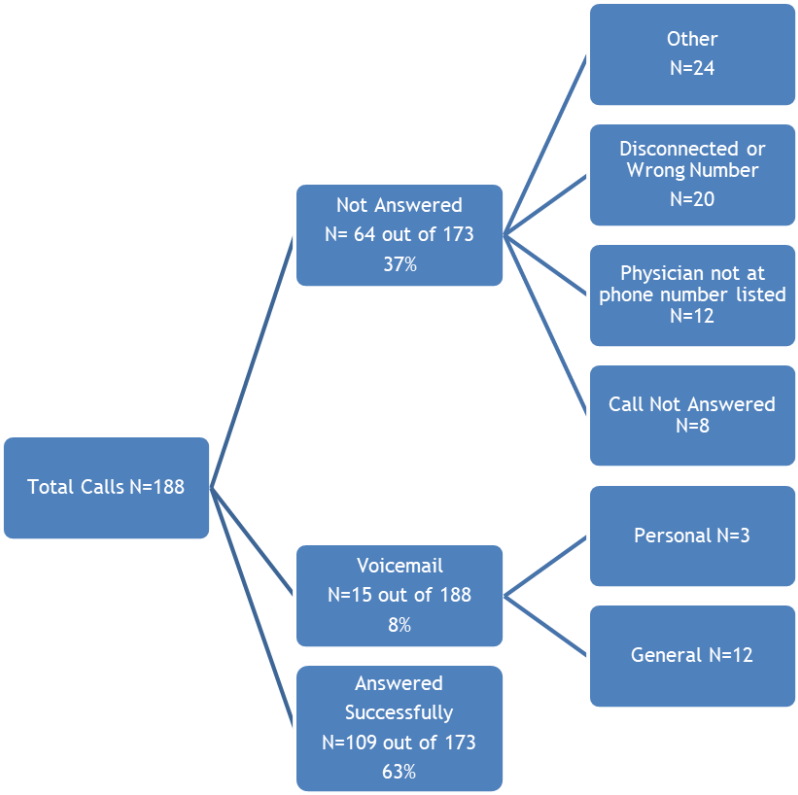
Provider Access and Availability Study

As part of United's annual EQR process, CCME conducted a Telephonic Provider Access Study for CAN and CHIP that focused on primary care providers (PCPs). CCME selected a random sample PCPs from a list of current PCPs provided by United. Attempts were made to contact these providers to ask a series of questions regarding access that members have with United's contracted providers. The results of each *Provider Access Study* are as follows.

CAN Telephonic Provider Access Study Results

The Telephonic Provider Access Study CCME conducted shows improvement from the previous study's results. CCME conducted a modified review last year, so the most recent Telephonic Provider Access Study was conducted in the 2016 review and had a success rate of 40% (71 out of 177 calls). Since that review, CCME adjusted its definition of a successful call. Now, the success rate is based on an adjusted denominator instead of the total calls made. The denominator is the total calls made minus those answered with voicemail messages, since this is now standard for many provider offices. With the new formula, the success rate for the 2019 Telephonic Provider Access Study was 63% (109 out of 173 total calls). *Figure 3: CAN Telephonic Provider Access Study,* provides an overview of the CAN results.

Figure 3: CAN Telephonic Provider Access Study



188 total calls were made, with 15 being answered by voicemail. Of the 64 unsuccessful calls, the main reason was that the phone number was disconnected, or the wrong number was listed (n=20, 31%). Of the 81 providers that answered the question about whether they accept United, 71 of those 81 (88%) said they accepted United.

Of the 69 providers that responded to the question about accepting new Medicaid patients, 50 of those 69 (73%) said they do accept new Medicaid patients.

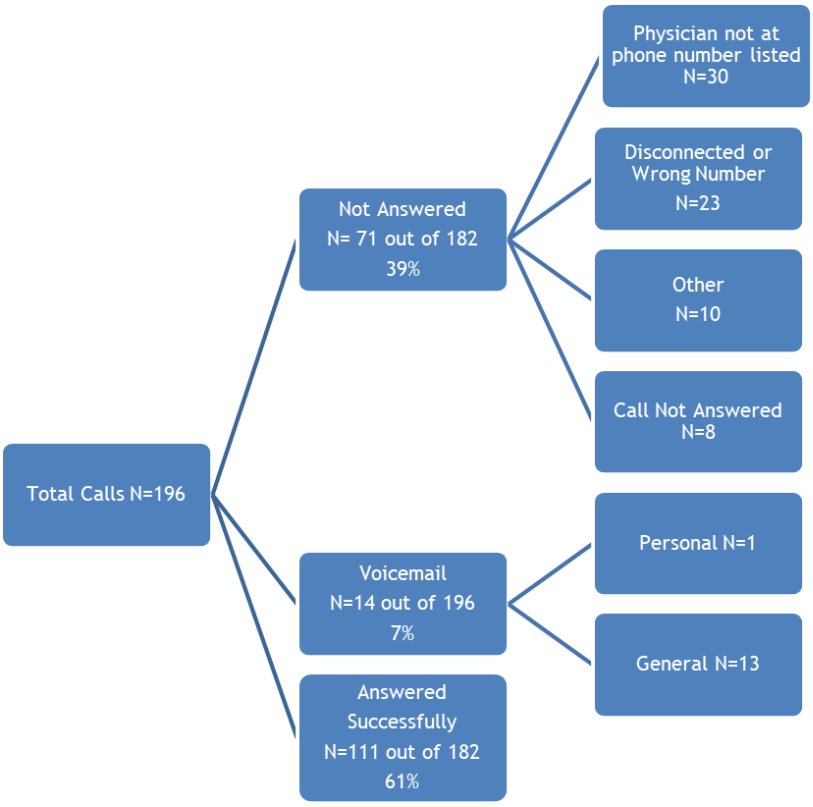
39 providers answered the question regarding prescreening requirements for new patients, and 8 of the 39 (21%) said they do require a prescreen. Of those 8 providers that required a prescreen for new patients, 2 out of 8 (25%) required a medical record review, 4 out of 8 (50%) required an application, and 1 out of 8 (12.5%) required both.

CHIP Telephonic Provider Access Study Results

The Telephonic Provider Access Study CCME conducted shows improvement from the previous study's results. CCME conducted a modified review last year, so the most recent Telephonic Provider Access Study was conducted in the 2016 review and had a success rate of 41% (77 out of 189 calls). Since that review, CCME adjusted its definition of a successful call. Now, the success rate is based on an adjusted denominator instead of the

total calls made. The denominator is the total calls made minus those answered with voicemail messages, since this is now standard for many provider offices. The following Figure provides an overview of the CHIP Telephonic Provider Access Study.

Figure 4: CHIP Telephonic Provider Access Study



For the 2019 Telephonic Provider Access Study, 196 calls were made, of which 14 were answered with voicemail. Of those 182, 111 (61%) were answered successfully and 71 (39%) were not. Of the unsuccessful calls, the main reason was that the physician was not at the phone number listed (n=30, 42%)

Of the 91 providers that answered the question about whether they accept United, 76 (84%) said they accepted United. Of the 79 providers that responded to the question about accepting new Medicaid patients, 69 (87%) said they do accept new Medicaid patients.

61 providers answered the question regarding prescreening requirements for new patients, and 11 of the 61 (18%) said they do require some method of prescreening. One

(9%) required medical record review, 2 (18%) required an application, and 4 (36%) required both.

Provider Satisfaction Survey

During this EQR, CCME validated the *Provider Satisfaction Survey* using the *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. *Table 7, Provider Satisfaction Survey Validation Results* shows the area that needs improvement, the reason, and the recommendation. The complete worksheet is available as an attachment in this report.

Table 7: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	Survey had a low response rate (3%) This is well below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.	Focus on previously successful strategies that would help increase response rates for this population. Enlist the help of the survey vendor.

As noted in *Figure 5, Provider Services Findings*, the CAN Program received "Met" scores for 92% of the Provider Services standards. For the CHIP Program, the percentage of "Met" scores in Provider Services was 90.6%.

Figure 5: Provider Services Findings

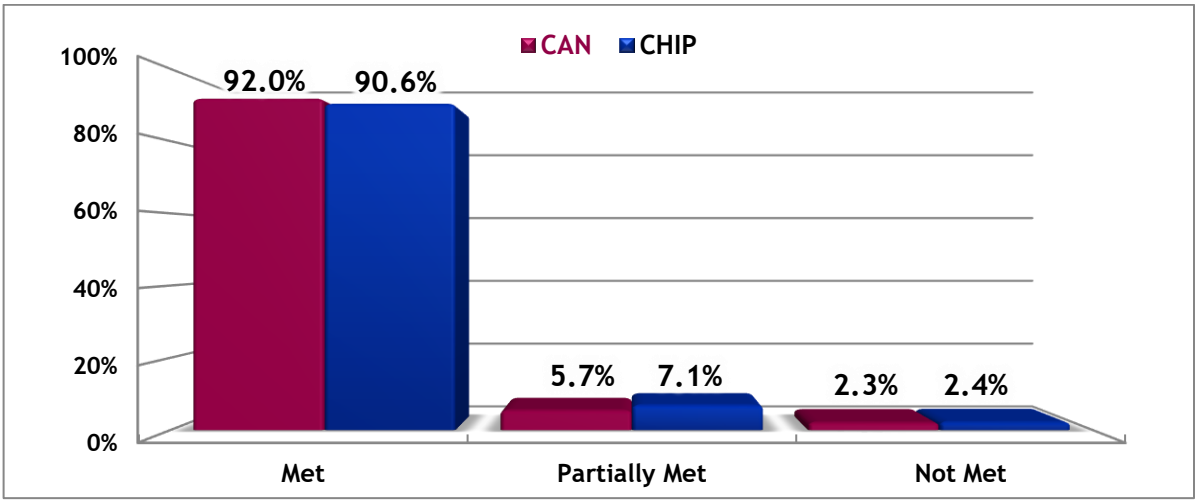


Table 8: Provider Services

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Partially Met
	Credentialing Verification of information on the applicant, including: Ownership Disclosure form	Not Met	Not Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Partially Met	Met
	Recredentialing Verification of information on the applicant, including: Ownership Disclosure form	Not Met	Not Met
Credentialing and Recredentialing	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 ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers	Partially Met	Partially Met
	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Partially Met	Partially Met
	Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Met	Partially Met

Strengths

- The *Telephonic Provider Access Study* showed improvement from the previous rate of successfully answered calls.

- United conducts quarterly *Provider Appointment Availability* and *After-hours* surveys to assess provider compliance.

Weaknesses

- CCME noted that *Policy C.02, Clinician Credentialing Process; Policy C.03, Clinician Recredentialing Process;* and *Policy C.07, Organization Provider Credentialing and Recredentialing* omit the requirement to query the State Medicaid Provider Sanction List. The MS sanction list is referenced in the *Mississippi Addendum to Credentialing Policies* document, but none of the said policies reference this document.
- CCME's NCC meeting minutes review showed very few meetings documented absent voting members.
- The previous Interim CMD did not attend any meetings.
- In the previous EQR corrective action, United presented an updated *Provider Entity Disclosure of Ownership form* for CAN and CHIP that contained a statement ensuring the signer had authority to legally bind the entity. However, the updated *Ownership Disclosure* form was not implemented.
- The following weaknesses relate to the CAN provider credentialing and recredentialing file review:
  - One provider credentialing file showed an *Ownership Disclosure* form that was dated 1½ years prior to the Credentialing Committee approval date.
  - Documentation for provider office site visits was not in credentialing files for NPs when the application shows the NP would act as a PCP.
  - Two recredentialing BH file *Ownership Disclosure* forms were dated more than 3 years prior to the Credentialing Committee approval date.
  - Six recredentialing provider files showed *Ownership Disclosure* forms that were dated 2½ to 3 years prior to the Credentialing Committee approval date.
  - Two organizational credentialing files were missing the MS DOM Sanctioned Provider List query.
  - Three organizational recredentialing files had *Ownership Disclosure* forms that were dated 1½ to 2 years prior to the Credentialing Committee approval date.
- The following weaknesses relate to the CHIP provider credentialing and recredentialing file review:
  - One credentialing provider file showed an *Ownership Disclosure* form that was dated 1½ years prior to the Credentialing Committee approval date.
  - One credentialing provider file showed an *Ownership Disclosure* form that was dated almost 3 years prior to the Credentialing Committee approval date.

- One recredentialing BH file *Ownership Disclosure* form was dated 3½ years prior to the Credentialing Committee approval date.
- Eight recredentialing provider files showed *Ownership Disclosure* forms that were dated 1½ to 2+ years prior to the Credentialing Committee approval date.
- Three recredentialing organizational files showed *Ownership Disclosure* forms that were dated 1½ to 2 years prior to the Credentialing Committee approval date.

- The following appointment standards listed in the CHIP *2019 Care Provider Manual* do not match the standards defined in *Policy PS2* or the CHIP *Member Handbook*:
  - Specialty Care – Page 53
    - Non-urgent "sick" visit within 48–72 hours of request, as clinically indicated
    - Non-urgent care within four to six weeks of request
  - BH (Mental Health and Substance Use Disorder (SUD)) – Page 54
    - Non-urgent problems within two weeks of member's request
    - Following an emergency room visit or hospitalization within five days, or as medically necessary
  - Assessments for the purpose of making recommendations regarding a recipient's services (LDSS) within 10 days of member's request.
- *Policy PS11, Provider Orientation Plan* was received in the desk materials as an active policy; however, minutes in the September 17, 2018 Service Quality Improvement Subcommittee meeting stated this policy was retired due to Provider Relations introducing a new provider orientation process. Onsite discussion confirmed the policy is outdated and omits information relating to a new Provider Orientation Program that includes offering online training.
- CCME noted the following inconsistencies when comparing the benefits listed in the CAN *2019 Care Provider Manual* to the CAN *Member Handbook*:
  - Durable Medical Equipment – The CAN *Member Handbook* states, "Prior authorization needed for items over $500"; however, this is not mentioned on page nine of the CAN *2019 Care Provider Manual*.
  - Psychiatric Care Inpatient - Page 37 of the CAN *Member Handbook* lists Psychiatric Care Inpatient as available for persons under age 21; however, page 13 of the CAN *2019 Care Provider Manual* does not limit the benefit to age 21.
  - Hearing Services – Page 36 of the CAN *Member Handbook* says prior authorization is required for Durable Medical Equipment over $500, but page 10 of the CAN *2019 Care Provider Manual* states prior authorization is required for any services beyond

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) covered services and all hearing aids.

- Outpatient Physical and Occupational Therapies – Page 11 of the CAN *2019 Care Provider Manual* has a statement about Speech Therapy that should be deleted or moved to page 12 of the Speech Therapy section.
- Orthotics & Prosthetics – The CAN *Member Handbook* lists prior authorization for over $500 but this is not mentioned on page 11 of the CAN *2019 Care Provider Manual*.
- Transplant Services – Page 11 of the CAN *2019 Care Provider Manual* does not specify which organs are included. Information is listed on page 38 of the CAN *Member Handbook*.
- Prescription Drugs - The CAN *Member Handbook* states six per month with no more than two of the six being brand-name non-preferred drugs; however, page 11 of the CAN *2019 Care Provider Manual* states a five-per-month limit.
- Dental – Page 12 of the CAN *2019 Care Provider Manual* states preventive, diagnostic, and restorative care is covered; however, page 35 of the CAN *Member Handbook* only shows that emergency pain relief and palliative care is covered for adults.

- The following are issues or inconsistencies when comparing the benefits listed in the CHIP *2019 Care Provider Manual* to the CHIP *Member Handbook:*
  - Ambulance – Page 30 of the CHIP *Member Handbook* lists limitations that are not addressed in the CHIP *2019 Care Provider Manual*.
  - Organ Transplants – Page 37 of the CHIP *Member Handbook* says prior authorization is needed and this is not mentioned in the CHIP *2019 Care Provider Manual*.
  - Podiatry Services – Not mentioned in the CHIP *Member Handbook* but palliative or cosmetic foot care is excluded on page 38. The CHIP *2019 Care Provider Manual* says covered 100% for podiatry services.
  - Routine Hearing – Page 32 of the CHIP *Member Handbook* includes coverage for one hearing aid per ear every three years, but this is not mentioned in the CHIP *2019 Care Provider Manual*.
- The CHIP *2019 Care Provider Manual* omits the emergency supply of medication information.
- The *Provider Satisfaction Survey* had a low response rate (3%). This is well below the National Committee on Quality Assurance target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey.

Corrective Action

- Update *Policy C.02, Clinician Credentialing Process*; *Policy C. 03, Clinician Recredentialing Process*; and *Policy C.07, Organization Provider Credentialing and Recredentialing* to reference the *Mississippi Addendum to Credentialing Policies* which defines MS state-specific credentialing criteria.
- Implement the updated *Provider Entity Disclosure of Ownership* form presented in the previous EQR corrective action and ensure *Ownership Disclosure* forms show current information at credentialing and recredentialing.
- Ensure provider office site visits are conducted for NPs at credentialing when the application shows they are acting as a PCP.
- Ensure appointment standards documented in the CHIP *2019 Care Provider Manual* are consistent with *Policy PS2* and the CHIP *Member Handbook*.
- Update *Policy PS11, Provider Orientation Plan* or create a new policy that addresses the current provider orientation process.
- Update the CAN *2019 Care Provider Manual* and/or the CAN *Member Handbook* to address benefit issues and inconsistencies.
- *Update the* CHIP *2019 Care Provider Manual* and/or *the* CHIP *Member Handbook* to address benefit issues and inconsistencies.
- Update the CHIP *2019 Care Provider Manual* to include the emergency supply of medication information.

Recommendations

- Ensure MS representation is present for NCC meetings when it makes decisions about MS providers.
- Ensure NCC meeting minutes document absent voting committee members.
- Focus on strategies that help increase response rates for the *Provider Satisfaction Survey*. Enlist the help of the survey vendor.

C. Member Services

CCME conducted a Member Services review of United focused on the following areas of the CAN and CHIP lines of business:

- Policies and procedures
- Member rights
- Member informational materials

- Grievances and grievance files
- *Member Satisfaction Survey*

The *Member Handbooks* are thorough, easily understood, and meet the sixth-grade reading comprehension level.

United's CAN and CHIP websites have quick links and resources for members to access information. During the onsite, CCME discussed its finding that some information on topics on the website, such as obtaining Advance Directive forms and Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)/Well-Child Care services, is limited or is not easily located. CCME provided recommendations for improvement.

The CAN and CHIP *Member Handbooks*, which are also located on the website, provide useful information. The handbooks inform members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and explain how to access benefits. In addition, the CAN and CHIP *Member Handbooks* provide information on Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The handbooks are available in Spanish and alternate formats including large font, audio, and Braille. Member Services staff are available per *DOM Contract* requirements via a toll-free number. Text telephone (also known as TTY 711) services are available for members with hearing difficulties. Members are informed that translation services are available for calls and during appointments with providers.

The toll-free Member Services telephone number routes calls to reach appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. CST., Monday through Friday. Callers also have the option to transfer to the 24-hour NurseLine. Call center functions are correctly conducted.

Policies define requirements and processes for handling member grievances and complaints. In addition to the policies, grievance information is found in the *CAN* and *CHIP Member Handbooks, Care Provider Manuals*, and on United's CAN and CHIP websites. The *Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01)* applies to both CAN and CHIP and describe operating procedures for processing member grievances. United staff reported that as of October 1, 2018, Optum is no longer delegated to conduct appeal and grievance functions for members.

CCME's review of United's documentation revealed several issues related to definitions of grievance terminology, filing processes, and requirements. Of note, these issues were previously identified during the 2018 EQR, resulting in scores of "Not Met" for the applicable review standards. CCME's review of CAN and CHIP grievance files reflected timely resolutions and notification of resolutions; however, five files contained acknowledgement letters sent beyond the five-calendar day acknowledgement timeframe required by *Policy POL2015-01*. CCME noted an improper resolution in one CHIP grievance

file regarding billing for ambulance transportation for a medical emergency. CCME addresses these issues in the Weaknesses section that follows.

The CAN and CHIP *2019 Quality Improvement Program Description*s indicate the Service Quality Improvement Committee's (SQIC's) responsibilities include monitoring member complaint and grievance trends. CCME's review of SQIC meeting minutes, however, did not confirm this. For two SQIC meetings, minutes indicated a grievance report was not available, and minutes for the remaining three meetings did not clearly reflect discussion and monitoring of member complaint and grievance trends.

Overall, the majority of United's Member Services standards follow *CAN and CHIP Contract* requirements, and state and federal guidelines. CCME provides recommendations and advises on corrective actions for identified issues.

Member Satisfaction Survey

A third-party vendor continues to conduct *Consumer Assessment of Healthcare Providers and Systems (CAHPS®)* surveys annually. Members Satisfaction Survey validation, for United CAN and CHIP, was performed based on the CMS Survey Validation Protocol. Generalizability of the survey results is difficult to discern due to low response rate. CCME provides recommendations to address the issue.

As noted in *Figure 6: Member Services Findings*, United achieved "Met" scores of 90.9% for CAN and 93.8% for CHIP in Member Services standards. CAN scores continue with 3% "Partially Met" and 6.1% "Not Met." CHIP scores continue with 3.1% for both "Partially Met" and "Not Met."

Figure 6: Member Services Findings

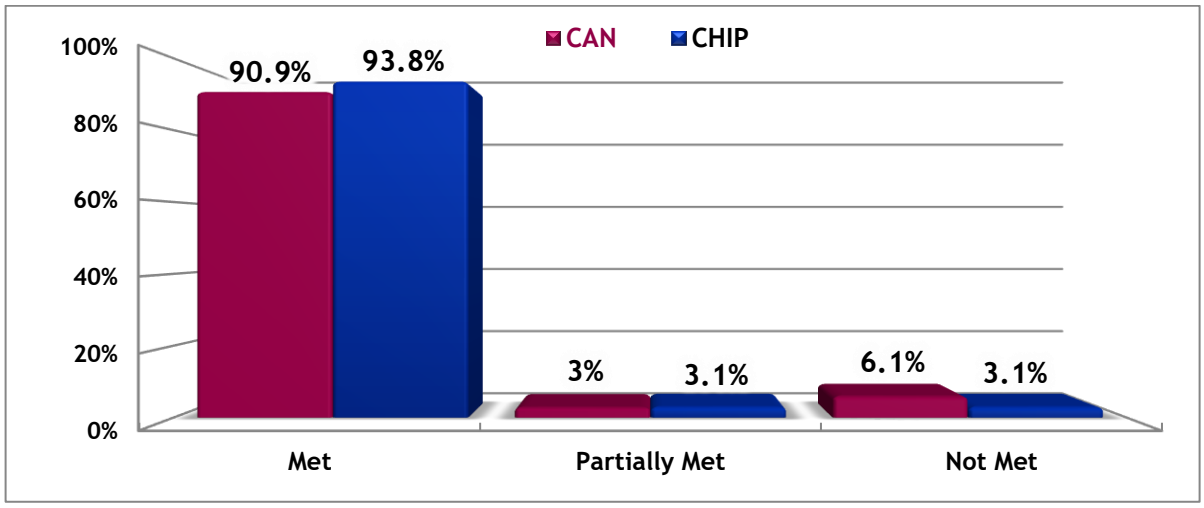


Table 9: Member Services

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Member Rights and Responsibilities	Member responsibilities include the responsibility: To inform the CCO of changes in family size, address changes, or other health care coverage	Partially Met	Partially Met
Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: Definition of a grievance and who may file a grievance	Not Met	Met
	The procedure for filing and handling a grievance	Not Met	Not Met

Strengths

- The Outreach Department and Quality Team conduct member outreach events monthly and quarterly such as Farm to Fork, Health Fairs, baby showers, and clinic days.

Weaknesses

- Page 57 in the CAN *Member Handbook* and page 47 in the CHIP *Member Handbook* fail to completely include the member's right to participate in decisions regarding his or her health care.
- For both CAN and CHIP, *Policy MBR4a, Notification of Rights* does not indicate the member is responsible for informing the plan of changes in family size, address, or health care coverage.
- The CHIP *Care Provider Manual* does not list member responsibilities.
- Pages 17 and 43 in the CAN *Member Handbook* and pages 18 and 32 in the CHIP *Member Handbook* do not clearly indicate members may have a Women's Health Specialist in addition to their designated Primary Care Practitioner (PCP).
- Minimal information on EPSDT services is provided on page 48 of the CAN *Member Handbook* and no ESPDT information is available on the website.
- The *CHIP Member Handbook* gives a vague reference to the American Academy of Pediatrics for Well-Baby/Well-Child Care guidelines and the CHIP website has brief information on Well-Baby/Well-Child Care services.

- For both CAN and CHIP, instructions for obtaining *Advance Directive* forms and receiving assistance to complete them are not well described in the *Member Handbook*, *Care Provider Manual*, or website.
- For CAN and CHIP, when a provider is terminated from the network, CCME did not identify how members are informed about selecting a new provider and the date after which they cannot use the terminated provider.
- CCME did not find that member materials are written using a minimum 12-point font and large size items are printed in a font size no smaller than 18 point.
- CCME found the following documentation issues for CAN and CHIP Member and Provider Services:
  - The differences between the Mental Health Crisis Line and the Crisis intervention/access, 24-hour hotline referred to in the *Member Handbooks* could not be determined.
  - The CAN *Care Provider Manual* lists the hours of operation for Provider Services as Monday - Friday from 8 am to 5 pm.
  - On the CAN and CHIP websites under "See more benefits and features," a phone number is not provided for the NurseLine or for Member Services; the Member Services section erroneously notes members can call "24/7"; and the NurseLine availability is written as "24/7." This abbreviated format may not be understood by all readers.
- The CAN website glossary defines a grievance as, "Your statement of dissatisfaction with any part of your care." It does not convey that a grievance can be about any matter other than an adverse benefit determination. This is an uncorrected deficiency from the 2018 EQR.
- The timeframe for filing a complaint is not documented in the CAN and CHIP *Member Handbooks*. These are uncorrected deficiencies from the 2018 EQR.
- The CAN and CHIP *Member Handbooks* do not inform members that assistance is available for the grievance filing process. These are uncorrected deficiencies from the 2018 EQR.
- Three CAN grievance files and two CHIP grievance files were noted with acknowledgement letters sent beyond the 5-calendar day acknowledgement timeframe specified in *Policy POL2015-01*.
- One CHIP grievance regarding billing for ambulance transportation for a medical emergency was inadequately resolved. According to file notes, the provider was contacted on several occasions and had been sent a Cease Billing letter. The resolution letter only informed the grievant she could contact the service provider or the collections agency for more information. The grievant was not informed she should

disregard the bill as ambulance transportation is a covered service under medical benefits for a medical emergency.

- CCME's review of SQIC meeting minutes revealed very little evidence that the SQIC monitors member complaint and grievance trends, as stated in the CAN and CHIP *2019 Quality Improvement Program Descriptions*. For two meetings, minutes indicated a report was not available and did not indicate a reason. The remaining three meetings do not clearly show discussion and monitoring of member complaint and grievance trends. During the onsite, United staff agreed that the program descriptions are inaccurate about the SQIC's responsibility for monitoring member complaints and grievance trends and should be revised.
- For both CAN and CHIP, generalizability of the *CAHPS Survey* results is difficult to discern due to low response rates.

Corrective Actions

- For CAN and CHIP, edit *Policy MBR4a, Notification of Rights* to indicate members are responsible for informing the CCO of changes in family size, address changes, or other health care coverage to meet requirements of the *CAN Contract, Section 6(J)*.
- Revise the CHIP *Care Provider Manual* to include all member responsibilities required in the *CHIP Contract, Section (D)(15)* and *Section (I)*.
- Revise the definition of the term "grievance" in the CAN website glossary to include that grievances are an expression of dissatisfaction about any matter other than an adverse benefit determination. Refer to *42 CFR §438.400 (b)* and the *CAN Contract, Section 6 (K)* and *Exhibit D*.
- Revise the CAN *Member Handbook* and CHIP *Member Handbook* to include the filing timeframe for a complaint.
- Revise the CAN *Member Handbook* and CHIP *Member Handbook* to include that assistance can be provided in the grievance filing process.

Recommendations

- Edit the Member Rights and Responsibilities section of the CAN and CHIP *Member Handbooks* to include the complete requirement in *CAN Contract, Section 6 (9)(d)* and *CHIP Contract Section 6 (D)* to address member's rights.
- Edit the CAN and CHIP *Member Handbooks* to clarify that female members may receive women's routine and preventive care from a Women's Health Specialist in addition to services by their designated PCP. Refer to the *CAN Contract, Section 7(B)(3)* and the *CHIP Contract, Section 7(A)*.
- Edit the CAN *Member Handbook* and website to include complete descriptions of required EPSDT services and age-appropriate health screenings and immunizations. In

addition, reference the American Academy of Pediatrics (AAP) Bright Futures Medical Periodicity schedule in the *Member Handbook* and the website. Refer to the *CAN Contract, Section 5(D)*.

- Ensure the CHIP website includes complete descriptions of required Well-Baby/Well-Child services and age-appropriate periodic health screenings and immunizations.
- Ensure the CHIP *Member Handbook* and website reference the AAP Bright Futures Medical Periodicity schedule.
- For CAN and CHIP, edit *Policy MBR15a, Advanced Directives*, the *Member Handbooks*, *Care Provider Manuals*, and websites to clarify how members can obtain *Advance Directive* forms and how to receive assistance completing the forms if needed.
- FOR CAN and CHIP, edit *Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes* and *Policy MBR8b, 15 Day Written Notices of Termed Provider* to reflect written notices of terminated providers include a cutoff date and a statement that the member is given the option to choose another PCP.
- Ensure the requirements to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font size are documented in *Policy MBR 7, Member Materials/Sixth Grade Level of Reading Comprehension* or other policy. Refer to the *CAN Contract, Section 6 (F)*.
- For both CAN and CHIP, edit the *Member Handbooks* to specify either Mental Health Crisis Line or Crisis intervention/access, 24-hour hotline; include the hours of operation hours for Provider Services in the *Care Provider Manual*, and provide the toll-free number for Member Services and the Nurse Line on the CHIP member website. Additionally, on the CAN and CHIP websites, clearly state the NurseLine availability as “24 hours a day, 7 days a week” instead of “24/7”.
- For both CAN and CHIP, ensure acknowledgement letters for grievances are sent within the required five calendar day timeframe from receipt of the grievance.
- Ensure correct information is provided in CHIP grievance resolution letters.
- Revise the CAN *2019 Quality Improvement Program Description* and CHIP *2019 Quality Improvement Program Description* to include accurate information regarding the committee responsible for reviewing grievance data to identify quality improvement opportunities.
- Continue to work on interventions to increase *CAHPS Survey* response rates, such as website banners and reminders on call center scripts.

D. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed program descriptions, committee structures and minutes, performance measures, performance improvement projects (PIPs), and the QI program evaluations for the CAN and CHIP programs. United has implemented a QI Program as described in the *2019 Quality Improvement Program Description* for the MississippiCAN Program and in the *2019 Quality Improvement Program Description* for the CHIP Program. The aim of the QI Program is to monitor, evaluate, and improve the quality of clinical care and services provided to United's members. Program descriptions are updated annually and submitted to the Board of Directors, Quality Management Committee (QMC), and to DOM for review and approval.

The QMC is charged with implementing, coordinating, and integrating all QI activities. This committee reviews decisions of the National Quality Oversight Committee and offers feedback as needed. The QMC oversees other committees including the Provider Advisory Committee (PAC). The PAC and the Healthcare Quality and Utilization Management Committee monitor QI activities and provide recommendations as needed.

The PAC includes a variety of network providers. QMC membership includes senior executives, directors, and other health plan staff. CCME identified the following issues about who chairs this committee:

- According to the CAN and CHIP QI program descriptions, the committee is chaired by the health plan's Chief Medical Officer. However, the committee Charter received with the desk materials shows the committee is chaired by the health plan's Chief Executive Officer.
- Meeting minutes for June 2018, December 2018, and March 2019 show the meeting was Chaired by the Director, Clinical Quality.
- The September 2018 meeting minutes showed the meeting was chaired by Dr. Phillips; however, the minutes were signed by the Director, Clinical Quality.

United's standard operating procedures titled *EPSDT Services – Tracking Process* and *Well Child Services – Tracking Process* explain that any problem identified during the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Well-Child exams that required referrals are tracked quarterly. The reports did not contain EPSDT or Well-Child visits in the result samples United provided. The reports appeared to include encounters not related to a diagnosis found on the EPSDT or Well-Child exams, such as emergency room visits or unspecified effects of drowning and nonfatal submersion. According to United staff the tracking reports are run for members who had an EPSDT or Well Child exam and had an encounter for a service received after the exam, not necessarily related to a diagnosis found on the EPSDT or Well Child exam. The tracking reports are sent to the Case Management Department for follow-up with the member to ensure referrals are

provided if needed. CCME recommends the tracking reports only include the problems or diagnoses identified during the EPSDT or Well Child exams that required referrals.

Performance Measure Validation

As part of the EQR for United, CCME conducted a validation review of the Healthcare Effectiveness Data Informational Set (HEDIS®) performance measures following the CMS-developed protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid. United was found to be "Fully Compliant" and met all the requirements for the HEDIS measures as per the report by Attest Health Care Advisors.

All relevant HEDIS performance measures for United CAN for the current review year (MY 2018), as well as the previous year (MY 2016) and the change from 2016 to 2018 are reported in *Table 10: CAN HEDIS Performance Measure Results*. The change in rates shown in green indicates a substantial (>10%) improvement and the rates shown in red indicates a substantial (>10%) decline.

Table 10: CAN HEDIS Performance Measure Results

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	80.79%	88.75%	7.96%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	45.99%	54.99%	9.00%
Counseling for Nutrition	48.91%	50.85%	1.94%
Counseling for Physical Activity	40.63%	46.23%	5.60%
Childhood Immunization Status (cis)			
DTaP	77.86%	83.21%	5.35%
IPV	92.70%	94.65%	1.95%
MMR	90.75%	93.67%	2.92%
HiB	87.10%	91.24%	4.14%
Hepatitis B	89.78%	94.65%	4.87%
VZV	90.27%	92.94%	2.67%
Pneumococcal Conjugate	77.13%	86.86%	9.73%
Hepatitis A	76.89%	81.27%	4.38%
Rotavirus	75.18%	81.27%	6.09%
Influenza	26.03%	31.63%	5.60%
Combination #2	73.48%	80.78%	7.30%
Combination #3	69.83%	79.32%	9.49%

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
Combination #4	59.61%	69.59%	9.98%
Combination #5	61.31%	70.07%	8.76%
Combination #6	21.90%	27.49%	5.59%
Combination #7	52.31%	62.04%	9.73%
Combination #8	20.19%	26.03%	5.84%
Combination #9	19.71%	24.33%	4.62%
Combination #10	18.00%	23.36%	5.36%
Immunizations for Adolescents (ima)			
Meningococcal	51.58%	54.26%	2.68%
Tdap	79.81%	77.13%	-2.68%
HPV	6.81%	18.98%	12.17%
Combination #1	51.58%	51.34%	-0.24%
Combination #2	6.08%	17.27%	11.19%
Lead Screening in Children (lsc)	66.52%	72.51%	5.99%
Breast Cancer Screening (bcs)	50.21%	48.49%	-1.72%
Cervical Cancer Screening (ccs)	56.82%	54.90%	-1.92%
Chlamydia Screening in Women (chl)			
16-20 Years	48.43%	46.84%	-1.59%
21-24 Years	62.73%	59.53%	-3.20%
Total	51.15%	49.04%	-2.11%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	62.76%	68.64%	5.88%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	29.49%	32.89%	3.40%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	32.40%	41.33%	8.93%
Bronchodilator	67.17%	76.77%	9.60%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	52.55%	48.92%	-3.63%
5-11 Years: Medication Compliance 75%	21.94%	23.29%	1.35%
12-18 Years: Medication Compliance 50%	49.25%	50.35%	1.10%
12-18 Years: Medication Compliance 75%	21.89%	22.75%	0.86%
19-50 Years: Medication Compliance 50%	50.97%	57.73%	6.76%
19-50 Years: Medication Compliance 75%	23.30%	30.41%	7.11%
51-64 Years: Medication Compliance 50%	57.45%	57.89%	0.44%
51-64 Years: Medication Compliance 75%	40.43%	31.58%	-8.85%
Total: Medication Compliance 50%	51.38%	50.47%	-0.91%

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
Total: Medication Compliance 75%	23.69%	23.91%	0.22%
Asthma Medication Ratio (amr)			
5-11 Years	82.52%	82.28%	-0.24%
12-18 Years	67.70%	67.85%	0.15%
19-50 Years	47.69%	48.75%	1.06%
51-64 Years	46.67%	44.83%	-1.84%
Total	62.44%	71.62%	9.18%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	47.69%	53.53%	5.84%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	64.29%	65.00%	0.71%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy: 21-75 Years (Male)	69.29%	67.14%	-2.15%
Statin Adherence 80%: 21-75 Years (Male)	37.25%	45.42%	8.17%
Received Statin Therapy: 40-75 Years (Female)	61.17%	66.17%	5.00%
Statin Adherence 80%: 40-75 Years (Female)	35.65%	35.98%	0.33%
Received Statin Therapy: Total	65.19%	66.67%	1.48%
Statin Adherence 80%: Total	36.49%	40.88%	4.39%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	87.10%	84.43%	-2.67%
HbA1c Poor Control (>9.0%)	56.93%	45.50%	-11.43%
HbA1c Control (<8.0%)	35.04%	46.23%	11.19%
HbA1c Control (<7.0%)	NR	NR	NR
Eye Exam (Retinal) Performed	63.50%	55.72%	-7.78%
Medical Attention for Nephropathy	93.67%	89.78%	-3.89%
Blood Pressure Control (<140/90 mm Hg)	49.39%	52.31%	2.92%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	NR	49.62%	NA
Statin Adherence 80%	NR	34.61%	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	NR	71.63%	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	42.17%	39.66%	-2.51%
Effective Continuation Phase Treatment	24.65%	21.59%	-3.06%

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	58.10%	58.11%	0.01%
Continuation and Maintenance (C&M) Phase	70.30%	69.09%	-1.21%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	66.04%	NA
6-17 years - 7-Day Follow-Up	NR	41.03%	NA
18-64 years - 30-Day Follow-Up	NR	53.09%	NA
18-64 years - 7-Day Follow-Up	NR	29.59%	NA
65+ years - 30-Day Follow-Up	NR	100.00%*	NA
65+ years - 7-Day Follow-Up	NR	0.00%*	NA
Total 30-Day Follow-Up	NR	60.37%	NA
Total 7-Day Follow-Up	NR	35.94%	NA
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	42.79%	NA
6-17 years - 7-Day Follow-Up	NR	30.77%	NA
18-64 years - 30-Day Follow-Up	NR	41.34%	NA
18-64 years - 7-Day Follow-Up	NR	25.05%	NA
65+ years - 30-Day Follow-Up	NR	NR	NA
65+ years - 7-Day Follow-Up	NR	NR	NA
Total - 30-Day Follow-Up	NR	41.78%	NA
Total- 7-Day Follow-Up	NR	26.78%	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NR	9.09%	NA
7-Day Follow-Up: 13-17 Years	NR	9.09%	NA
30-Day Follow-Up: 18+ Years	NR	8.41%	NA
7-Day Follow-Up: 18+ Years	NR	5.53%	NA
30-Day Follow-Up: Total	NR	8.46%	NA
7-Day Follow-Up: Total	NR	5.79%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	70.59%	70.53%	-0.06%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	67.25%	68.60%	1.35%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	NR	70.59%	NA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	56.87%	55.79%	-1.08%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	35.42%	23.91%	-11.51%

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
6-11 Years	23.23%	18.36%	-4.87%
12-17 Years	21.21%	24.38%	3.17%
Total	22.39%	21.80%	-0.59%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.09%	88.86%	0.77%
Diuretics	87.08%	88.18%	1.10%
Total	87.33%	88.55%	1.22%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.88%	1.49%	-1.39%
Appropriate Treatment for Children with URI (uri)	60.15%	65.15%	5.00%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.18%	37.09%	4.91%
Use of Imaging Studies for Low Back Pain (lbp)	65.59%	66.67%	1.08%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	2.63%	NA
6-11 Years	NR	0.47%	NA
12-17 Years	NR	0.14%	NA
Total	NR	0.36%	NA
Use of Opioids at High Dosage (uod)	NR	1.45%	NA
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	NR	19.74%	NA
Multiple Pharmacies	NR	5.82%	NA
Multiple Prescribers and Multiple Pharmacies	NR	3.16%	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	10.31%	NA
18-64 years - >=31 Days covered	NR	4.39%	NA
65+ years - >=15 Days covered	NR	11.11%*	NA
65+ years - >=31 Days covered	NR	11.11%*	NA
Total - >=15 Days covered	NR	10.31%	NA
Total - >=31 Days covered	NR	4.39%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.31%	86.84%	0.53%
45-64 Years	91.83%	90.88%	-0.95%
65+ Years	93.62%	93.62%	0.00%
Total	88.35%	88.54%	0.19%

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.02%	97.72%	0.70%
25 Months - 6 Years	88.23%	90.12%	1.89%
7-11 Years	92.46%	92.10%	-0.36%
12-19 Years	89.78%	90.90%	1.12%
Annual Dental Visit (adv)			
2-3 Years	48.93%	53.87%	4.94%
4-6 Years	71.12%	75.63%	4.51%
7-10 Years	71.38%	76.75%	5.37%
11-14 Years	67.75%	73.46%	5.71%
15-18 Years	58.41%	64.53%	6.12%
19-20 Years	44.87%	45.90%	1.03%
Total	64.98%	70.20%	5.22%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	72.41%	79.41%	7.00%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	8.74%	2.94%	-5.80%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NR	66.67%*	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NR	0.00%*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NR	63.68%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NR	9.45%	NA
Total: Initiation of AOD Treatment: 13-17 Years	NR	62.15%	NA
Total: Engagement of AOD Treatment: 13-17 Years	NR	8.88%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	42.67%	42.20%	-0.47%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	6.57%	4.46%	-2.11%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	NR	20.54%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	NR	6.55%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	NR	40.70%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NR	5.61%	NA

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
Total: Initiation of AOD Treatment: 18+ Years	NR	32.41%	NA
Total: Engagement of AOD Treatment: 18+ Years	NR	5.86%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	NR	43.71%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	NR	4.39%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total	NR	20.81%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total	NR	6.51%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	NR	43.45%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total	NR	6.07%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.89%	34.37%	-11.52%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.80%	6.06%	-0.74%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.49%	88.29%	-2.20%
Postpartum Care	62.93%	68.29%	5.36%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	35.90%*	36.00%*	NA
6-11 Years	65.69%	63.05%	-2.64%
12-17 Years	68.74%	63.43%	-5.31%
Total	66.42%	62.68%	-3.74%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	4.15%	NR	NA
21-40 Percent	1.95%	NR	NA
41-60 Percent	3.41%	NR	NA
61-80 Percent	8.29%	NR	NA
81+ Percent	82.20%	NR	NA
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.95%	0.00%	-1.95%
1 Visit	3.89%	3.06%	-0.83%
2 Visits	6.08%	5.36%	-0.72%
3 Visits	9.00%	4.59%	-4.41%
4 Visits	10.46%	7.91%	-2.55%
5 Visits	17.03%	19.64%	2.61%

Measure/Element	MY2016 (HEDIS 2017)	MY2018 (HEDIS 2019)	Change
6+ Visits	51.58%	59.44%	7.86%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	60.74%	54.98%	-5.76%
Adolescent Well-Care Visits (awc)	45.01%	45.50%	0.49%

NA: Indicates denominator was too small or data were not available; NR: Not reported. *Indicates rate was calculated with small denominator.

As shown, several measures had substantial improvement of greater than 10%. Those included HPV and Combination #2 Vaccinations for Adolescents, and Comprehensive Diabetes Care HbA1c Control. The measures with a substantial decrease in rate were Comprehensive Diabetes Care HbA1c Poor Control, Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5-year olds, and Alcohol Abuse or Dependence: Initiation of AOD Treatment: Total.

All relevant CHIP HEDIS performance measures for United CHIP for the current review year (MY 2018), as well as the previous year (2016) and the change from 2016 to 2018 are reported in the Table that follows.

Table 11: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	46.23%	54.26%	8.03%
Counseling for Nutrition	46.72%	41.12%	-5.60%
Counseling for Physical Activity	42.34%	36.50%	-5.84%
Childhood Immunization Status (cis)			
DTaP	81.02%	85.89%	4.87%
IPV	89.78%	93.92%	4.14%
MMR	91.97%	93.67%	1.70%
HiB	87.59%	90.75%	3.16%
Hepatitis B	88.56%	94.40%	5.84%
VZV	90.27%	92.94%	2.67%
Pneumococcal Conjugate	82.48%	86.86%	4.38%
Hepatitis A	79.56%	79.81%	0.25%
Rotavirus	78.10%	84.43%	6.33%
Influenza	31.63%	39.90%	8.27%
Combination #2	76.89%	84.91%	8.02%

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Combination #3	74.94%	83.45%	8.51%
Combination #4	64.48%	72.26%	7.78%
Combination #5	67.64%	76.40%	8.76%
Combination #6	27.98%	36.74%	8.76%
Combination #7	57.91%	67.15%	9.24%
Combination #8	26.28%	34.55%	8.27%
Combination #9	26.76%	34.55%	7.79%
Combination #10	25.06%	32.60%	7.54%
Immunizations for Adolescents (ima)			
Meningococcal	54.26%	54.26%	0.00%
Tdap/Td	85.40%	82.48%	-2.92%
HPV	13.63%	16.30%	2.67%
Combination #1	54.01%	53.04%	-0.97%
Combination #2	12.65%	14.36%	1.71%
Lead Screening in Children (lsc)	63.50%	63.99%	0.49%
Chlamydia Screening in Women (chl)			
16-20 Years	37.56%	37.13%	-0.43%
21-24 Years	NA*	NA*	NA
Total	37.56%	37.13%	-0.43%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	66.05%	71.99%	5.94%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	62.16%	59.48%	-2.68%
5-11 Years: Medication Compliance 75%	30.81%	30.48%	-0.33%
12-18 Years: Medication Compliance 50%	50.81%	54.59%	3.78%
12-18 Years: Medication Compliance 75%	25.41%	26.09%	0.68%
Total Medication Compliance 50%	56.49%	57.23%	0.74%
Total Medication Compliance 75%	28.11%	28.51%	0.40%
Asthma Medication Ratio (amr)			
5-11 Years	86.39%	87.73%	1.34%
12-18 Years	77.11%	74.55%	-2.56%
Total	81.63%	81.87%	0.24%
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	38.71%	60.00%*	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Effective Acute Phase Treatment	47.62%	32.35%	-15.27%
Effective Continuation Phase Treatment	33.33%	17.65%	-15.68%
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	50.00%	50.00%	0.00%
Continuation and Maintenance (C&M) Phase	60.87%	58.51%	-2.36%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	63.44%	NA
6-17 years - 7-Day Follow-Up	NR	36.02%	NA
18-64 years - 30-Day Follow-Up	NR	37.50%*	NA
18-64 years - 7-Day Follow-Up	NR	25.00%*	NA
Total-30-day Follow-Up	76.97%	61.39%	-15.58%
Total-7-day Follow-Up	53.95%	35.15%	-18.80%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	68.42%*	NA
6-17 years - 7-Day Follow-Up	NR	26.32%*	NA
18-64 years - 30-Day Follow-Up	NR	75.00%*	NA
18-64 years - 7-Day Follow-Up	NR	50.00%*	NA
Total-30-day Follow-Up	NR	69.57%*	NA
Total-7-day Follow-Up	NR	30.43%*	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	50.00%*	100.00%*	NA
6-11 Years	28.33%	21.43%	-6.90%
12-17 Years	28.46%	23.33%	-5.13%
Total	28.65%	23.04%	-5.61%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.78%	0.77%	-1.01%
Appropriate Treatment or Children with URI (uri)	54.17%	58.21%	4.04%
Use of Imaging Studies for Low Back Pain (lbp)	63.33%	76.92%*	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	0.00%*	NA
6-11 Years	NR	2.04%	NA
12-17 Years	NR	0.00%	NA
Total	NR	0.75%*	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NR	3.39%	NA
18-64 years - >=31 Days covered	NR	0.00%	NA

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
Total - >=15 Days covered	NR	3.39%	NA
Total - >=31 Days covered	NR	0.00%	NA
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	99.80%	98.56%	-1.24%
25 Months-6 Years	91.38%	92.30%	0.92%
7-11 Years	94.24%	95.51%	1.27%
12- 19 Year	92.72%	93.13%	0.41%
Annual Dental Visit (adv)			
2-3 Years	53.34%	55.52%	2.18%
4-6 Years	75.82%	77.98%	2.16%
7-10 Years	80.69%	83.04%	2.35%
11-14 Years	75.35%	79.34%	3.99%
15-18 Years	67.14%	70.37%	3.23%
19-20 Years	51.69%	58.65%	6.96%
Total	72.95%	75.75%	2.80%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 years	61.76%	56.25%	-5.51%
Engagement of AOD Treatment: 13-17 years	5.88%	3.13%	-2.75%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	NR	51.02%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total	NR	2.04%	NA
Initiation of AOD Treatment: Total	53.03%	45.61%	-7.42%
Engagement of AOD Treatment: Total	4.55%	1.75%	-2.80%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	50.00%	50.00%*	NA
Postpartum Care	16.67%	50.00%*	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NR	100.00%*	NA
6-11 Years	NR	42.86%	NA
12-17 Years	NR	54.69%	NA
Total	NR	51.00%	NA
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.59%	0.31%	-1.28%
1 Visit	2.87%	2.18%	-0.69%
2 Visits	0.96%	1.56%	0.60%

Measure/Data Element	HEDIS 2017 (MY 2016) CHIP Rates	HEDIS 2019 (MY 2018) CHIP Rates	Change
3 Visits	3.18%	2.49%	-0.69%
4 Visits	10.83%	9.03%	-1.80%
5 Visits	15.29%	13.71%	-1.58%
6+ Visits	65.29%	70.72%	5.43%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	61.35%	62.50%	1.15%
Adolescent Well-Care Visits (awc)	47.45%	48.18%	0.73%

NA: Indicates denominator was too small or data were not available; NR: Not reported. * indicates rate was calculated with small denominator.

As shown, there were no measures that had substantial improvement of greater than 10%, although many rates improved. The measures of Antidepressant Medication Management and Follow-Up After Hospitalization for Mental Illness declined substantially.

Non-HEDIS Overview

Non-HEDIS performance measures include EPSDT Screening (<1 Year), EPSDT Screening (>1, >21 Years), Well-Child Visits in the First 15 months of life, Nephropathy Screening, and Screening for Clinical Depression. CCME did not validate the CAN non-HEDIS measures but reviewed the reported rates in comparison to target rates. *Table 12: CAN Non-HEDIS Performance Measure Rates* displays the CY 2018 rate for United CAN and the target rate.

Table 12: CAN Non-HEDIS Performance Measure Rates

Measure	Source	MS CAN Target Rate	CAN 2018 Rate
EPSDT Screening (<1 Year)	CMS 416-Report	85%	116.74%
EPSDT Screening (>1, >21 Years)	CMS 416-Report	75%	54.13%
Well-Child Visits in the First 15 months of life	HEDIS Modifier	59.76%	59.44%
Nephropathy Screening	CDC	90.33%	89.78%
Screening for Clinical Depression	CMS Adult Core Measure	25%	5.87%

The non-HEDIS performance measure, as per the *CHIP Contract*, includes the measure: EPSDT Screening (<1 Year), EPSDT Screening (>1, <21 Years), and the Well Child Visits in the First 15 Months of Life. CCME did not validate the CHIP non-HEDIS measures but reviewed the reported rates in comparison to target rates. *Table 13:* CHIP *Non-HEDIS Performance Measure Rates* displays the CY 2018 rate for United CHIP and the target rate.

Table 13: CHIP Non-HEDIS Performance Measure Rates

Measure	Source	MS CHIP Target Rate	CHIP 2018 Rate
EPSDT Screening (<1 Year)	CMS 416-Report	85%	107.27%
EPSDT Screening (>1, <21 Years)	CMS 416-Report	75%	47.92%
Well-Child Visits in the First 15 Months of Life	HEDIS Modifier	59.76%	48.18%

Performance Improvement Project Validation

CCME conducted validation of PIPs in accordance with CMS protocol, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates project components and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are:

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

As of July 1, 2019, there are four new topics required for the CAN PIPs. The required topics are: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). United submitted four PIPs for the required topics. *Table 14: CAN Performance Improvement Project Validation Scores* provides an overview of the scores for the CAN PIPs.

Table 14: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Comprehensive Diabetes Care	116/116= 100% High Confidence in Reported Results	CLOSED
Congestive Heart Failure- Annual Monitoring for Patients on Persistent Medications (MPM) ACE Inhibitors or ARBs-	96/96= 100% High Confidence in Reported Results	CLOSED
Adult BMI Assessment (ABA) and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	116/116= 100% High Confidence in Reported Results	CLOSED

Project	Previous Validation Score	Current Validation Score
Getting Needed Care Quickly	92/98=94% High Confidence in Reported Results	CLOSED
Behavioral Health Readmissions	N/A	78/78=100% High Confidence in Reported Results
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	N/A	62/62=100% High Confidence in Reported Results
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	N/A	57/62=92% High Confidence in Reported Results
Respiratory Illness: COPD/Asthma	N/A	62/62=100% High Confidence in Reported Results

As shown, four of the projects (4/4=100%) received a score of "High Confidence in Reported Results." There are no corrective actions for the PIPs. There is one Recommendation as shown in Table 15 that follows.

Table 15: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Sickle Cell Disease	Did the study use objective, clearly defined, measurable indicators?	Measure is defined. The denominator is reported to be a percentage and should be a number instead.	Change wording for denominator from "The percentage of members meeting criteria…" to "the number of members meeting criteria"

For CHIP, United submitted four projects for desk material review. As per the contract, the topic of obesity should be selected annually for study providing continuous evaluation. The Table that follows displays all four submitted projects, and their current and previous validation score. All four PIPs also scored in the "High Confidence in Reported Results" range, although there are several recommendations that apply to the most recent reports submitted. *Table 16: CHIP Performance Improvement Project Validation Scores* provides an overview of the scores for the CHIP PIPs.

Table 16: CHIP Performance Improvement Project Validation Scores

PROJECT	PREVIOUS VALIDATION SCORE	CURENT VALIDATION SCORE
Adolescent Well Child Visits	111/111=100% High Confidence in Reported Results	104/105=99% High Confidence in Reported Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-formerly called Reducing Adolescent and Childhood Obesity	111/111=100% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Getting Needed Care CAHPS	92/98=94% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	95/95=100% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results

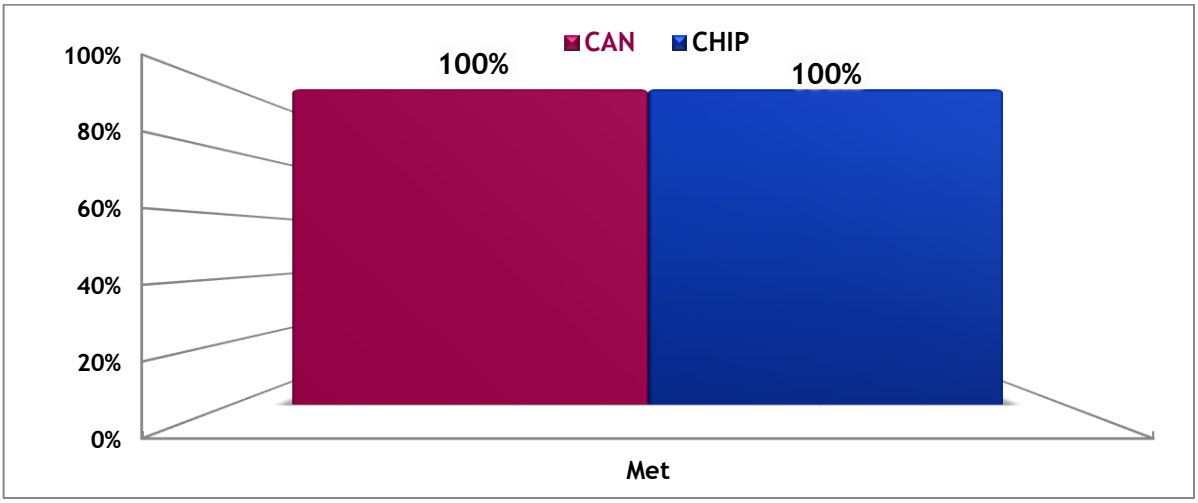
There are no corrective actions for the submitted PIPs. After the onsite, updated PIPs were uploaded and validated. The Table that follows lists the specific errors by project and recommendations to correct the errors.

Table 17: CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Adolescent Well Child Visits	Was there any documented, quantitative improvement in processes or outcomes of care?	Latest rates showed a decrease in AWC. The rate is below benchmark but above DOM goal rate	Continue member and provider education efforts to increase adolescent well check visits.
Follow Up After Hospitalization for Mental Illness	Was there any documented, quantitative improvement in processes or outcomes of care?	Both FUH rates decreased. The rates are above DOM goal rates but below benchmark rates for 7 and 30 day follow up.	Continue plan and member focused interventions to increase follow up rates.

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*. As shown in *Figure 7: Quality Improvement Findings* all the standards received a "Met" score in the QI Section.

Figure 7: Quality Improvement Findings



Strengths

- HEDIS performance measures were "Fully Compliant."

Weaknesses

- United has established the Multicultural Health Program to reduce health disparity and improve culturally and linguistically appropriate services. The description of the Multicultural Health Program appeared incomplete in the CAN and CHIP QI Program descriptions.
- There was a discrepancy between the CAN and CHIP QI Program Descriptions, the QMC Charter and the QMC minutes regarding who chairs the QMC.
- The PIPs were addressed in the CHIP QI work plan; however, the projects listed were not the ongoing CHIP projects. The CAN projects were listed in error.
- The EPSDT and Well Child visit tracking reports appeared to include encounters not related to a diagnosis found on the EPSDT or Well Child exams.

Recommendations

- Update the Multicultural Health Program description in the CAN and CHIP QI program descriptions.
- Correct the QMC Charter to reflect the Chief Medical Officer chairs the committee.
- Update the CHIP workplan to include the current CHIP PIPs are tracked.
- The EPSDT and Well-Child tracking reports should only include the problems or diagnoses identified during the EPSDT or Well-Child exam that required referrals.

E. Utilization Management

CCME conducted a utilization management (UM) review of United's CAN and CHIP UM activities, including the following:

- Program descriptions and evaluations
- Policies
- *Member Handbooks*
- *Care Provider Manuals*
- Approval, denial, appeal, and care management files
- Websites

The *Utilization Management (UM) Program Description* and policies guide staff on how to conduct UM activities for physical, behavioral health, and pharmaceutical services for members. Service authorization reviews are conducted by appropriate reviewers using an established clinical hierarchy. United assesses consistency in criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers.

United uses the most current version of the MS *Medicaid Program Preferred Drug List* (PDL), located on the State's website, to fulfill pharmacy requirements. However, information for accessing the PDL and other medications is not clear. The *Care Management Program Description/Whole Person Care Program Description and Addendum* outlines the framework for the Whole Person Care (WPC) Management Program's goals, scope, and lines of responsibility. During the Care Management (CM) file review, it was either difficult or impossible for CCME to find member risk levels. However, onsite discussions confirmed documentation of risk levels. CCME provides recommendations for both issues.

United's policy defines how to handle both CAN and CHIP appeals of adverse benefit determinations. CCME's documentation review revealed some issues, including:

- Incomplete definitions of appeal terminology
- Incorrect and incomplete information about the appeal filing timeframe
- Lack of information that members can present evidence or review the case file for an appeal
- Unclear information about the expedited appeal resolution timeframe
- No information about continuation of benefits pending the resolution of an initial member appeal

CCME's review of appeal files confirmed timely acknowledgement, resolution, and notification of resolution. Appropriate physicians rendered appeal determinations. However, both CAN and CHIP appeal resolution letters documented that two different physicians reviewed the appeal, which could result in confusion for the reader. Onsite discussion confirmed a MS-licensed physician signs off on appeal determinations rendered by physicians in other states; therefore, two physician's names are listed in the letter. CCME recommends including an explanation in resolution letters that clarifies the two physicians' roles in the appeal process. Several CHIP appeal resolution letters used the word "upheld" when referencing the initial denial of services. This, too, could confuse the reader. Onsite discussion confirmed this was an error.

The CAN and CHIP *2019 Quality Improvement Program Description*s indicate the SQIC monitors member appeal data and activities. CCME's review of SQIC meeting minutes did not confirm this. For two SQIC meetings, minutes showed an appeal report was not available. Minutes for the remaining three meetings did not clearly reflect discussion and monitoring of appeal data and activities.

As noted in *Figure 8: Utilization Management Findings*, United achieved "Met" scores 94.3% for CAN and 92.5% for CHIP for the UM standards. The plan received "Partially Met" scores of 5.7% for CAN and 7.5% for CHIP.

Figure 8: Utilization Management Findings

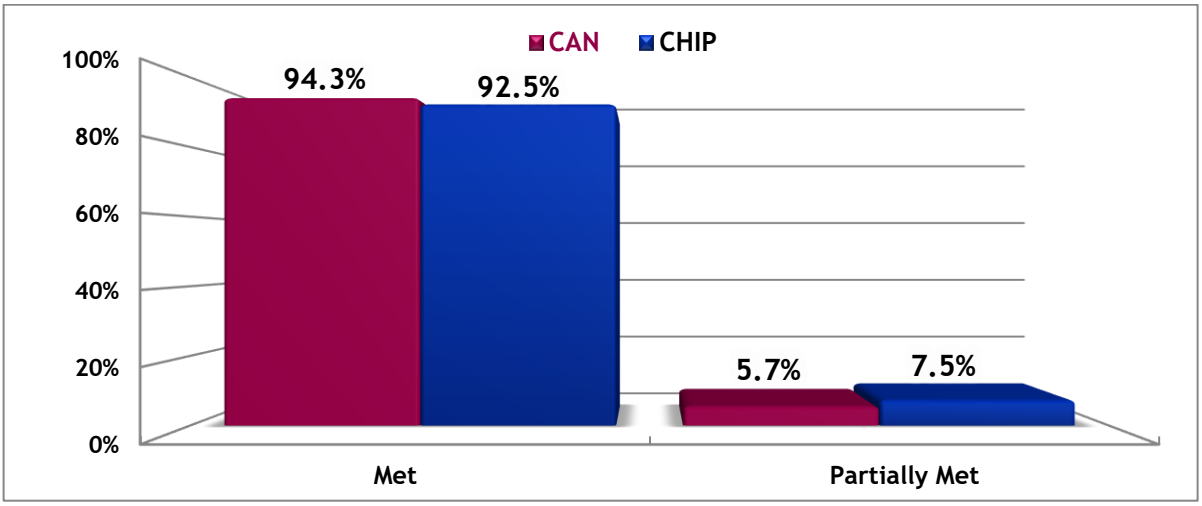


Table 18: Utilization Management

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Partially Met
	The procedure for filing an appeal	Partially Met	Partially Met
	Timeliness guidelines for resolution of the appeal	Met	Partially Met
	Other requirements as specified in the contract	Partially Met	Partially Met

Strengths

- Care Managers consistently conduct Heath Insurance Portability and Accountability Act (HIPAA) verification and assess for gaps in care during member contacts.

Weaknesses

- For both CAN and CHIP, some process steps for the PDL on the website and information in the *Member Handbook* are not clear. The following issues are identified:
  - Instructions in the *Member Handbooks* to access links for the PDL and over-the-counter medication lists indicate these lists are located on United's website when they are actually located on the Division of Medicaid's website.
  - An error message, "page not found", returns when accessing these links in the Member Handbooks.
  - To view the PDL from United's website requires several clicks before receiving the message "You are leaving this site". This message may discourage the reader from proceeding to DOM's website where the PDL is located.
- United's CAN *Member Handbook*, CAN website glossary, and CHIP website glossary incompletely define the term "adverse benefit determination." The following components of the definition are missing:

  - For residents in a rural area with only one Managed Care Organization (MCO), the denial of an enrollee's request to exercise his or her right, under *42 CFR §438.52(b)(2)(ii)*
  - The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

- Page 35 of the CAN 2019 *Care Provider Manual* correctly states the appeal filing timeframe is 60 calendar days from the date of receipt of the notice of adverse benefit determination. However, the table on page 39 incorrectly states the appeal filing timeframe is "within 60 calendar days of the event."
- Page 33 of the CHIP *2019 Care Provider Manual* contains information in a table about appeal filing timeframes. Identified issues include:
  - The information references an appeal filing timeframe of within 60 calendar days of the notice of adverse benefit determination for members but fails to specifically indicate the timeframe begins with the member's receipt of the notice.
  - The information references a timeframe of within 30 calendar days of the notice of adverse benefit determination for providers to file an appeal. Onsite discussion confirmed the timeframe for providers to file an appeal refers to provider disputes and not appeals of adverse benefit determinations. CCME noted provider disputes are addressed in a different section of the CHIP *2019 Care Provider Manual*. Including the filing timeframe for provider disputes in this table could confuse the reader.
- The CAN *Member Handbook* does not tell members that they can present evidence, review the case file for an appeal.
- Page 30 of the CHIP *2019 Care Provider Manual* does not clearly explain the 72-hour timeframe for expedited appeal resolution. It states United "makes reasonable efforts to give prompt verbal notice of an expedited appeal decision and follows-up with a written notice within two calendar days."
- Page 54 of the CHIP *Member Handbook* addresses continuation of benefits pending an Independent External Review but does not address continuation of benefits pending an initial appeal.
- The CAN *Member Handbook* does not include that the member can be held responsible for the cost of the continued benefits if the outcome of an initial appeal is adverse to the member.
- Some CAN and CHIP appeal resolution letters list two different physicians as reviewing the appeal, which could confuse the reader. Onsite discussion confirmed a MS-licensed

physician signs off on appeal determinations rendered by physicians in other states, and, therefore, two physician's names are listed in the letter.

- Several CHIP appeal resolution letters used the word "upheld" when referencing the initial denial of services. This could confuse the reader. Onsite discussion confirmed this was an error. The letters should have used the word "denied" when referencing the outcome of the initial authorization review.
- CCME's review of SQIC meeting minutes revealed very little evidence that the SQIC monitors member appeal activities, as stated in the *CAN* and *CHIP 2019 Quality Improvement Program Descriptions*. For two meetings, minutes showed a report was not available and did not provide a reason. The remaining 3 meetings do not clearly reflect discussion and monitoring of member appeal activities.
- Member risk levels could not be found or were difficult to identify in reviewed CAN and CHIP CM files.

Corrective Actions

- Revise the CAN *Member Handbook,* CAN website glossary, and CHIP website glossary definitions of the term "adverse benefit determination" to include the full definition as stated in the *CAN Contract, Section 2 (A)* and *42 CFR § 438.400 (b)*.
- Correct the appeal filing timeframe in the table on page 39 of the CAN *2019 Care Provider Manual*.
- Revise the information about appeal filing timeframes in the table on page 39 of the CHIP *2019 Care Provider Manual*. The revision should include that the filing timeframe for member appeals begins with receipt of the initial notice of adverse benefit determination. Also, remove the filing timeframe for provider appeals (provider disputes) which are addressed elsewhere in the *Care Provider Manual*.
- Revise the CHIP *2019 Care Provider Manual* to clarify the expedited appeal resolution timeframe is 72 hours from receipt of the appeal.
- Revise the CAN *Member Handbook* to include information that the member can present evidence or review the case file for an appeal.
- Revise the CAN and CHIP *Member Handbooks* to include full information about continuation of benefits for an initial appeal.

Recommendations

- In the CAN and CHIP *Member Handbooks* and on websites, provide clear information explaining that the PDL is located on DOM's website. Ensure the embedded links in the *Member Handbooks* are in working order and consider editing the PDL links on United's websites to land directly on the PDL on DOM's website.

- Revise CAN and CHIP appeal resolution letter contents to clearly show the physician who rendered the determination and the MS-licensed physician who signed off on the determination.
- Ensure correct terminology is used in CHIP appeal resolution letters when referencing the initial prior authorization review outcome.
- Revise the CAN *2019 Quality Improvement Program Description* and CHIP *2019 Quality Improvement Program Description* to include accurate information about the committee responsible for reviewing appeal activities to identify QI opportunities.
- Include clear documentation of member risk levels in CAN and CHIP CM documents such as care plans and care notes.

F. Delegation

United ensures all delegation arrangements are governed by written agreements between the delegate and the health plan that describe the roles and responsibilities of the health plan and the delegated entity, the delegated activities, reporting requirements, the process by which the delegated entity's performance is evaluated, and the terms for revoking delegation.

United has delegation agreements with the following entities:

Table 19: Delegated Entities and Services

Delegated Entities	Delegated Services
OptumHealth	Behavioral health services
Optum RX	Pharmacy benefit administration services
Dental Benefit Providers	Dental network services and third-party dental administration
eviCore National	Radiology and cardiology management services and prior authorizations
MARCH Vision Care	Vision and eye care services
National MedTrans (CAN Only)	Non-emergency transportation benefit services
•Hattiesburg Clinic •River Region Health System •HubHealth •University Physicians, PLLC	Credentialing/Recredentialing

Delegated Entities	Delegated Services
•HCA Physician Services •Health Choice, LLC •North Mississippi Medical Clinic •Ochsner •Premier Health, Inc.	

Policy DCO-01, Delegated Vendor Oversight Strategy explains how United measures and monitors delegated vendor compliance and performance. United develops monitoring tools that are tailored to the vendor's delegated services. Vendors must report their performance monthly. United uses standing joint operating committee monthly meetings to review vendor performance, identify trends or areas of concern, and develop performance improvement activities. CCME saw evidence of monthly oversight monitoring for the corporate delegated entities.

Policy UCSMM 03.14, Delegated Credentialing Oversight Policy & Procedure provides guidelines for all delegated entities. These guidelines apply to entities delegated to credential and recredential licensed independent practitioners and organizational providers (hospitals, ancillaries). The guidelines cover pre-assessment audits for potential delegates, annual oversight, and ongoing monitoring of monthly and quarterly reports. When United finds deficiencies, the health plan implements Improvement Action Plans with follow-up, as needed.

As defined in the *2019 Quality Improvement Program Description*, the executive level Delegation Oversight Governance Committee monitors and approves delegated activities for care providers. The committee also monitors and approves delegated activities for intersegment partners related to claims, credentialing, and medical management. This may include complex care management, disease management, population management, observation/inpatient hospital review, appeals, and grievances if contractually agreed upon.

The regional Delegation Oversight Committee provides ongoing oversight of delegation activities for claims/credentialing and medical management, including disease management and complex care management. The Provider Advisory Committee provides local delegation oversight.

CCME reviewed proof of annual oversight for all delegated entities. For credentialing and recredentialing oversight, United conducted annual audits to assess compliance with defined standards. The audit tool is comprehensive and included file review. However, the delegated credentialing and recredentialing tools omit the requirement for ensuring

the entities collect *Ownership Disclosure* forms and query the Social Security Death Master File.

As indicated in *Figure 9: Delegation Findings*, one of the two standards in the Delegation section was scored as "Met" for CAN and for CHIP.

Figure 9: Delegation Findings

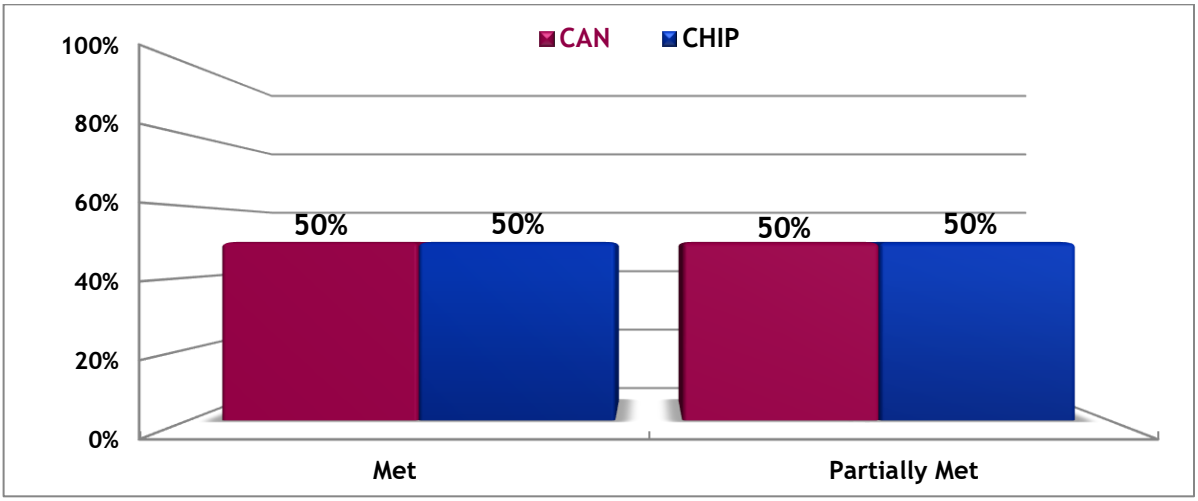


Table 20: Delegation

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Delegation	The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	Partially Met	Partially Met

Weaknesses

- The delegated credentialing and recredentialing tools omit the requirement for ensuring the entities collect *Ownership Disclosure* forms and query the SSDMF.

Corrective Actions

- Monitor the entities where credentialing and recredentialing is delegated to ensure *Ownership Disclosure* forms are collected and the SSDMF is queried. Update the delegation oversight tools to include monitoring the delegate for *Ownership Disclosure* forms and querying the SSDMF.

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

July 9, 2019

Mr. Jeff Wedin
Chief Executive Officer
UnitedHealthcare Community Plan - Mississippi
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Mr. Wedin:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2019 External Quality Review (EQR) of UnitedHealthcare Community Plan – Mississippi 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) and an 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 – Mississippi's office on **October 7, 2019** through **October 8, 2019** for the MississippiCAN Program and the Mississippi CHIP Program.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **August 8, 2019**.

Please upload all the desk materials electronically to CCME through our secure file transfer website. 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. We will also send written desk instructions on how to use the file transfer site. 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 803-212-7586 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

External Quality Review 2019 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MississippiCAN (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. Submit a complete list of network providers for the MSCAN members. The lists should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for MississippiCAN Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

   Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information.

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 and CHIP programs and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

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 2018 and 2019.

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 and 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 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 an MSCAN provider and for a CHIP provider.

18. Provide reports for measuring provider adherence to medical record standards for 2018 and 2019.

19. A complete list of all MSCAN members enrolled in the Care Management program from June 2018 through June 2019. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

20. 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 MSCAN and CHIP program and changes.

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

22. 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, final report provided by the subcontractor, and any other documentation of the requested scope of work.

23. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on MSCAN and CHIP programs.

24. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on MSCAN and CHIP programs.

25. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of June 2018 through June 2019.

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

27. 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 and after-hours access monitoring.

28. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed. Please identify which preventative guidelines apply to CHIP and which ones apply to MSCAN.

29. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed. Please identify which practice guidelines apply to CHIP and which ones apply to MSCAN.

30. A list of physicians for the MSCAN and CHIP programs currently available for utilization consultation/review and their specialty.

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

32. A sample provider contract for the MSCAN program.

33. 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.

34. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO. Please indicate if the delegates apply to MSCAN or CHIP or both.

35. Contracts for all delegated entities.

36. 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.

37. 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.

38. Provide electronic copies of the following files for the MSCAN program:

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

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

c. Twenty-five medical necessity denial files for the MSCAN program made in the months of June 2018 through June 2019. 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 June 2018 through June 2019, 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://eqro.thecarolinascenter.org**
- **should be submitted in the categories listed.**

External Quality Review 2019 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. Submit a complete list of network providers for the CHIP members. The lists should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for Mississippi CHIP Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

   Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information.

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 MSCAN and CHIP programs and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

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 2018 and 2019.

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 (MSCAN and 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 MSCAN provider and for a CHIP provider.

18. Provide reports for measuring provider adherence to medical record standards for 2018 and 2019.

19. A complete list of all CHIP members enrolled in the Care Management program from June 2018 through June 2019. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

20. 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 MSCAN and CHIP program and changes.

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

22. 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, final report provided by the subcontractor, and any other documentation of the requested scope of work.

23. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on MSCAN and CHIP programs.

24. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on MSCAN and CHIP programs.

25. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of June 2018 through June 2019.

26. 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.

27. 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 and after-hours access monitoring.

28. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed. Please identify which preventative guidelines apply to CHIP and which ones apply to MSCAN.

29. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed. Please identify which practice guidelines apply to CHIP and which ones apply to MSCAN.

30. A list of physicians for the MSCAN and CHIP programs currently available for utilization consultation/review and their specialty.

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

32. A sample provider contract for the CHIP program.

33. 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.

34. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO. Please indicate if the delegates apply to MSCAN or CHIP or both.

35. Contracts for all delegated entities.

36. 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.

37. 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.

38. Provide electronic copies of the following files for the CHIP program:

a. Credentialing files (including signed Ownership Disclosure Forms and provider office site visits as appropriate) for:
    i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
    ii. Two OB/GYNs;
    iii. Two specialists;
    iv. Two network hospitals; and
    v. One file for each additional type of facility in the network.
b. Recredentialing (including signed Ownership Disclosure Forms) files for:
    i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
    ii. Two OB/GYNs;
    iii. Two specialists;
    iv. Two network hospitals; and
    v. One file for each additional type of facility in the network.
c. Twenty-five medical necessity denial files for the CHIP program made in the months of June 2018 through June 2019. 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 June 2018 through June 2019, 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://eqro.thecarolinascenter.org**
- **should be submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Policies or other documentation describing exclusion status monitoring of subcontractors, persons with an ownership or control interest, agents or managing employees of the health plan

3. The following Optum policies:
    a. National Policy Definitions List: Medicaid
    b. National Policy Definitions List
    c. Mississippi CAN Addendum to Enrollee Grievances
    d. Mississippi CHIP Addendum to Enrollee Grievances
    e. Mississippi CAN Addendum to Enrollee Enrollee Appeals of Adverse Benefits Determinations
    f. Mississippi CHIP Addendum to Enrollee Enrollee Appeals of Adverse Benefits Determinations

4. Addendum 1 – 2018 Annual MississippiCAN Performance Measures Report and Addendum 2 – 2018 Annual MississippiCAN Multicultural Health Care QI Evaluation

5. The UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy report. The one received for the previous EQR was dated May 2017.

6. Standard Operating Procedure documents for the Member Services Call Center and the Provider Services Call Center (staffing, hours of operations, trainings, call scripts, etc.)

7. Quarterly reports for newly initiated Performance Improvement Projects: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult- COPD)

8. HEDIS Attest Audit Report for HEDIS 2019 (MY 2018) CAN Measures

9. Minutes from the May 8, 2019 PAC meeting. Received attachments but did not receive the minutes from that meeting in the desk materials.

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

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. HEDIS Attest Audit Report for HEDIS 2019 (MY 2018) CHIP Measures

3. Addendum 1 – 2018 Annual Mississippi CHIP Performance Measures Report and Addendum 2 – 2018 Annual Mississippi CHIP Multicultural Health Care QI Evaluation

4. Standard Operating Procedure documents for the Member Services Call Center and the Provider Services Call Center (staffing, hours of operations, trainings, call scripts, etc.)

Materials should be uploaded to the secure CCME EQR File Transfer site at https://egro.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
- PIP Validation CAN
  - CARE MANAGEMENT TO REDUCE PRETERM DELIVERIES
  - RESPIRATORY ILLNESS MANAGEMENT
  - CARE COORDINATION FOR SCD PATIENTS TO REDUCE ER UTILIZATION
  - REDUCING 30 DAY PSYCHIATRIC READMISSIONS
- PIP Validation CHIP
  - ADOLESCENT WELL-CARE VISITS
  - WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY/REDUCING ADOLESCENT AND CHILDHOOD OBESITY
  - FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS
  - CHILD MEMBER SATISFACTION, GETTING NEEDED CARE

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare Community Plan MS (CAN and CHIP)**
Survey Validated	**PROVIDER SATISFACTION (CAN AND CHIP)**
Validation Period	2018
Review Performed	2019

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**	-Purpose is documented. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Objectives are clear and measurable. *Documentation:* Market Strategies Provider Satisfaction Report- 2018
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Audience is identified. *Documentation:* Market Strategies Provider Satisfaction Report- 2018

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**Met**	-Survey is reliable *Documentation:* -Market Strategies Provider Satisfaction Report- 2018
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**Met**	-Survey is valid *Documentation:* -Market Strategies Provider Satisfaction Report- 2018

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 defined. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were clearly defined. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
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**	- Sample size was sufficient for intended use of the survey. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**Met**	- Procedures to select the sample were appropriate. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**Met**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018

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**	-Quality assurance plan was reflected in documentation. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
5.2	Did the implementation of the survey follow the planned approach?	**Met**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
5.3	Were confidentiality procedures followed?	**Met**	-Confidentiality was considered and procedures were appropriate. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018

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**	-Data and responses were analyzed. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018 -2018 MSCAN Evaluation
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	Statistical tests were applied correctly to responses. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* - Market Strategies Provider Satisfaction Report- 2018

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.	-Market Strategies provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Survey had a low response rate (3%) This is well below the NCQA target response rate for surveys of 40%. The low response rate may impact the generalizability of the survey. *Recommendation: Continue to work on interventions to increase response rates (e.g. reminders in Provider Newsletters)* *Documentation:* -Market Strategies Provider Satisfaction Report- 2018

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	Compared to last year, there was significant improvement on overall satisfaction, the determination of claims appeals, help taking care of patients, attentiveness to needs, easy to do business with, and UHC as a leader in simplifying healthcare. Care management remains an area of improvement, although scores improved. *Documentation:* -2018 MSCAN Evaluation Final
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 the report. *Documentation:* - Market Strategies Provider Satisfaction Report- 2018
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	**CONSUMER SATISFACTION (MEDICAID ADULT)**
Validation Period	2018
Review Performed	2019

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Uses standard CAHPS for measurement and use *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018

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**	- Study population was clearly defined. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were clearly defined. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
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**	- Sample size was sufficient for intended use of the survey. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**Met**	- Procedures to select the sample were appropriate. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**Met**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018

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 National Committee for Quality Assurance in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set Volume Three Technical Update Specifications. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
5.2	Did the implementation of the survey follow the planned approach?	**Met**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA-certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018

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 *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified vendor *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018

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.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate (22.87%). The National UnitedHealthcare Community Plan Average Response Rate for 2018 was 23.62 percent. The 2018 MississippiCAN Adult Response Rate is 0.75 percentage points below the National UnitedHealthcare Community Plan average. *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts).* *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	• Getting Needed Care (85.35) increased by 3.02 percentage points over year 2017 (82.33) • Getting Care Quickly (87.25) increased by 5.03 percentage points over year 2017 (82.22) • How Well Doctors Communicate (93.98) increased by 1.22 percentage points over year 2017 (92.76) • Customer Service (88.77) decrease by 2.45 percentage points over year 2017 (91.22) • Rating of Personal Doctor (87.37) increased by 0.54 percentage points over year 2017 (86.83) • Rating of Health Plan (81.69) increased by 2.67 percentage points over year 2017 (79.02) *Documentation:* -CAHPS Final Analysis and Executive Summary December 2018 QMC
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 the MCO furnished to beneficiaries is provided in the report. *Documentation:* -DSS Research *2018 CAHPS Adult Medicaid Survey* Summary Report: June 2018
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	**CONSUMER SATISFACTION (MEDICAID CHILD AND CHILD WITH CCC)**
Validation Period	2018
Review Performed	2019

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Uses standard CAHPS for measurement and use *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**Met**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H 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**	- Study population was clearly defined. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were clearly defined. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
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**	- Sample size was sufficient for intended use of the survey. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**Met**	- Procedures to select the sample were appropriate. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

Survey Element		Element Met / Not Met	Comments And Documentation
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**Met**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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 National Committee for Quality Assurance in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set Volume Three Technical Update Specifications. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
5.2	Did the implementation of the survey follow the planned approach?	**Met**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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 *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified vendor *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

Survey Element		Element Met / Not Met	Comments And Documentation
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rates for general population and total population. General Population Survey Responses: 404 completed (17.72% responses rate). Total Population Survey Responses: 912 (18.84% response rate). The 2018 MississippiCAN Child Response Rate (17.72) is 4.12 percentage points below the National UnitedHealthcare Community Plan average. *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts).* *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
7.4	What conclusions are drawn from the survey data?	• Getting Needed Care (90.07) increased by 1.41 percentage points over year 2017 (88.66) • Getting Care Quickly (92.58) increased by 2.38 percentage points over year 2017 (90.20) • How Well Doctors Communicate (94.98) increased by 2.99 percentage points over year 2017 (91.99) • Rating of Personal Doctor (91.49) increased by 2.78 percentage points over year 2017 (88.71) • Rating of All Health Care (87.54) increased by 2.85 percentage points over year 2017 (84.69) • Rating of Health Plan (87.06) increased by 2.13 percentage points over year 2017 (84.93) *Documentation:* - CAHPS Final Analysis and Executive Summary Dec 2018 QMC

Results Elements		Validation Comments And Conclusions
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and/or timeliness of healthcare the MCO furnished to beneficiaries is provided in the report. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
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	**CONSUMER SATISFACTION (MEDICAID CHILD AND CHILD WITH CCC)**
Validation Period	2018
Review Performed	2019

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and its standardized purpose *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
1.2	Review that the study objectives are clear, measurable, and in writing.	**Met**	-Uses CAHPS and its standardized objectives. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**Met**	-Uses standard CAHPS for measurement and use *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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**	- Study population was clearly defined. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**Met**	-Specifications for sample frame were clearly defined. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**Met**	- Sampling strategy was appropriate. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
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**	- Sample size was sufficient for intended use of the survey. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**Met**	- Procedures to select the sample were appropriate. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**Met**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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 National Committee for Quality Assurance in their CAHPS 5.0H guidelines and Healthcare Effectiveness Data and Information Set Volume Three Technical Update Specifications. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
5.2	Did the implementation of the survey follow the planned approach?	**Met**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
5.3	Were confidentiality procedures followed?	**Met**	-Uses a NCQA-certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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 *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
6.2	Were appropriate statistical tests used and applied correctly?	**Met**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
6.3	Were all survey conclusions supported by the data and analysis?	**Met**	- Conclusions were supported by data analysis of responses *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

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.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate (25.53%) for total sample and 23.46% for general population. The National UnitedHealthcare Community Plan Average Response Rate for 2018 was 21.84 percent, so this response rate was above the national average for last year. *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts).* *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018

Results Elements		Validation Comments And Conclusions
7.4	What conclusions are drawn from the survey data?	• Getting Needed Care (93.43) increased by 5.96 percentage points over year 2017 (87.47) • Getting Care Quickly (96.42) increased by 1.30 percentage points over year 2017 (95.12) • How Well Doctors Communicate (97.18) increased by 1.28 percentage points over year 2017 (95.90) • Customer Service (93.23) increased by 3.19 percentage points over year 2017 (90.04) • Rating of Personal Doctor (93.41) increased by 1.06 percentage points over year 2017 (92.35) • Rating of Specialist (89.38) increased by 2.09 percentage points over 2018 General Population UnitedHealthcare Community Plan Average (87.29) • Rating of All Health Care (92.46) increased by 1.42 percentage points over year 2017 (91.04) • Rating of Health Plan (89.46) increased by 2.71 percentage points over year 2017 (86.75) *Documentation:* -Final CAHPS Analysis and Executive Summary Report- Dec 2018 QMC
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 the report. *Documentation:* -DSS Research *2018 CAHPS Child Medicaid and Child with CCC Survey* Summary Report: June 2018
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR PM Validation Worksheet

Plan Name:	**UNITEDHEALTHCARE COMMUNITY PLAN – MIS (CAN)**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2018**
Review Performed:	**2019**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019

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**	The health plan uses National Committee for Quality Assurance (NCQA)-certified software. Review requirements for documentation are "Met."

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**Met**	The health plan uses NCQA-certified software. Review requirements for documentation are "Met."
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	The health plan uses NCQA-certified software. Review requirements for documentation are "Met."
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	The health plan uses certified software for medical record abstraction.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	The health plan uses certified software for medical record abstraction.
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.	MET	The health plan uses certified software for medical record abstraction.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**Met**	The sampling methods passed audit.
S2. Sampling	Sample treated all measures independently.	**Met**	The sampling methods passed audit.
S3. Sampling	Sample size and replacement methodologies met specifications.	**Met**	The sampling methods passed audit.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**Met**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to technical specifications?	**Met**	The health plan uses NCQA-certified software. Review requirements for reporting are "Met."

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	MET	5

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

Plan's Measure Score	**85**
Measure Weight Score	**85**
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:	**Measurement Year 2018**
Review Performed:	**2019**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019

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**	The health plan uses National Committee for Quality Assurance (NCQA)-certified software. Review requirements for documentation are "Met."

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) were complete and accurate.	**Met**	The health plan uses NCQA-certified software. Review requirements for documentation are "Met."
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	The health plan uses NCQA-certified software. Review requirements for documentation are "Met."
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	The health plan uses certified software for medical record abstraction.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	The health plan uses certified software for medical record abstraction.
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.	**Met**	The health plan uses certified software for medical record abstraction.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**Met**	The sampling methods passed audit.
S2. Sampling	Sample treated all measures independently.	**Met**	The sampling methods passed audit.
S3. Sampling	Sample size and replacement methodologies met specifications.	**Met**	The sampling methods passed audit.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**Met**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to technical specifications?	**Met**	The health plan uses NCQA-certified software. Review requirements for documentation are "Met."

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	MET	5

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

Plan's Measure Score	**85**
Measure Weight Score	**85**
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:	**CARE MANAGEMENT TO REDUCE PRETERM DELIVERIES**
Reporting Year:	2018
Review Performed:	2019

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**	Preterm births are a public health challenge in Mississippi.
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**	The research question is documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	The measure is 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**	The 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**	The 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**	The studied population 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**	No sampling was 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**	No sampling was used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was used.

Component / Standard (Total Points)	Score	Comments
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**	Data sources were clearly specified.
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**	The data collection method 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 annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that were 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)**	**NA**	Baseline data were not available.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Baseline data were not available.
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 were not available.
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)**	**NA**	Baseline data were not available.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data were not available.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data were not available.
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)**	**NA**	Baseline data were not available.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable.

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**	Baseline data were not available.

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

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

Project Score	**62**
Project Possible Score	**62**
Validation Findings	**100%**

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:	**RESPIRATORY ILLNESS MANAGEMENT**
Reporting Year:	2018
Review Performed:	2019

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**	More than 140,000 Mississippians are diagnosed with Chronic Obstructive Pulmonary Disease (COPD); and childhood asthma is a major concern in Mississippi.
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 health 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**	The research question is documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	The measures are 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**	The measures are related to functional and 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**	The 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**	The studied population 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**	No sampling was 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**	No sampling was used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was used.

Component / Standard (Total Points)	Score	Comments
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**	Data sources were clearly specified.
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**	The data collection method 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 annually, with quarterly reviews.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that were 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**	Initial barriers and interventions were 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)**	**NA**	Baseline data were not available.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Baseline data were not available.
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 were not available.
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)**	**NA**	Baseline data were not available.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data were not available.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data were not available.
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)**	**NA**	Baseline data were not available.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable.

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**	Baseline data were not available.

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 OFSTUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

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

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

Project Score	62
Project Possible Score	62
Validation Findings	100%

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:	**CARE COORDINATION FOR SCD PATIENTS TO REDUCE ER UTILIZATION**
Reporting Year:	2018
Review Performed:	2019

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**	Sickle Cell Disease is a major public health concern.
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 health 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**	The research question is documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	The measure is defined. The denominator is reported to be a percentage and should be a number instead. *Recommendation: Change wording for denominator from "The percentage of members meeting criteria…" to "the number of members meeting criteria."*
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**	The measure is related to functional and 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**	The 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**	The studied population 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**	No sampling was 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**	No sampling was used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was 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**	Data sources were clearly specified.
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**	The data collection method 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 annually, with quarterly reviews.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel that were 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**	Initial barriers and interventions were 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)**	**NA**	Baseline data were not available.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NA**	Baseline data were not available.
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 were not available.
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)**	**NA**	Baseline data were not available.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data were not available.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data were not available.

Component / Standard (Total Points)	Score	Comments
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)**	**NA**	Baseline data were not available.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data were not available.

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

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

Project Score	**57**
Project Possible Score	**62**
Validation Findings	**92%**

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 30 DAY PSYCHIATRIC READMISSIONS**
Reporting Year:	2018
Review Performed:	2019

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**	30 -day readmission rates in Hinds County are high.
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 documented.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are 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**	Measures are related to functional 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 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**	No sampling 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**	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling used.

Component / Standard (Total Points)	Score	Comments
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.
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 annually, with interim checks as well.
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**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented for baseline- MY 2018.
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**	Only baseline data are available.
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**	Rates are analyzed and follow-up activities reported.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Only baseline data are available.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Only baseline data are available.
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)**	**NA**	Only baseline data are available.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not applicable.

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**	Only baseline data are available.

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

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

Project Score	**78**
Project Possible Score	**78**
Validation Findings	**100%**

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 VISITS**
Reporting Year:	2018
Review Performed:	2019

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 opportunity for improvement regarding the CHIP population Adolescent Well-Care Visit (AWC) rate.
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 health 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**	The 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**	The 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**	The studied population 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**	Healthcare Effectiveness Data and Information Set (HEDIS®) sampling techniques were applied to the population.
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 sampling techniques were applied to the population.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS sampling techniques were applied to the population.
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**	Data sources 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**	The data collection method 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 were 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**	Analyses are conducted according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	The latest rates were added after the onsite.
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.
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**	The latest rates were added after the onsite and documentation showed analysis of latest available rate.
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 methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The latest rates showed a decrease in AWC. The rate is below the benchmark but above the Division of Medicaid (DOM) goal rate. *Recommendation: Continue member and provider education efforts to increase AWC.*

Component / Standard (Total Points)	Score	Comments
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)**	**NA**	No improvement was reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement was reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	CCME is unable to judge sustainment due to lack of rates above benchmark for consistent remeasurements.

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

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

Project Score	**104**
Project Possible Score	**105**
Validation Findings	**99%**

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:	**WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY/REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	2018
Review Performed:	2019

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 health 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**	The 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**	The 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**	The studied population 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)**	**Met**	Healthcare Effectiveness Data and Information Set (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.
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**	Data sources 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**	The data collection method 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 were 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**	Results are presented for annual rates.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	The latest rates were reported.
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 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 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**	The methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	The rates for all three outcomes improved.

Component / Standard (Total Points)	Score	Comments
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**	Improvement appears to be a result of interventions in effect.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical analyses for latest rates was conducted.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	It is too early to judge.

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

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

Project Score	111
Project Possible Score	111
Validation Findings	100%

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:	**FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	2018
Review Performed:	2019

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 a 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 health 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**	The 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**	The 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**	The studied population 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**	A 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**	A sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	A 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**	Data sources 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**	The data collection method 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 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**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	The latest rates are reported in documentation uploaded after the onsite meeting.
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.
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**	The latest rates were analyzed.

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 methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	Both Follow-Up After Hospitalization for Mental Illness rates decreased. The rates are above Division of Medicaid goal rates, but below benchmark rates for 7- and 30-day follow up. *Recommendation: Continue plan and member focused interventions to increase Follow-Up After Hospitalization for Mental Illness rates.*
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)**	**NA**	CCME is unable to judge. The latest rates were not reported.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	CCME is unable to judge. The latest rates were not reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	CCME is unable to judge sustainment due to lack of rates above benchmark for consistent remeasurements.

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

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

Project Score	84
Project Possible Score	85
Validation Findings	99%

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:	**CHILD MEMBER SATISFACTION, GETTING NEEDED CARE**
Reporting Year:	2018
Review Performed:	2019

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**	UHC shows a downward trend for the question that related to getting needed care.
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 enrollee satisfaction.
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)**	**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 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**	Opportunities, barriers, and interventions are documented and were discussed during the onsite visit.
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**	Annual rates are presented,
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**	Repeat measurements are noted.
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 opportunities were noted.
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 was the same at both timepoints.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rate improved and is above benchmark rate of 80.0% but below UHC Plan Goal of 92.7%.
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**	Improvement appears to be a result of interventions in effect.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical analysis was conducted.

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**	Not enough measurement data to determine sustainment.

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

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

Project Score	111
Project Possible Score	111
Validation Findings	100%

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.*

D. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CAN**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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				Policies are organized by department or functional area within the organization. The last review/revision date is noted on each policy. Employees access policies through a SharePoint site. United staff reported during onsite discussion that policies are reviewed annually. This corresponds with page two of *Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures*. However, the header for *Policy CE-01* does not reflect an annual review. Examples of additional policies, procedures, and standard operating procedures that do not reflect an annual review include, but are not limited to:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•*Policy MBR1a, DOM's Limited English Proficiency Policy* •*Standard Operating Procedure: Mississippi Medicaid Deliverable Reporting Process* •*Policy ADM36, Notice of Legal Actions* •*Policy MBR1b2, Notification of Oral Interpretation Services (Free of Charge)* •*Policy MBR1c, Marketing Schedules* •*Policy MBR3a, Assignment of Primary Care Provider (PCP)* CCME noted some policies do not reveal the line(s) of business to which they apply and reminded United staff that, according to a directive from the Mississippi (MS) Division of Medicaid (DOM), all policies and procedures should clearly show the line(s) of business to which they should apply. *Corrective Action: Ensure compliance with the requirement documented in Policy CE-01 that all policies, procedures, and standard operating procedures are reviewed at least annually.* *Recommendation: Ensure all policies and procedures clearly show the line(s) of business to which they apply.*
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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:						
1.1 *Chief Executive Officer;	X					Jeff Wedin is the Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Douglas "Mitch" Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					United's *Organizational Chart* shows Sharon Estess is the Chief Financial Officer (CFO); however, onsite discussion revealed Heath Seaman is the CFO. *Recommendation: Update the Organizational Chart to show the current CFO.*
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					Onsite discussion confirmed information systems staff, including claims and encounter data staff, are corporate staff. United's local Business Segment Liaison serves as the designated person in MS for data processing and providing reports and encounter data to DOM.
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					The *Organizational Chart* shows Rhona Waldrep is the Provider Services Manager/Network Strategy Director (effective 8/5/19). However,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						onsite discussion confirmed Tamara Keane is the Provider Services Manager and is located in MS. *Recommendation: Update the Organizational Chart to show the current Provider Services Manager.*
1.6.1 *Provider credentialing and education;		X				Corporate staff conduct credentialing activities. Provider Services staff and Provider Relations staff are local to MS. United staff reported they first offer online training to new network providers and if not completed, face-to-face training is provided. The *CAN Contract, Section 7 (H) (3)* states, "The Contractor shall employ sufficient representatives as a proportion of contracted providers to address all provider inquiries within a reasonable time frame. Provider representatives shall be allocated by the Contractor based on provider density within network areas and shall be reallocated based on provider density changes. Unless otherwise approved by the Division, Contractor shall employ a minimum of eight (8) provider representatives with two (2) additional representatives designated for out of state providers." Onsite discussion revealed there are currently five field staff who provide face-to-face services to the provider network. Two vacancies are noted in Field Representatives and these are being covered by current Representatives. DOM's requirement for a minimum of eight

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Representatives to provide face-to-face provider services, along with the contractual requirement for two additional Representatives designated for out-of-state providers, is not met. An additional 41 Provider Services Call Agents provide telephonic support to the provider network via the Provider Services Call Center. *Corrective Action: Recruit two additional Provider Advocates to provide field-based services for provider inquiries/issues. In addition, recruit two additional representatives to be designated for out-of-state providers.*
1.7 *Member Services Manager;	X					Kenisha Potter is Director of Member Services and Kobie Wells is Member Outreach Manager. Both are located in MS. Marriane Bullian, Member Services Manager, is a corporate employee.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					
1.9 Utilization Management Coordinator;	X					Latrina McClenton is the Health Services Director.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Quality Management Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 *Marketing, member communication, and/or public relations staff;	X					Both local and corporate staff conduct marketing, member communication, and/or public relations activities.
1.12 *Medical Director;	X					Amit Prasad, MD, is the Chief Medical Officer.
1.13 *Compliance Officer.	X					Cheryl Hicks is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
3. A professionally staffed all service/help line/nurse line which operates 24 hours per day, 7 days per week.	X					The CAN and CHIP *Member Handbooks* describe the availability of NurseLine for 24/7 telephonic access to Registered Nurses who can provide information, support, and education for health related questions or concerns.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.		X				The *CAN Contract, Section 18 (A)* requires CCOs to pay at least 90% of all clean claims for covered services within 30 calendar days of receipt and pay at least 99% of all clean claims within 90 calendar days of receipt. United did not provide exact claim completeness statistics, claims processing goals, or benchmarks. *Information Systems Capabilities Assessment* (ISCA) documentation provided by United states, "In general, claims are 85% to 90% complete after 3 months." This general estimate does not meet the claims processing rate required by the *CAN Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						While not a *CAN Contract* requirement, United reported an excellent claim payment accuracy average of 98.90% for a recent 12-month period. *Corrective Action: Improve clean claims completion rate. This may require claim completion data to be reanalyzed so accurate clean claims completion statistics can be reported. If bottlenecks are limiting the claim completion rate, audit and upgrade those systems.*
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					The information provided by United shows it has the systems, processes, and policies to adequately collect, store, process, monitor, and report on member and provider characteristics. For example, new incoming data is validated for accuracy using a claims verification system. Submissions that contain missing fields are returned to providers for completion. CCME also noted that United's IT systems use common data elements to ensure information remains consistent across systems. Finally, United can query collected data and report on that data for the State.
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					United's ISCA documentation clearly explained the processes followed to receive report requests, code database queries for reports, review report data, format reports, and deliver Medicaid reports. It also noted data is validated (for accuracy) using a claims verification system, and submissions that contain missing fields are returned to providers for completion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Finally, United maintains a data warehouse system to store report data and National Committee for Quality Assurance-certified software to create Healthcare Effectiveness Data and Information Set (HEDIS®)/HEDIS-like reports.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United considers its business continuity and disaster recovery plans and tests to be confidential; therefore, detailed information was not provided. Instead, United provided business continuity plans that summarize its approach to keeping systems available during events that could cause interruptions. Additionally, documentation was provided that summarizes steps to restore operations if a disaster does occur. During May 14-16, 2019, United conducted tabletop disaster recovery exercises to evaluate its ability to recover from a disaster. The tabletop disaster recovery test results indicate there were no problems found during the tabletop recovery exercise. *Recommendation: Actual disaster recovery tests are always preferable to simulated tabletop or desktop tests. If tests are conducted that restore critical systems and their supporting infrastructure, results should be documented (and redacted as needed) so they can be reviewed.*
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The *UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2018-2019* (FWA Program), along with *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019*, define processes to guard against fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				Issues are addressed in the standards that follow.
2.1 Standards of conduct;						The *UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity* (Code) defines standards of ethical behavior for all employees. Contact information for various ways of reporting potential ethics concerns or violations is included. The Compliance & Ethics HelpCenter is available online or via toll-free telephone number around the clock and allows anonymous reporting of violations of the Code, company policy, laws, regulations, etc.
2.2 Identification of the Compliance Officer;						
2.3 Information about the Compliance Committee;						The FWA Program states the Compliance Program Integrity Oversight Committee is accountable for ensuring "UHC businesses maintain an effective program to prevent, detect, and correct FWA." The *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019* omits information about the local Compliance Oversight Committee (COC). Onsite discussion confirmed COC is the local committee charged with oversight of the Compliance Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019 to the UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2018-2019 to include information about the local COC.
2.4 Compliance training and education;						The FWA Program addresses compliance training and education: •Employees, internal vendors and contractors are provided with mandatory training about compliance/ethics and FWA at the start of employment and annually thereafter. •External vendors and contractors are informed of annual FWA training and education requirements. Training is completed via web-based modules followed by testing or attestation. Compliance with training is monitored by the Compliance Officer. •Health care providers receive educational materials about billing practices and identifying and reporting suspected FWA. This information is provided during face-to-face educational sessions and through newsletters and the provider portal. The FWA Program indicates United distributes educational materials about FWA detection to members through written communications to raise awareness of how to identify and report potential FWA. CCME could not find member educational materials about FWA in the submitted desk materials. Onsite discussion

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						confirmed there are no materials provided to members other than the information in the CAN and CHIP *Member Handbooks*. Page 51 of the CAN *Member Handbook* and page 45 of the CHIP *Member Handbook* provide only minimal information about FWA and include a telephone number for reporting. The information lacks a full explanation of FWA and does not explain how to recognize FWA, etc. *Recommendation: Revise the CAN and CHIP Member Handbooks to include full information about FWA, such as definitions of terminology, examples of FWA, all ways of reporting suspected or actual FWA, etc.*
2.5 Lines of communication;						Page eight of the FWA Program states United's communication channels include, but are not limited to the following: •UnitedHealth Group Compliance & Ethics Help Center •Member Call Center •Provider Call Center •Optum Fraud, Waste and Abuse Hotline •UnitedHealthcare Fraud Tip Line Staff are also encouraged to discuss concerns with their manager, Human Resources staff, and/or the Compliance Officer.
2.6 Enforcement and accessibility;						The Code informs employees that violations of laws, company policies, and contractual obligations may result in disciplinary action, up

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to and including termination of employment, and could be referred to law enforcement. The CAN and CHIP 2019 *Care Provider Manuals* inform providers that they are expected to cooperate with investigations of potentially irregular, inappropriate, or fraudulent provider activity and that if a violation is substantiated, appropriate authorities will be notified. The CAN and CHIP *Member Handbooks* inform members that intentional false statements or claims to receive or increase benefits may result in criminal charges and may lead to prosecution for fraud. It may also cause loss of benefits.
2.7 Internal monitoring and auditing;						The FWA Program addresses the following monitoring and auditing activities: •Prospective Detection (includes pre-payment data analysis, data mining, and analysis of abnormal billing patterns) •Additional prospective activities to determine if a provider claim payment should be stopped may include reviewing provider quality care complaints; conducting additional claim history/trend data mining; reviewing the hospital bill; contacting the provider to obtain and review medical/billing records; interviewing providers, patients, members and/or witnesses; and checking provider qualifications, licensure status, disciplinary activity, civil litigation, criminal history, and/or financial records.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Retrospective detection (includes post-payment data analysis, payment error analysis, analysis of industry trends, monitoring and verifying exclusions and sanctions, delegation oversight and monitoring, provider audits, and FWA Program compliance and performance audits)
2.8 Response to offenses and corrective action;						The Special Investigations Unit (SIU) conducts investigations of credible suspicions of fraud against United plans and programs. The SIU staff includes qualified Investigators experienced in health care and prescription drug fraud and abuse, industry business practices and systems, infrastructure, and federal and state law enforcement and litigation practices. The Legal Department is consulted regarding planned formal FWA enforcement actions and reporting of suspected FWA to law enforcement officials, compliance with regulatory requirements, and other legal issues. For FWA, responses to detected offenses and actions include but are not limited to: •Provider notification, education, recovery efforts, and/or termination from the network •Referral of suspected FWA to law enforcement, regulatory, and administrative agencies •Recovery actions against paid claims
2.9 Exclusion status monitoring.						The *CAN Contract, Section 17 (E)* requires CCOs to monitor the exclusion status of any person with an ownership or control interest or who is an agent or managing employee of the CCO through routine checks of Federal databases,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						including the Social Security Administration's Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities, the System for Award Management, and the any such other databases as the Secretary may prescribe. In addition to the databases specified above, DOM requires checks of the MS DOM *Sanctioned Provider List*. *Policy ID-5881, New Hire and Periodic Employee Sanction Review* and the *Government Sanctions Policy-U.S.* do not address the requirements to monitor the SSDMF or the NPPES. *Corrective Action: Revise Policy ID-5881, New Hire and Periodic Employee Sanction Review and the Government Sanctions Policy-U.S. (or other applicable document) to include requirements to monitor the SSDMF or the NPPES for any person with an ownership or control interest or who is an agent or managing employee of the CCO. Refer to 42 CFR §438.610 and the CAN Contract, Section 1 (I).*
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The COC provides oversight of the Compliance Program, meets quarterly and as needed, and is chaired by the Compliance Officer. A quorum is established as 51% of committee membership. CCME's review of committee minutes confirms the presence of a quorum for all meetings.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					United Payment Integrity staff, Optum entities, and other vendors and contractors conduct various functions, including prospective and retrospective activities, to ensure reimbursement accuracy. The SIU performs investigations of suspected fraud.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes are in place for recoupment of provider payments and documented in the *Optum Post Pay Negotiations PICTS Policy and Procedure*.
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					Confidentiality training is required for all staff at the time of hire and then annually. According to *Policy 3A, Personnel Security*, employees and contractors are required to sign a confidentiality agreement and the agreement must be in place before a person is permitted access to confidential or protected information. Onsite discussion confirmed non-employee committee members must also sign a confidentiality agreement annually. Access to protected health information is determined by an employee's role/position and need to know.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. A. Credentialing and Recredentialing						
1. The CCO formulates and acts within policies and procedures related to credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				United defines processes for credentialing and recredentialing of licensed independent practitioners and facilities in the *UnitedHealthcare Credentialing Plan 2019- 2021.* The plan addresses MS-specific credentialing criteria in the *Additional State and Federal Credentialing Requirements* addendum. The *Optum Physical Health Credentialing Risk Management Plan 2019* is applicable to physical medicine providers, including chiropractors, physical therapists, occupational therapists and speech therapists. Mississippi specific credentialing criteria are addressed in the document. The *United Behavioral Health Clinician and Facility Credentialing Plan 2019-2020* defines credentialing and recredentialing processes for clinicians and facilities that provide behavioral health (BH) care and services to enrollees. The *Mississippi Addendum to Credentialing Policies* defines state credentialing criteria and additional UBH/OPTUM Policies support the credentialing plans. CCME noted that *Policy C.02, Clinician Credentialing Process*; *Policy C.03, Clinician Recredentialing Process*; and *Policy C.07, Organization Provider Credentialing and*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recredentialing do not include the requirement to query the State Medicaid Provider Sanction List. The MS State Medicaid Provider Sanction List is referenced in the *Mississippi Addendum to Credentialing Policies* document but none of the said policies reference this document. *Corrective Action: Update Policy C.02, Clinician Credentialing Process; Policy C.03, Clinician Recredentialing Process; and Policy C.07, Organization Provider Credentialing and Recredentialing to reference the Mississippi Addendum to Credentialing Policies which defines MS state specific credentialing criteria.*
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. Amit Prasad, Chief Medical Officer (CMO). Dr. Prasad took over as chair of the PAC in August 2019 from the Interim Chief Medical Director (CMD). Additional voting members of the committee include 10 participating network providers. Their specialties include pediatrics, psychiatry, dentistry, obstetrics/gynecology (OB/GYN), internal medicine, family medicine, and emergency medicine. A quorum of at least 51% of voting members in attendance is established at each meeting and the Committee Chair votes only to break a tie. The PAC meets quarterly and acts as the health plan's Credentialing Committee. The PAC reviews all National Credentialing Committee (NCC) recommendations. The PAC can approve, deny, or suspend NCC recommendations

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						related to the Mississippi (MS) Medicaid network. Onsite discussion confirmed that clean files, unclean files, and credentialing reconsiderations are promptly communicated to the CMO and PAC. The NCC is chaired by two Market Medical Directors. Voting members include 16 network providers from local plans. Dr. George Russell, an orthopedic surgeon and committee member, represents MS. The NCC reviews all credentialing/recredentialing decisions. 51% of the voting members in attendance constitutes a quorum. CCME's review of meeting minutes revealed very few meetings documented absent voting members. CCME noted that the previous Interim CMD did not attend any meetings. Onsite discussion confirmed that Dr. Prasad is now a member of the committee and will attend the meetings frequently. The Market Medical Directors are non-voting committee members. *Recommendation: Ensure MS representation is present for NCC meetings when it makes decisions about MS providers. Also ensure NCC meeting minutes document absent committee voting members.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized and contained proper documentation. Any issues are discussed in the standards that follow.
3.1 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the 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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;						
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 Query of the Social Security Administration's Death Master File (SSDMF);	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 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					
3.1.15 Ownership Disclosure form.			X			In the previous EQR, CCME noted *Ownership Disclosure* forms showed signatures from unauthorized signers. This contradicted the *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* document, which says 'an individual must have the power to legally bind the entity.' During the corrective action process, United presented an updated *Provider Entity Disclosure of Ownership* form that contained a statement ensuring the signer had authority to legally bind the entity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, the updated *Ownership Disclosure* form was not implemented. The *Provider Disclosures/National Disclosure Program* policy received in the onsite materials states, "A contracted provider is required to complete and submit a Disclosure Form upon enrolling, contracting, or credentialing and every three (3) years, or at any time there is a revision to the information, or upon a request for updated information." However, one provider credentialing file showed an *Ownership Disclosure* form that was dated 1½ years prior to the Credentialing Committee approval date. *Corrective Action: Implement the updated Provider Entity Disclosure of Ownership form presented in the previous EQR corrective action and ensure Ownership Disclosure forms show current information at credentialing.*
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				United conducts provider office site visits during credentialing for Primary Care Practitioners (PCPs) and OB/GYNs. Evidence of site visits was in the credentialing files. However, CCME noted that provider office site visits were not in credentialing files for Nurse Practitioners (NPs) when the NP showed on the application they would act as a PCP. United acknowledged that it was not making provider office site visits when the NP was practicing in a PCP capacity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Ensure provider office site visits are conducted for NPs at credentialing when the application shows they are acting as a PCP.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files were organized and contained proper documentation. Any issues are discussed in the standards that follow.
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 Re-query the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query 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 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.12 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					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure form.			X			In the previous External Quality Review (EQR), *Ownership Disclosure* forms showed signatures from unauthorized signers. This contradicted the *Provider Disclosure of Ownership and Control*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Interest Statement Frequently Asked Questions document, which says 'an individual must have the power to legally bind the entity.' During the corrective action process, United presented an updated *Provider Entity Disclosure of Ownership* form that contained a statement regarding the signer having authority to legally bind the entity. However, the updated *Ownership Disclosure* form was not implemented. *Policy Provider Disclosures/National Disclosure Program* received in the onsite requested materials states, "A contracted provider is required to complete and submit a Disclosure Form upon enrolling, contracting, or credentialing and every three (3) years, or at any time there is a revision to the information, or upon a request for updated information." However, the following recredentialing files showed *Ownership Disclosure* forms that were outdated upon recredentialing: •2 BH *Ownership Disclosure* forms were dated over 3 years prior to the Credentialing Committee approval date. •6 provider files showed *Ownership Disclosure* forms that were dated 2 ½ to 3 years prior to the Credentialing Committee approval date. *Corrective Action: Implement the updated Provider Entity Disclosure of Ownership form presented in the previous EQR corrective action. Ensure Ownership Disclosure forms show current information at recredentialing.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Processes are in place to regularly monitor office site quality for issues related to the physical accessibility, physical appearance, cleanliness, and adequacy of the waiting and exam room space. Once a threshold is met, a site visit is conducted within 45 calendar days of the receipt of the complaint as defined in *Policy QM-02, Timeframes for Ongoing Monitoring of Office Site Visit Quality* and *UnitedHealthcare Policy 5299, Ongoing Monitoring of Office Site Quality*.
4.4 Review of practitioner profiling activities.	X					During the recredentialing process, the Credentialing Committee reviews the history of quality of care/quality of service concerns. If substantiated, the applicant may be subject to denial of recredentialing. Evidence of quality of care/service review was found in the recredentialing files. *Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization* defines measures United uses to create provider profiles and monitor PCP over- and under-utilization. The profiles are generated annually and are distributed to suitable identified network physicians and health plan staff. Samples of the provider profiles were received in the desk materials.
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					The *UnitedHealthcare Credentialing Plan 2019-2021* defines the process for evaluating potential quality of care concerns which could include suspension, restriction, or termination of a participation provider. This process includes Medical Director review, with possible referrals

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to the Peer Review Committee and Regional Peer Review Committee. Any appeal process related to the termination, suspension or non-renewal of practitioners will be communicated to the affected practitioner. *UnitedHealthcare Policy 5776, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions* details the process for investigating, evaluating, and reviewing potential quality of care concerns which includes determining severity levels, improvement actions, disciplinary actions, and fair hearings as appropriate.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				Credentialing and recredentialing guidelines for organizational providers are addressed in the *UnitedHealthcare Credentialing Plan 2019- 2021.* The plan addresses MS-specific credentialing criteria in the *Additional State and Federal Credentialing Requirements Addendum*. CCME's organizational files review showed two credentialing files that were missing the MS DOM *Sanctioned Provider List* query. In addition, three recredentialing files had *Ownership Disclosure* forms that were dated 1½ to 2 years prior to the Credentialing Committee approval date. *Policy Provider Disclosures/National Disclosure Program* received in the onsite requested materials states, "A contracted provider is required to complete and submit a Disclosure Form upon enrolling, contracting, or credentialing and every three (3) years, or at any time there is a revision to the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information, or upon a request for updated information." *Corrective Action: Ensure proof of query of the MS DOM Sanctioned Provider List is included for all organizational credentialing and recredentialing files. Ensure recredentialing files show current Ownership Disclosure forms.*
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* addresses the requirement that PCPs must be notified of members assigned to them, including notification of panel changes, within five business days of the date on which United receives the Member Listing Report from DOM. To notify providers of panel composition and keep them informed of any changes to their member panels, United makes member panel details available to all participating PCPs via the secure provider portal.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Participating providers have access to member enrollment information via the secure, password-protected online provider portal and any provider may call the telephone number listed on the CAN or CHIP ID cards as defined in *Policy PS4, Member Enrollment Verification*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					PCPs communicate desired restrictions regarding member panel composition to United during initial credentialing or contracting setup as defined in *Policy PS10a, PCP Panel Notification*. If no panel restrictions are requested, it is understood that the PCP agrees to accept all members as assigned. If the PCP requests panel restrictions, these variables are applied to the provider setup and it is understood that the PCP will accept all member assignments in alignment with the desired panel profile. When PCPs request a fully closed panel, that information is included in the provider profile and that PCP will not be considered in the assignment logic for new members. Member panel details are available to all providers via the secure provider portal. The *Provider Directory*, paper and online, explains if providers are accepting new patients.
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					*Policy PS3, Geographic Access Standards*, defines the PCP geographic access standards for the CAN and CHIP programs that comply with contract requirements. CAN GeoAccess Reports show correct measurements for PCP urban and rural standards. The *CAN 2018 Quality Improvement Program Evaluation* shows that ongoing network assessments are conducted of the provider network and are reported quarterly and annually to DOM. The network for 2018 remained steady for primary care providers which includes family/general practice, internal medicine, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pediatrics. For PCPs, the goal of 90% of members having access was met for the urban and rural access standards. The health plan will continue to monitor availability of practitioners to identify future opportunities for improvement.
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					*Policy PS3, Geographic Access Standards*, defines the specialist geographic access standards for the CAN and CHIP Programs that comply with contract requirements. CAN GeoAccess Reports show correct measurements for urban and rural specialist standards. The *CAN 2018 Quality Improvement Program Evaluation* detailed the analysis results of geographic access standards for specialists, dental, emergency, urgent care, mental health, pharmacy, dialysis, and hospital providers. The goal is for 90% of members to have access to the specific practitioner types within the miles designated based on the population of the geographic area. All provider categories received met scores except pharmacy for the rural standard, which was not met for 24-hour pharmacy; and urgent care providers for the rural standard was coded as not applicable. United indicated there were insufficient 24-hour pharmacies in the state to meet the 90% access goal and DOM waived this contract requirement.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within 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 United to provide services to members enrolled in the CAN and CHIP Programs. The standards comply with contract requirements. United performs quarterly assessments to gauge the level of compliance among PCPs, OB/GYNs, and BH providers. United performs quarterly and annual assessments to gauge level of compliance among high-volume specialty providers. United submits these results to DOM and the United Service Quality Improvement Subcommittee. The subcommittee uses the results to monitor, track, trend, and promote identification of improvement opportunities and development of corrective action initiatives. United documents appointment standards in the *CAN 2019 Care Provider Manual* and reinforces them through provider education. Failure to meet access requirements results in direct outreach to the provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *CAN 2018 Quality Improvement Program Evaluation* showed detailed monitoring for access and availability which included monitoring access via questions from the *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey*, member complaints and appeals, assessing claims data for BH, and conducting *Practitioner Telephonic Surveys* for PCPs and high volume specialists/high impact specialists. Results show areas not meeting the 80% goal were as follows: •*CAHPS Survey* - Adult after-hours (71.59); Child after-hours (73.8); and the child urgent care (91.38) did not meet the 2017 QC 50th percentile of 91.67% by 0.29 percentage points. •Practitioner Survey - OB/GYN urgent (69.18) and routine (79.87) Barriers were identified and the plan will continue to monitor access and availability to identify future opportunities for improvement.
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* CCME conducted shows improvement from the previous study's results. CCME conducted a modified review last year, so the most recent *Telephonic Provider Access and Availability Study* was conducted in the 2016 review and had a success rate for 71 out of 177 calls (40%). Since that review, CCME adjusted its definition of a successful call. Now, the success rate is based on an adjusted denominator instead of the total calls made. The denominator is the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						total calls made minus those answered with voicemail messages, since this is now standard for many provider offices. With the new formula, the success rate for the 2019 *Telephonic Provider Access Study* was 63% (109 out of 173 total calls).
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* was received in the desk materials as an active policy; however, minutes in the September 17, 2018 Service Quality Improvement Subcommittee meeting stated this policy was retired due to Provider Relations introducing a new provider orientation process. Onsite discussion confirmed the policy is outdated and omits information relating to a new Provider Orientation Program that includes offering online training. United meets with the provider if the provider does not complete the online training. *Corrective Action: Update Policy PS11, Provider Orientation Plan or create a new policy that addresses the current provider orientation process.*
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;		X				The following are issues or inconsistencies noted when comparing the benefits listed in the CAN *2019 Care Provider Manual* to the CAN *Member Handbook*: •Durable Medical Equipment – The CAN *Member Handbook* states, "Prior authorization needed for items over $500"; however, this is not mentioned on page 9 of the CAN *2019 Care Provider Manual*. •Psychiatric Care Inpatient - Page 37 of the CAN *Member Handbook* lists Psychiatric Care Inpatient as available for persons under age 21; however, page 13 of the CAN *2019 Care Provider Manual* does not limit the benefit to age 21. •Hearing Services – Page 36 of the CAN *Member Handbook* says prior authorization is required for Durable Medical Equipment over $500, but page 10 of the CAN *2019 Care Provider Manual* states prior authorization is required for any services beyond Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) covered services and all hearing aids. •Outpatient Physical and Occupational Therapies – Page 11 of the CAN *2019 Care Provider Manual* has a statement about Speech Therapy that should be deleted or moved to page 12 of the Speech Therapy section. •Orthotics & Prosthetics – The CAN *Member Handbook* lists prior authorization for over $500 but this is not mentioned on page 11 of the CAN *2019 Care Provider Manual*. •Transplant Services – Page 11 of the CAN *2019 Care Provider Manual* does not specify which

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						organs are included. Information is listed on page 38 of the CAN *Member Handbook*. •Prescription Drugs - The CAN *Member Handbook* states 6 per month with no more than 2 of the 6 being brand-name non-preferred drugs; however, page 11 of the CAN *2019 Care Provider Manual* states a 5 per month limit. •Dental – Page 12 of the CAN *2019 Care Provider Manual* states preventive, diagnostic, and restorative care is covered; however, page 35 of the CAN *Member Handbook* only shows that Emergency pain relief and Palliative care is covered for adults. *Corrective Action: Update the CAN 2019 Care Provider Manual and/or the CAN Member Handbook to address benefit issues and inconsistencies.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
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	Not Applicable	Not Evaluated	
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with contract requirements.	X					United maintains the *Provider Directory* as an online searchable directory and a PDF directory formatted for print production. Both versions are available to members, potential members, network providers and all United staffs. United continues to make available hard copy *Provider Directories* in State Medicaid Regional Offices, United's office, Women Infant and Children offices, and upon member request. During 2018, *Provider Directories* were sent in new member Welcome Kits. The *Provider Directory* is available on the general website. *Policy NQM-052, Web-based Directory Usability Testing* describes the process for evaluating the accuracy of the online *Provider Directory,* which United does annually. United corrects inaccurate information on an ongoing basis. United trends ongoing issues, finds opportunities for improvement, and implements interventions when applicable. *NQM-052 MS Rider 1* provides state-specific requirements for the *Provider Directory* and addresses the contract requirement that changes to the web-based *Provider Directory* must be updated within 5 business days.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider education is accomplished through physician newsletters, webinars, and resource information available on the provider website portal such as pre-recorded training sessions, bulletins, *Care Provider Manuals* for CAN and CHIP, policies and clinical practice

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines (CPGs), and prior authorization guidelines.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The Medical Technology Assessment Committee and the National Medical Care Management Committee review and accept preventive health practice guidelines on a national level. The local PAC reviewed and approved the 2019 guidelines on July 22, 2019.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Preventive health and CPGs are available on the website provider portal. Providers may also request that hard copies of the guidelines be sent to them by contacting the Provider Services Center. Additionally, when new guidelines are added or current guidelines are revised, United 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 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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 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					Evidenced-based CPGs are used to monitor and improve the quality of care provided by participating providers. United clinical guidelines are annually reviewed and accepted by the Physician Advisory Committee, presented to the Quality Management Committee, and distributed to the network providers. The CPGs are available on the provider portal of the website and provider education is also provided on the CPGs. United continues to establish and update guidelines based on medical evidence, either by expert advice and/or recognized clinical publications.
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					Providers are educated about CPGs through information listed in the CAN and CHIP *2019 Care Provider Manuals*, and all adopted guidelines are posted on the website. When new guidelines are added or current guidelines are revised, United notifies providers of these changes in the *Provider Newsletter*. The *2019 Clinical Practice Guidelines* document was posted to the website and providers may request hard copies of the guidelines be sent to them by contacting the Provider Services Center.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					*Policy NQM-025 Ambulatory Medical Record Review Process* defines the procedures for ensuring that member medical records, both paper and electronic, are maintained in a manner that is current, detailed and organized, and permits effective and confidential patient care and quality review. United explains medical record standards to Practitioners in the *Care Provider Manual* and other ad hoc communication documents. The record review is completed annually, unless required more frequently. If standards are not met, an Improvement Action Plan is implemented.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					During the 3rd quarter of 2018, the medical record review audit was completed in-house by the Clinical Practice Consultants. The Clinical Practice Consultants audited 27 Primary Care Providers who rendered services to adults as well as children in their clinics. The results of the adult medical record review showed all Primary Care Providers audited met the goal of 85%. Results for EPSDT/Well-Child/ showed only 67% of the clinics unclothed members while performing the exam (having the member unclothed is required). Another area not meeting the requirements for EPSDT/Well-Child/Baby was getting certain labs and immunizations at the correct age. The Clinical Practice Consultants educated the staff of the missing elements not found in the medical records before leaving the clinic.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					CCME performed *Provider Satisfaction Survey* validation using a validation worksheet based on the *CMS Survey Validation Protocol*. The *Provider Satisfaction Survey* had a low response rate (3%). This is well below the National Committee for Quality Assurance target response rate of 40% for surveys. The low response rate may impact the generalizability of the survey. The complete worksheet is available as an attachment in this report. *Recommendation: Focus on strategies that help increase response rates for the Provider Satisfaction Survey. Enlist the help of the survey vendor.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The health plan analyzed the survey.
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					United presented survey results to the Quality Management Committee in the December 2018 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					United guarantees member rights and responsibilities as outlined in *Policy MBR4a, Notification of Rights* and as described in the CAN *Member Handbook* and *Care Provider Manual*.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in *Policy MBR4a, Notification of Rights*, the *Member Handbook*, Care *Provider Manual*, and member website. See standards 2.1 – 2.4 for specific comments.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						Page 57 of the *Member Handbook* states the member has a right to "Refuse care and be told what you may risk if you do." This statement fails to completely include the member's right to participate in decisions regarding his or her health care. Onsite discussions revealed member rights are listed in some issues of the *Health TALK* SM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member newsletter and in handouts that are distributed at community events. *Recommendation: Edit the Member Rights and Responsibilities section of the CAN Member Handbook to include the complete requirement in the CAN Contract, Section 6 (9) (d) to address member's rights.*
2.5 To access 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 to 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;						
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 listed in *Policy MBR4a, Notification of Rights,* the *Member*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Handbook, *Care Provider Manual*, and the member website. See standards 3.1 – 3.5 for specific comments.
3.1 To pay for unauthorized health care services obtained from non-participating 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.						*Policy MBR4a, Notification of Rights* does not indicate the member is responsible for informing the plan of changes in family size, address, or health care coverage. *Corrective Action: To be consistent with information in the CAN Member Handbook and website, and to meet requirements in the CAN Contract, Section 6 (J), edit Policy MBR4a, Notification of Rights to indicate members are responsible for informing the plan of changes in family size, address changes, or other health care coverage.*
III B. Member CCO Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 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)* notes new members will receive an Information Packet, which contains a welcome letter, CAN ID card, *Member Handbook*, and *Care Provider Manual*, within 14 days after United receives information of enrollment. See ccomments in standards 1.1 to 1.20.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						The CAN *Member Handbook* includes information that Women's Health Specialists are types of PCPs and that female members may access a women's health specialist for routine and preventive health services. However, it does not clearly indicate members may have a Women's Health Specialist in addition to their designated PCP, as required by the *CAN Contract, Section 7 (B) (3)*. Onsite discussion confirmed female members are not restricted from seeing a Women's Health Specialist in addition to their PCP. *Recommendation: Edit pages 17 and 43 of the CAN Member Handbook to clarify that female members may receive women's routine and preventive care from a Women's Health Specialist in addition to services by their designated PCP. Refer to the CAN Contract, Section 7 (B) (3).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						
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;						
1.9 A description of the member's identification card and how to use the card;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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;						
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, call center, nurse advice line, and member portal;						The *Member Handbook* provides correct toll-free contact information and descriptions for United CAN Member Services, the NurseLine, and secure website access to the member portal at myuhc.com/CommunityPlan.
1.13 A description of EPSDT services;						Minimal information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services is provided on page 48 of the CAN *Member Handbook*, and no ESPDT information is available on the website. *Recommendation: Edit the Member Handbook and website to include complete descriptions of required EPSDT services and age-appropriate health screenings and immunizations. Consider referencing or including information on the American Academy of Pediatrics (AAP) Bright Futures Medical Periodicity schedule so the reader can obtain specific information if desired. Refer to the CAN Contract, Section 5 (D).*
1.14 Procedures for disenrolling from the CCO;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						*Policy MBR15a, Advanced Directives* describes information about Advance Directives. Additionally, the *Member Handbook*, *Care Provider Manual*, and website describe two types of Advance Directives—a Living Will and a Medical Power of Attorney. The website provides links for two fillable electronic forms. Initially it is not clear that Advance Directive forms are located on the website because the links are named "Example1" and "Example2." During the onsite, CCME discussed that instructions for obtaining Advance Directive forms and receiving assistance to complete them are not clearly described in the *Member Handbook* or website. United advised health plan staff can provide members with assistance in completing forms if needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit Policy MBR15a, Advanced Directives, page 52 of the Member Handbook, page 67 of the Care Provider Manual, and the website to clarify how members can obtain Advance Directive forms and how to receive assistance completing it if needed.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					United notifies members by mail 30 days before the effective date of any material changes and 14 days prior to implementing changes to covered benefits/services as described in *Policy MBR8a, Proper notice to members on written notices in material changes.* *Policy MBR8b, 15 day written notices of termed provider* indicates members who received primary care from, or were seen on a regular basis by, a terminated provider will be notified in writing within 15 days after a provider's termination notice is received by United. CCME did not identify how United includes information about selecting a new provider, and a date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required. During the onsite, United confirmed the written notice has a cutoff date and the member is given the option to choose another PCP. *Recommendation: Edit Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes and Policy MBR8b, 15 Day*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Written Notices of Termed Provider to reflect written notices of termed providers include a cutoff date and a statement that the member is given the option to choose another PCP. Refer to MS CAN Contract, Section 6 (D).
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 MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension* and *Policy MBR1b2, Notification of Oral Interpretation Services* confirm member materials are written at no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. Onsite discussion revealed materials are written using a minimum 12-point font and large print items are printed in a font size no smaller than 18 point. When 5% or more of the resident population of a county is non-English speaking and speaks a specific language, materials are made available in the respective language. *Recommendation: Ensure the requirement to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font size are documented in Policy MBR 7, Member Materials/Sixth Grade Level of Reading Comprehension or other policy. Refer to the CAN Contract, Section 6 (F).*
4. The CCO maintains and informs members 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					United provides interpreter and translation services, free of charge, to members who speak another language or have limited English proficiency as described in the *Member Handbook* and *Policy MBR1b2, Notification of Oral*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Interpretation Services. Written materials in alternative formats, such as large print or simple language, can be obtained by calling Member Services. The toll-free telephone number for CAN Member Services and the 24-Hour NurseLine are located on the member's ID card, in the *Member Handbook*, and the United website. In addition, this information is located in education materials such as the Spring 2019 *Health TALK* member newsletter.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					
III C. 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					United maintains a Member Services Call Center and 24-Hour NurseLine. In addition, members can access a 24-hour behavioral health hotline staffed with mental health professionals. The following documentation issues were identified: •CCME could not determine the difference between the Mental Health Crisis Line (referenced on page 14 in the *Member Handbook*) and the Crisis intervention/access, 24-hour hotline (referenced on page 25). At the onsite,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						United advised these refer to the same telephone line. •Page 6 of the *Care Provider Manual* states the toll-free Provider Services Call Center is maintained Monday -Friday from 8 am to 5 pm. The *CAN Contract, Section 7 (H) (1)* requires operating hours between 7:30 am - 5:30 pm. At the onsite, United confirmed Provider Services Call Center hours are from 7:30 am- 5:30 pm. •On the CAN website under "See more benefits and features," a phone number is not provided for the NurseLine or for Member Services; the Member Services section erroneously notes members can call "24/7"; and the NurseLine availability is written as "24/7," which may not be understood by all readers. *Recommendation: Edit page 14 or page 25 of the Member Handbook to specify either Mental Health Crisis Line or Crisis intervention/access, 24-hour hotline. Refer to the CAN Contract, Section 7 (H) (1) to correct the hours of operation on page 6 of the Care Provider Manual. Provide the toll-free number for Member Services and the NurseLine on the CAN member website. In addition, on the CAN website, clearly state NurseLine availability as "24 hours a day, 7 days a week" instead of "24/7". Refer to page 16 of the CHIP Member Handbook.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					United has several scenarios of Call Center scripts in place, such as Language Line Standard Operating Procedure and Primary Care Physician Change. Training logs confirm Call Center staff receive training at least quarterly, as required in *CAN Contract Section 6 (A)(4)*.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					During the onsite United confirmed disenrollment requests are submitted to DOM for approval.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Members are informed of scheduled preventive health services, available case management programs, and how to obtain educational support for medical, behavioral health and pharmaceutical services through the *Member Handbook* and member newsletters; both are available on the website. Additionally, United mails postcards and sends email messages to eligible members reminding them of screenings and well visits.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					The *Member Handbook* informs members about the Healthy First Steps™ (HFS) Program, where pregnant members receive services, support and education which can assist in achieving a healthy pregnancy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy HFS 001, Healthy First Steps Maternity Program states members can be identified for HFS through enrollment data, claims data, case management contacts or referrals, etc. Member engagement in the HFS Program is tracked and monitored by various methods, such as communication with the OB provider. Referrals to the Women, Infant and Children is provided by HFS staff.
3. The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
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 CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. United contracts with DSS Research, a certified *Consumer Assessment of Healthcare Providers and Systems Survey* vendor, to conduct the *Adult and Child Surveys*. The actual sample sizes were adequate and met the National Committee for Quality Assurance minimum sample size and number of valid surveys (at least 411), but the response rates were below the National Committee for Quality Assurance target of 40%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						For adults, the generalizability of the survey results is difficult to discern due to low response rate (22.87%). For the child survey, generalizability of the survey results is also difficult to discern due to low response rates for general population and total population. General Population Survey Responses: 404 completed (17.72% responses rate). Total Population Survey Responses: 912 (18.84% response rate) *Recommendation: In addition to the other ongoing interventions, continue working with DSS Research to increase response rates for Adult and Child surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the *Member Satisfaction Survey* to identify quality problems.
3. The CCO reports results of the member satisfaction survey to providers.	X					The CCO reports the results of the *Member Satisfaction Survey* to providers.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The CCO reports results of the *Member Satisfaction Survey* and the impact of measures taken to address any quality problems that were identified to the correct committee.
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member	X					The *Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01)* is applicable to both the CAN and MS CHIP lines of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
grievances in a manner consistent with contract requirements, including, but not limited to:						business and describes operating procedures for processing member appeals and grievances. United staff reported during the onsite that, as of October 1, 2018, Optum is no longer delegated to conduct appeal and grievance functions for members.
1.1 Definition of a grievance and who may file a grievance;			X			The CAN website glossary defines a grievance as, "Your statement of dissatisfaction with any part of your care." This could be misleading to members. It does not convey that a grievance can be about any matter other than an adverse benefit determination. Note: This is an uncorrected deficiency from the 2018 EQR. *Corrective Action: Revise the definition of the term "grievance" to include that grievances are an expression of dissatisfaction about any matter other than an adverse benefit determination. Refer to the CAN Contract, Section 6 (K) and Exhibit D and 42 CFR §438.400 (b).*
1.2 The procedure for filing and handling a grievance;			X			The timeframe for filing a grievance is correctly documented in all information sources reviewed. The timeframe for filing a complaint is included in policy and in the CAN *2019 Care Provider Manual*. It is not documented in the CAN *Member Handbook*. Note: This is an uncorrected deficiency from the 2018 EQR. Also, the CAN *Member Handbook* does not inform members that assistance is available for the grievance filing process. Note: This is an uncorrected deficiency from the 2018 EQR.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Revise the CAN Member Handbook to include the filing timeframe for a complaint and that assistance can be provided in the grievance filing process.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					*Policy POL2015-01* indicates grievance records are retained for a minimum of 10 years and include a general description of the reason for the grievance; receipt date; the date of review or, if applicable, review meeting; resolution; date of resolution; and name of the covered person for whom the grievance was filed.
2. The CCO applies the grievance policy and procedure as formulated.	X					Grievance files reflected timely determinations and notifications. Three grievance files were noted with acknowledgement letters sent beyond the 5-calendar day acknowledgement timeframe specified in *Policy POL2015-01*. *Recommendation: Ensure acknowledgement letters for grievances are sent within the required 5 calendar day timeframe from receipt of the grievance.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement	X					The CAN *2019 Quality Improvement Program Description* states complaint and grievance data

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
opportunities, and reported to the appropriate Quality Committee.						are collected, analyzed and monitored to identify opportunities for improvement. Responsibilities of the Service Quality Improvement Committee (SQIC) include monitoring member complaint and grievance trends. The Provider Advisory Committee also reviews summary data regarding quality of care complaints and grievances to identify trends, conducts barrier analysis, and recommends corrective actions as needed. Review of SQIC meeting minutes revealed very little evidence that the SQIC monitors member complaint and grievance trends, as stated in the *2019 Quality Improvement Program Description*. •For the February and June 2019 meetings, minutes indicated a report was not available and did not indicate a reason. •The remaining three meetings (June, September, and December 2018) do not clearly reflect discussion and monitoring of member complaint and grievance trends. United staff agreed during the onsite that the program description is inaccurate about SQIC's responsibility for monitoring member complaint and grievance trends and should be revised. *Recommendation: Revise the CAN 2019 Quality Improvement Program Description to include accurate information regarding the committee responsible for reviewing grievance data to identify quality improvement opportunities.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					During the onsite, United confirmed Member Services staff assist members with PCP change requests for any reason including dissatisfaction. United investigates these requests.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					During the onsite, United confirmed requests for PCP changes related to dissatisfaction are categorized and tracked.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. 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					United has implemented a Quality Improvement (QI) Program described in the *2019 Quality Improvement Program Description* for the CAN Program. The purpose of the QI Program is to monitor, evaluate, and improve the quality of clinical care and services provided to United's members. The program description is updated annually and submitted to the Board of Directors, Quality Management Committee (QMC) and to the Mississippi Division of Medicaid for review and approval.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					According to the QI Program Description and workplan, one of the goals is to serve member with complex health needs and monitor for appropriate quality healthcare services. To help meet this goal, United has established the Multicultural Health Program to reduce health disparity and improve culturally and linguistically appropriate services. The description of the Multicultural Health Program appeared to be incomplete. *Recommendation: Update the Multicultural Health Program description in the QI Program description.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 QI Program description discusses data sources used to support the QI activities; however, it does not specifically mention utilization data. *Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization* describes the process for monitoring utilization data to monitor for potential issues. The Healthcare Quality and Utilization Management Committee is charged with reviewing utilization data to identify over and underutilization and recommend Corrective Actions as needed.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, United develops a QI work plan that identifies activities to be conducted to help the program meet its goals and objectives. The workplan is reviewed and updated quarterly. The 2018 and 2019 workplans were provided for this EQR.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					United's Quality Management Committee is charged with the implementation, coordination, and integration of all QI activities. This committee reviews decisions of the National Quality Oversight Committee and offers feedback as appropriate. The QMC oversees several committees including the Provider Advisory Committee (PAC). The PAC and the Healthcare Quality and Utilization Management Committee are responsible for monitoring QI activities and providing recommendations as appropriate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.	X					A variety of network providers are included on the PAC. The membership for the QMC include senior executives, directors and other health plan staff. There were issues identified regarding who chairs this committee, as follows: •According to the QI Program Description, the committee is chaired by the health plan's Chief Medical Officer. •The committee charter received with the desk materials indicates the committee is chaired by the plan's Chief Executive Officer. •Meeting minutes for June 2018, December 2018, and March 2019 indicate the meeting was Chaired by the Director, Clinical Quality. •The September 2018 meeting minutes indicated the meeting was chaired by Dr. Phillips however, the minutes were signed by the Director, Clinical Quality. *Recommendation: Correct the QMC Charter to reflect the Chief Medical Officer chairs the committee.*
3. The QI Committee meets at regular intervals.	X					The QMC meets at least quarterly and the PAC and Healthcare Quality and Utilization Management Committee meets a minimum of four times per year. A minimum of 51% of voting members constitutes a quorum.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Committee minutes received demonstrated that the committees met the established meeting frequency and quorum.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					United was found to be "Fully Compliant" and met all the requirements for the Healthcare Effectiveness Data Informational Set measures as per the report by Attest Health Care Advisors. There were several measures that had substantial improvement of greater than 10%. Those included HPV and Combination #2 Vaccinations for Adolescents, and Comprehensive Diabetes Care HbA1c Control. The measures with a substantial decrease in rate were Comprehensive Diabetes Care HbA1c Poor Control, Metabolic Monitoring for Children and Adolescents on Antipsychotics for 1-5-year olds, and Alcohol Abuse or Dependence: Initiation of AOD Treatment: Total. Details of the validation activities for the performance measures may be found in *Attachment 3, CCME EQR Validation Worksheets*.
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					As of July 1, 2019, there are four new topics required for Coordinated Care Organization performance improvement projects. The required topics are: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). United submitted four PIPs for the required topics.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					Four of the projects (4/4=100%) received a score of "High Confidence in Reported Results." Details of the validation activities for the PIPs, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specific outcomes may be found in *Attachment 3, CCME EQR Validation Worksheets*.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					United collects physician profile reports at the group and individual level and uses these reports to measure provider performance and educate the provider.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per Policy *QM-01, Monitoring of Clinical and Preventive Health Guidelines*, United annually monitors provider compliance with the clinical and preventive health guidelines.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						United's Standard Operating Procedure titled *EPSDT Services - Tracking Process* outlines the process used to track EPSDT Services and includes the initial visit for newborns, screenings and reporting of results, and any diagnosis, treatment and/or referrals.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					United's Standard Operating Procedure titled *EPSDT Services - Tracking Process* indicates any problem identified during the EPSDT exam that required referrals are tracked quarterly. United provided a sample of the results of this tracking report onsite. However, the report did not contain EPSDT visits. The report appeared to included encounters not related to a diagnosis found on the EPSDT exam, such as emergency

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						room visits or unspecified effects of drowning and nonfatal submersion. According to United staff, the tracking report is run for members who had an EPSDT exam and had an encounter for a service received after the EPSDT exam not necessarily related to a diagnosis found on an EPSDT exam. The tracking reports are sent to the Case Management Department for follow-up with the member to ensure referrals are provided if needed. *Recommendation: The tracking reports should only include the problems or diagnoses identified during the EPSDT exam that required referrals.*
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					United provided the *2018 Quality Improvement Program Evaluation*.
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	Not Applicable	Not Evaluated	
V A. 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 *Mississippi Utilization Management Program Description Addendum* outlines the objectives, scope, staff roles for physical, behavioral health, and pharmaceutical services for members. Several policies, such as *Policy UCSMM.06.10, Clinical Review Criteria*, *Policy UCSMM.06.13 Non-Clinical Intake and Initial Screening, and Policy UCSMM.06.16, Initial Review Timeframes* provide guidance on utilization management (UM) processes and requirements.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description Addendum* shows the Chief Medical Officer, Amit Prasad, MD, oversees the UM Program by: supervising medical necessity decisions, conducting reviews, chairing the Healthcare Quality and Utilization Management Committee (HQUM) and Physician Advisory Committee, and co-chairing the Quality Management Committee (QMC) with the Chief Executive Officer. Operating authority is delegated to the UnitedHealthcare Health Services Director.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the National Medical Care Management Committee, the Community and State National Quality Management Oversight Committee and the HQUM for approval. Additionally, UM reports and activities are reported to the Physician Advisory Committee.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					The *CAN UM Program Description Addendum* states United uses external and internal clinical review standards. These standards are based upon applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as Milliman Care Guidelines. During the onsite, United staff confirmed procedures for determining service authorization requests follow the clinical hierarchy noted in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy UCSMM.06.10 Clinical Review Criteria Rider 1.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files reflect consistent decision making using evidenced base criteria and relevant medical information, as described in the *UM Program Description Addendum and Policy UCSMM.06.10, Clinical Review Criteria.* Member-specific needs are appropriately considered.
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					United conducts an annual inter-rater reliability (IRR) testing to evaluate consistency in application of UM criteria and guidelines among reviewer staff. The IRR includes BH and pharmaceutical segments. Staff scoring below 90% receive remediation and retesting. Results are reported in the *2018 UM Program Evaluation*.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					United's member website shows the *Preferred Drug List (PDL)* is a list of prescription drugs considered coverable by the DOM. United follows DOM's policy for generic substitution and therapeutic interchange, quantity limits, and step therapy as noted in the *PDL Quick Reference Guide*. Page 32 of the *CAN Member Handbook* describes over-the-counter medications are covered with a prescription

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						from an in-network provider and lists examples of drugs that may be covered. Some process steps to access the PDL on the website and information in the *Member Handbook* are not clear. The following issues are identified: •Instructions on page 32 of the *Member Handbook* indicate the list of covered OTC medicines and the PDL are located on United's website when they are located on DOM's website. •When CCME attempted to access the links provided on page 32 of the CAN *Member Handbook*, an error message, "page not found," returned. •To view the PDL from United's website requires several clicks before receiving the message "You are leaving this site." This message may discourage the reader from proceeding to DOM's website, where the PDL is located. *Recommendation: On page 32 of the CAN Member Handbook and the website, provide clearer information describing the PDL is located on DOM's website. Ensure the embedded links on page 32 in the CAN Member Handbook are in working order. Consider editing the links on United's website to land directly to the PDL on DOM's website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					The *UM Program Description Addendum* shows United has policies and procedures that follow DOM's prior authorization criteria for drugs listed on the PDL and for drugs not listed. *Policy MS Rx 001, MS Pharmacy Benefit* further describes processes used to provide pharmacy services for CAN members. United uses the most current version of the PDL available on DOM's website. *Policy RX-036, Emergency Medication Supply / Temporary Coverage Override* shows United allows for a 3-day emergency supply of medication that requires authorization if there is immediate need for the drug.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description Addendum* and policies such as *UCSMM.06.14, Initial Clinical Review and Non-Clinical Intake* and *Initial Screening* describe the role of licensed and unlicensed staff who are trained to perform physical and BH reviews. A Registered Nurse, Licensed Practical Nurse, or suitable licensed health professional performs clinical reviews. A MS-licensed physician makes all clinical denials or adverse decisions.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for approval files are consistent with *Policy UCSMM.06.16,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Initial Review Timeframes, the UM Program Description, and *CAN Contract* requirements.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists as outlined in *Policy UCSMM.06.16 Initial Review Timeframes*.
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					Review of denial files reveal denial decisions are made according to the processes described in *Policy UCSMM.06.16 Initial Review Timeframes*.
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 adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					*The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01)* describes operating procedures for processing member appeals and grievances.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				The terms "adverse benefit determination" and "appeal" are appropriately defined in: •*Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy* •2019 *Care Provider Manual* (CAN) United's CAN *Member Handbook* and website glossary appropriately define the term "appeal"

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						but incompletely define the term "adverse benefit determination." The following components of the definition are missing: •For residents in a rural area with only one Managed Care Organization, the denial of an enrollee's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii) •The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities *Corrective Action: Revise the CAN Member Handbook and website glossary definition of the term "adverse benefit determination" to include the full definition as stated in the CAN Contract, Section 2 (A) and 42 CFR § 438.400 (b).*
1.2 The procedure for filing an appeal;		X				*Policy POL2015-01* and the CAN *Member Handbook* correctly show the timeframe to file an appeal is 60 calendar days from the date of receipt of the adverse benefit determination notice, as allowed by the *CAN Contract, Section 6 (K)* and *Exhibit D*. Page 35 of the CAN *2019 Care Provider Manual* correctly states the appeal filing timeframe is 60 calendar days from the date of receipt of the notice of adverse benefit determination. However, the table on page 39 incorrectly states the appeal filing timeframe is "within 60 calendar days of the event."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CAN *Member Handbook* does not inform members they can present evidence or review the case file for an appeal. *Corrective Action: Correct the appeal filing timeframe in the table on page 39 of the CAN 2019 Care Provider Manual. Revise the CAN Member Handbook to include information that the member is provided an opportunity to present evidence or review the case file for an appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Appeal resolution timeframes are appropriately documented in *Policy POL2015-01*, the CAN *Member Handbook*, and the CAN *2019 Care Provider Manual*.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.		X				Page 62 of the CAN *Member Handbook* mentions that member can be held responsible for the cost of the continued benefits if a State Fair Hearing outcome is adverse to the member.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, the handbook does not include this information related to the outcome of an initial appeal. *Corrective Action: Revise the CAN Member Handbook to include full information about continuation of benefits for an initial appeal.*
2. The CCO applies the appeal policies and procedures as formulated.	X					Review of appeal files confirmed timely acknowledgement, resolution and notification of resolution. Appropriate physicians rendered appeal determinations. Six appeal resolution letters list 2 different physicians as reviewing the appeal. This could result in confusion for the reader. Onsite discussion confirmed a Mississippi-licensed physician signs off on appeal determinations rendered by physicians in other states and this is the reason two physician's names are listed in the letter. *Recommendation: Revise letter contents to clearly show the physician who rendered the determination and the MS-licensed physician who signed off on the determination.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The CAN 2019 *Quality Improvement Program Description* states appeal data are collected, analyzed, and monitored to identify opportunities for improvement, and the Service Quality Improvement Committee (SQIC) responsibilities include monitoring appeal activities. The Provider Advisory Committee also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviews summary data about appeals to identify trends, conducts barrier analysis, and recommends corrective actions as needed. Review of documentation in SQIC meeting minutes revealed very little evidence that the SQIC monitors member appeal activities, as stated in the CAN 2019 *Quality Improvement Program Description*: •For the February and June 2019 meetings, minutes show a report was not available and there was no explanation given. •The remaining three meetings (June, September, and December 2018) do not clearly reflect discussion and monitoring of member appeal activities. *Recommendation: Revise the CAN 2019 Quality Improvement Program Description to include accurate information about the committee responsible for reviewing appeal activities to identify quality improvement opportunities.*
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management Program.	X					The 2019 *Care Management Program Description/Whole Person Care Program Description and Addendum* outline the framework for *Whole Person Care (WPC) Management Program* goals, scope, and lines of responsibility, and shows the WPC Program is integrated within United Care Management (CM)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program. The scope of the WPC Management program spans the continuum of care and includes treating inpatient and outpatient practitioners, member (or caregiver) engagement and education, member self-management, and community resource linkage. The program is National Committee for Quality Assurance case management accredited.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The goal of the WPC Care Management Program is to focus interventions on members who are persistent super-utilizers, those with emerging risks, and those with complex medical, behavioral, social, pharmacy, and specialty needs. The Health Risk Assessment tool is primarily used to screen and identify eligible members into case management. Other methods include but are not limited to review of clinical claims, medical records, and utilization management data. Identified members are stratified into low risk, medium risk, and high-risk categories based on results from United's predictive modeling software and stratification algorithms.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					*Policy MS 002 Rider, Case Management Process* adequately addresses that a health risk assessment will occur within 30 calendar days for members newly assigned to medium and high-risk categories and the treatment plan will be completed within 30 calendar days after the assessment, as required by the *CAN Contract, Section 9 (A) (1).*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The detailed health risk assessment includes all required elements:						
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 of the health risk assessment.	X					A person-centered plan of care is developed by a Care Manager or Behavioral Health Advocate, caregiver/family, and the interdisciplinary care team in collaboration with the member. Qualifications for Care Managers include requirements such as holding an unrestricted RN license and CM certification; and Behavioral Health Advocate qualifications include holding a Master's degree or Ph.D. and unrestricted license in their state. Review of CM files reflect qualified health professionals conducting health risk assessments and other CM services.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Member risk levels could not be identified or were difficult to identify in CM files, however, during the onsite United staff confirmed documentation of risk levels of reviewed files. Discussions further revealed risk levels are documented in other systems outside of care plans and care management notes in which the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						format is understood internally by United's staff. *Recommendation: Include clear documentation of member risk levels into CM documents such as care plans and care notes.*
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 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;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required	X					In addition to providing high risk members all of the services accessible to low and medium risk members, United has a high-risk stratification for pregnant women. *Policy HFS 001, Healthy*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
by the contract including high risk perinatal and infant services.						*First Steps Maternity Program* and the accompanying policy rider outline the processes for identifying, assessing, and providing CM services for high risk pregnant members.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					*2019 WPC Program Description Addendum* describes United will transfer the member's care management history, six months of claims history, and other pertinent information to DOM when a member disenrolls. If a member transfers to another health plan, the CM will provide the member's utilization information and care plan data to the new health plan upon request.
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					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					*Policy MS021, Transitional Care Management* shows United monitors and evaluates physician/practitioner performance in coordinating care and ensuring continuity of care by tracking activities such as member complaints and appeals, medical record audits, and *Member* and *Provider Satisfaction Surveys*. The *2019 Care Management Program Description* describes the Transitional Care Management Program as a subgroup of the WPC Management Program and aspects of the program are measured annually or quarterly and reported to quality committees.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					*Policy MS021, Transitional Care Management* adequately outlines transition of care services before, during, and after members are discharged from an institutional clinic or inpatient setting back to the member's home or other community setting. As described in the CM Program Description, the four primary focus areas for the Transitional Care Management Program are medication self-management, personal health record/My Health Snapshot, provider and specialist follow-up visits, and knowledge of red flags.
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					*Policy MS021, Transitional Care Management* and the *WPC Program Description Addendum* indicate the transition of care team consists of Transitional Care Nurses in addition to any staff necessary to enhance services for members and provide support for their return to the home or other community setting. Additionally, the team consists of Medical Directors, Inpatient Care Managers, Discharge Planners, Pharmacy, Community Health Workers, Behavioral Care Advocates, and Care Managers.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The *2018 CAN Utilization Management Program Evaluation* provides an overall assessment of the effectiveness of the UM Program as well as analysis of program-specific outcomes. The evaluation notes the UM Program was effective in meeting its objectives. Program strengths include criteria development and approval. Improved member satisfaction with the UM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process and recommendations for 2019 were also listed. An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the National Medical Care Management Committee, the Community and State National Quality Management Oversight Committee, and the HQUM for approval.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The *2018 CAN Utilization Management Program Evaluation* was reviewed and approved by the HQUM on May 23, 2019 and by QMC on June 27, 2019.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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					United ensures all delegation arrangements are governed by written agreements between the delegate and the health plan that describe the detailed roles and responsibilities of the health plan and the delegated entity, the delegated activities, reporting requirements to the health plan, the process by which the health plan evaluates the delegated entity's performance, and the terms for revoking delegation. United has delegation agreements with the following entities: •OptumHealth - Behavioral health services •OptumRX - Pharmacy benefit administration services •Dental Benefit Providers - Dental network services and third-party dental administration •eviCore National - Radiology and cardiology management services and prior authorizations •MARCH Vision Care - Vision and eye care services •National MedTrans - Non-emergency transportation benefit services •Hattiesburg Clinic - credentialing •River Region Health System - credentialing •HubHealth - credentialing •University Physicians, PLLC - credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•HCA Physician Services - credentialing •Health Choice, LLC - credentialing •North Mississippi Medical Clinic- credentialing •Ochsner - credentialing •Premier Health, Inc. - credentialing
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				*Policy DCO-01, Delegated Vendor Oversight Strategy* outlines the ways United measures and monitors delegated vendor compliance and performance. United develops monitoring tools that are tailored to the vendor's delegated services. Vendors must report their performance monthly. United uses standing joint operating committee monthly meetings to conduct performance reviews, identify trends or areas of concern, and to develop performance improvement needs. CCME reviewed evidence of monthly oversight monitoring for the corporate delegated entities. *Policy UCSMM 03.14, Delegated Credentialing Oversight Policy & Procedure* provides guidelines for all delegated entities. These guidelines apply to entities delegated to credential and recredential licensed independent practitioners and organizational providers (hospitals, ancillaries). The guidelines cover pre-assessment audits for potential delegates, annual oversight, and ongoing monthly and quarterly report monitoring. When United finds deficiencies, the health plan implements Improvement Action Plans with follow-up, as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						As defined in the *2019 Quality Improvement Program Description*, the executive level Delegation Oversight Governance Committee monitors and approves delegated activities for care providers. The committee also monitors and approves delegated activities for intersegment partners related to claims, credentialing, and medical management. This may include complex care management, disease management, population management, observation/inpatient hospital review, appeals, and grievances if contractually agreed upon. The regional Delegation Oversight Committee handles ongoing oversight of delegation activities for claims/credentialing, and medical management including disease management and complex care management. The Provider Advisory Committee provides local delegation oversight. CCME reviewed proof of annual oversight for all delegated entities. For credentialing and recredentialing oversight, United conducted annual audits to assess compliance to with defined standards. The tool is comprehensive and included file review. However, the delegated credentialing and recredentialing tools omit the requirement for ensuring the entities collect *Ownership Disclosure* forms and query the Social Security Death Master File (SSDMF).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Monitor the entities where credentialing and recredentialing is delegated to ensure Ownership Disclosure forms are collected and the SSDMF is queried. The delegation oversight tools should be updated to include monitoring the delegate for Ownership Disclosure forms and querying the SSDMF.

CCME CHIP Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CHIP**
Collection Date:	2019

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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				Policies are organized by department or functional area within the organization. The last review/revision date is noted on each policy. Employees access policies through a SharePoint site. UnitedHealthCare Community Plan of Mississippi (United) staff reported during onsite discussion that policies are reviewed annually. This corresponds with documentation on page 2 of *Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Procedures. However, the header for Policy CE-01 does not reflect an annual review. Additional policies, procedures, and standard operating procedures also do not reflect annual review. Examples include but are not limited to the following: •*Policy MBR1a, DOM's Limited English Proficiency Policy* •*Standard Operating Procedure: Mississippi Medicaid Deliverable Reporting Process* •*Policy ADM36, Notice of Legal Actions* •*Policy MBR1b2, Notification of Oral Interpretation Services (Free of Charge)* •*Policy MBR1c, Marketing Schedules* •*Policy MBR3a, Assignment of Primary Care Provider (PCP)* CCME noted some policies do not indicate the line(s) of business to which they apply. CCME reminded United staff that, according to the Mississippi (MS) Division of Medicaid (DOM) directive, all policies and procedures should clearly indicate the line(s) of business to which they should apply. *Corrective Action: Ensure compliance with the requirement that all policies, procedures, and standard operating procedures are reviewed at least annually, as documented in Policy CE-01.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure all policies and procedures clearly show the line(s) of business to which they apply.
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:						
1.1 *Chief Executive Officer;	X					Jeff Wedin is the Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Douglas "Mitch" Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					United's *Organizational Chart* shows Sharon Estess is the Chief Financial Officer (CFO); however, onsite discussion revealed Heath Seaman is the CFO. *Recommendation: Update the Organizational Chart to show the current CFO.*
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					Onsite discussion confirmed information systems staff, including claims and encounter data staff, are corporate staff. United's local Business Segment Liaison serves as the designated person in MS for data processing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and providing reports and encounter data to DOM.
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					The *Organizational Chart* shows Rhona Waldrep is the Provider Services Manager/Network Strategy Director (effective 8/5/19). However, onsite discussion confirmed Tamara Keane is the Provider Services Manager and is located in MS. *Recommendation: Update the Organizational Chart to show the current Provider Services Manager.*
1.6.1 *Provider credentialing and education;		X				Corporate staff conduct credentialing activities. Provider Services and Provider Relations staff are local to MS. United staff reported they first offer online training to new network providers and if not completed online, face-to-face training is provided. Onsite discussion revealed there are currently 5 field staff who provide face-to-face services to the provider network. 2 vacancies are noted in Field Representatives and these are being covered by current Representatives. DOM's requirement for a minimum of 8 Representatives to provide face-to-face provider services, along with the contractual requirement for 2 added representatives designated for out-of-state providers, is not met.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						41 Provider Services Call Agents provide telephonic support to the provider network via the Provider Services Call Center. *Corrective Action: Recruit 2 additional Provider Advocates to provide field-based services for provider inquiries/issues. In addition, recruit 2 additional Representatives to be designated for out-of-state providers.*
1.7 *Member Services Manager;	X					Kenisha Potter is Director of Member Services and Kobie Wells is Member Outreach Manager. Both are located in MS. Marriane Bullian, Member Services Manager, is a corporate employee.
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					Crystal Webb is the Appeals and Grievances Coordinator.
1.9 Utilization Management Coordinator;	X					Latrina McClenton is the Health Services Director.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Quality Management Director.
1.11 *Marketing and/or Public Relations;	X					Both local and corporate staff conduct marketing, member communication, and/or public relations activities.
1.12 *Medical Director;	X					Amit Prasad, MD is the Chief Medical Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 *Fraud and Abuse/Compliance Officer.	X					Cheryl Hicks is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
3. A professionally staffed all service/help line/nurse line which operates 24 hours per day, 7 days per week.	X					The CAN and CHIP *Member Handbooks* describe the availability of NurseLine for 24/7 telephonic access to registered nurses who can provide information, support, and education for health related questions or concerns.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.		X				The *CHIP Contract, Section 7 (J) (1)* requires CCOs to pay at least 90% of all clean claims for covered services within 30 calendar days of receipt and pay at least 99% of all clean claims within 90 calendar days of receipt. United did not provide exact claim completeness statistics, claims processing goals, or benchmarks. The *Information Systems Capabilities Assessment* (ISCA) documentation United provided states, "In general, claims are 85% to 90% complete after 3 months." This general estimate does not meet the claims processing rate required by the *CAN Contract*. While not a requirement specified by the *CAN Contract*, United reported an excellent claim payment accuracy average of 98.90% for a recent 12-month period.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Improve clean claims completion rate. This may require claim completion data to be reanalyzed so accurate clean claims completion statistics can be reported. If bottlenecks are limiting the claim completion rate, audit and upgrade those systems.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					The information United provided shows it has the systems, processes, and policies to adequately collect, store, process, monitor, and report on member and provider characteristics. For example, new incoming data is validated for accuracy using a claims verification system. Submissions that contain missing fields are returned to providers for completion. CCME also noted that United's IT systems use common data elements to ensure information remains consistent across systems. Finally, United can query collected data and report on that data for the State.
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					United's ISCA documentation clearly explained the processes followed to receive report requests, code the database queries for the report, review the report data, format the report, and issue Medicaid reports. It also noted that data is validated (for accuracy) using a claims verification system, and submissions that contain missing fields are returned to providers for completion. Finally, United maintains a data warehouse system to store report data and National Committee for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Assurance-certified software to create Health Effectiveness Data and Information Set (HEDIS®)/HEDIS-like reports.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United considers its business continuity and disaster recovery plans and tests to be confidential, so detailed information on those areas were not provided. Instead, United provided business continuity plans that summarize its approach to keeping systems available during events that could cause interruptions. Additionally, documentation was provided that summarizes steps to restore operations if a disaster does occur. During May 14-16, 2019, United conducted tabletop disaster recovery exercises to evaluate its ability to recover from a disaster. The tabletop disaster recovery test results indicate there were no problems found during the tabletop recovery exercise. *Recommendation: Actual disaster recovery tests are always preferable to simulated tabletop or desktop tests. If tests are conducted that restore critical systems and their supporting infrastructure, results should be documented (and redacted as needed) so they can be reviewed.*
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The *UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2018-2019* (FWA Program) and the *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019* define processes to guard against fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				Issues are addressed in the standards that follow.
2.1 Standards of conduct;						The *UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity* (Code) defines standards of ethical behavior for all employees. Contact information for various ways of reporting potential ethics concerns or violations is included. The Compliance & Ethics HelpCenter is available online or via toll-free telephone number around the clock and allows anonymous reporting of violations of the Code, company policy, laws, regulations, etc.
2.2 Identification of the Fraud and Abuse Compliance Officer;						
2.3 Information about the Compliance Committee;						The FWA Program states the Compliance Program Integrity Oversight Committee is accountable for ensuring "UHC businesses maintain an effective program to prevent, detect, and correct FWA." The *UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019* omits information about the local Compliance Oversight Committee (COC). Onsite discussion

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						confirmed COC is the local committee charged with oversight of the Compliance Program. *Recommendation: Revise the UnitedHealthcare of Mississippi Anti-fraud, Waste, and Abuse Program 2018-2019 to include information about the local COC.*
2.4 Compliance training and education;						The FWA Program addresses compliance training and education: •Employees, internal vendors and contractors are provided with mandatory training about compliance/ethics and FWA at the start of employment and annually thereafter. •External vendors and contractors are informed of annual FWA training and education requirements. Training is completed via web-based modules followed by testing or attestation. Compliance with training is monitored by the Compliance Officer. •Health care providers receive educational materials about billing practices and identifying and reporting suspected FWA. This information is provided during face-to-face educational sessions, through newsletters, and the provider portal. The FWA Program shows United distributes educational materials about FWA detection to members through written communications to raise awareness of how to identify and report potential FWA. CCME could not find member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						educational materials about FWA in the submitted desk materials and onsite discussion confirmed there are no materials provided other than the information in the *Member Handbooks*. Page 51 of the CAN *Member Handbook* and page 45 of the CHIP *Member Handbook* provide only minimal information about FWA and include a telephone number for reporting. The information lacks a thorough explanation of FWA or how to recognize FWA. *Recommendation: Revise the CAN and CHIP Member Handbooks to include full information about FWA, such as definitions of terminology, examples of FWA, all ways of reporting suspected or actual FWA, etc.*
2.5 Lines of communication;						Page 8 of the FWA Program states United's communication channels include, but are not limited to the following: •UnitedHealth Group Compliance & Ethics Help Center •Member Call Center •Provider Call Center •Optum Fraud, Waste and Abuse Hotline •UnitedHealthcare Fraud Tip Line Staff are also encouraged to discuss concerns with their manager, Human Resources staff, and/or the Compliance Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Enforcement and accessibility;						The Code informs employees that violations of laws, company policies, and/or contractual obligations may result in disciplinary action, up to and including termination of employment, and could be referred to law enforcement. The CAN and CHIP 2019 *Care Provider Manuals* inform providers that they are expected to cooperate with investigations of potentially irregular, inappropriate, or fraudulent provider activity and that if a violation is substantiated, appropriate authorities will be notified. The CAN and CHIP *Member Handbooks* inform members that intentional false statements or claims to receive or increase benefits may result in criminal charges and may lead to prosecution for fraud. It may also cause loss of benefits.
2.7 Internal monitoring and auditing;						The FWA Program addresses the following monitoring and auditing activities: •Prospective Detection (includes pre-payment data analysis, data mining, and analysis of abnormal billing patterns) •Additional prospective activities to determine if a provider claim payment should be stopped may include reviewing provider quality care complaints; conducting additional claim history/trend data mining; reviewing the hospital bill; contacting the provider to obtain and review medical/billing records;

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						interviewing providers, patients, members and/or witnesses; and checking provider qualifications, licensure status, disciplinary activity, civil litigation, criminal history, and/or financial records. •Retrospective detection (includes post-payment data analysis, payment error analysis, analysis of industry trends, monitoring and verifying exclusions and sanctions, delegation oversight and monitoring, provider audits, and FWA Program compliance and performance audits)
2.8 Response to offenses and corrective action;						Special Investigations Units (SIUs) conduct investigations of credible suspicions of fraud against United plans and programs. The SIU staff includes qualified investigators experienced in health care and prescription drug fraud and abuse, industry business practices and systems, infrastructure, and federal and state law enforcement and litigation practices. The Legal Department is consulted regarding planned formal FWA enforcement actions and reporting of suspected FWA to law enforcement officials, compliance with regulatory requirements, and other legal issues. For FWA, responses to detected offenses and corrective actions include, but are not limited to the following: •Provider notification, education, recovery efforts, and/or termination from the network

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Referral of suspected FWA to law enforcement, regulatory, and administrative agencies •Recovery actions against paid claims
2.9 Exclusion status monitoring.						CCOs are required to monitor the exclusion status of subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the CCO through routine checks of Federal databases, including the Social Security Administration's Death Master File (SSDMF), the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities, the System for Award Management, and the any such other databases as the Secretary may prescribe. In addition to the databases specified above, DOM requires checks of the DOM Sanctioned Provider List. *Policy ID-5881, New Hire and Periodic Employee Sanction Review* and the *Government Sanctions Policy-U.S.* do not address the requirements to monitor the SSDMF or the NPPES. *Corrective Action: Revise Policy ID-5881, New Hire and Periodic Employee Sanction Review and the Government Sanctions Policy-U.S. (or other applicable document) to include requirements to monitor the SSDMF or the NPPES for any person with an ownership or control interest or who is an agent or managing employee of the CCO. Refer to 42*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CFR §438.610 and the CHIP Contract, Section 1 (I).
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The COC provides oversight of the Compliance Program, meets quarterly and as needed, and is chaired by the Compliance Officer. A quorum is established as 51% of committee membership. CCME's review of committee minutes confirms the presence of a quorum for all meetings.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					United Payment Integrity staff, Optum entities, and other vendors and contractors conduct various functions, including prospective and retrospective activities, to ensure reimbursement accuracy. The SIU performs investigations of suspected fraud.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes are in place for recoupment of provider payments and documented in the *Optum Post Pay Negotiations PICTS Policy and Procedure*.
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					Confidentiality training is required for all staff at the time of hire and then annually. According to *Policy 3A, Personnel Security* employees and contractors are required to sign a Confidentiality Agreement and the agreement must be in place before a person is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						permitted access to confidential or protected information. Onsite discussion confirmed non-employee committee members must also sign the Confidentiality Agreement annually. Access to protected health information is determined by an employee's role/position and need to know.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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 a manner consistent with contractual requirements.		X				United defines the processes for credentialing and recredentialing of licensed independent practitioners and facilities in the *UnitedHealthcare Credentialing Plan 2019-2021*. The health plan addresses Mississippi (MS)-specific credentialing criteria in the *Additional State and Federal Credentialing Requirements Addendum*. The *Optum Physical Health Credentialing Risk Management Plan 2019* is applicable to physical medicine providers, including chiropractors, physical therapists, occupational therapists, and

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						speech therapists. MS-specific credentialing criteria are addressed in the document. The *United Behavioral Health Clinician and Facility Credentialing Plan 2019-2020* defines credentialing and recredentialing processes for clinicians and facilities who provide behavioral health (BH) care and services to enrollees. The *Mississippi Addendum to Credentialing Policies* defines state credentialing criteria and additional UBH/OPTUM policies support the credentialing plans. CCME noted that *Policy C.02, Clinician Credentialing Process*; *Policy C.03, Clinician Recredentialing Process*; and *Policy C.07, Organization Provider Credentialing and Recredentialing* overlook the need to query the State Medicaid Provider Sanction List. The MS State Medicaid Provider Sanction List is mentioned in the *Mississippi Addendum to Credentialing Policies* document but none of the said policies reference this document. *Corrective Action: Update Policy C.02, Clinician Credentialing Process; Policy C.03, Clinician Recredentialing Process; and Policy C.07, Organization Provider Credentialing and Recredentialing to reference the Mississippi Addendum to Credentialing Policies which defines MS state-specific credentialing criteria.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such	X					Dr. Amit Prasad, Chief Medical Officer (CMO) chairs the Provider Advisory Committee (PAC). Dr. Prasad took over as PAC Committee Chair in August 2019 from the Interim Chief Medical

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decisions, if delegated, may be overridden by the CCO.						Director. Voting committee members include 10 participating network providers. Their specialties include pediatrics, psychiatry, dentistry, obstetrics (OB)/gynecology (GYN), internal medicine, family medicine, and emergency medicine. 51% of voting members in attendance constitutes a quorum. The Committee Chair votes only to break a tie. The PAC meets quarterly and acts as the health plan's Credentialing Committee. The PAC reviews all National Credentialing Committee (NCC) recommendations. The PAC can approve, deny, or suspend NCC recommendations related to the Mississippi (MS) Medicaid network. Onsite discussion confirmed that clean files, unclean files, and credentialing reconsiderations are promptly communicated to the CMO and PAC. Two Market Medical Directors chair the NCC. Voting members include 16 network providers from local plans. Dr. George Russell, an orthopedic surgeon and committee member, represents MS. The NCC reviews all credentialing/recredentialing decisions. 51% of voting members in attendance constitutes a quorum. CCME's meeting minutes review showed very few meetings document absent voting members. CCME noted that the previous Interim Chief Medical Director did not attend any meetings. Onsite discussion confirmed that Dr. Prasad, CMO, is now a committee member and

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						will attend the meetings. The Market Medical Directors are non-voting committee members. *Recommendation: Ensure MS representation is present for NCC meetings when it makes decisions about MS providers. Also ensure NCC meeting minutes document absent committee voting members.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized and contained proper documentation. Any issues are discussed in the standards that follow.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
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	X					

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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;						
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) and the MS DOM Sanctioned Provider List;	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 Query of the Social Security Administration's Death Master File (SSDMF)	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					

STANDARD	SCORE					COMMENTS
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3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 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					
3.1.15 Ownership Disclosure form.			X			During the previous EQR, *Ownership Disclosure* forms showed signatures from unauthorized signers. This contradicted the *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* document, which says 'an individual must have the power to legally bind the entity.' During the corrective action process, United presented an updated *Provider Entity Disclosure of Ownership* form that contained a statement regarding the signer having authority to legally bind the entity. However, the updated form was not implemented. *The Provider Disclosures/National Disclosure Program* policy received in the onsite requested materials states, "A contracted provider is required to complete and submit a Disclosure Form upon enrolling, contracting, or credentialing and every three (3) years, or at any time there is a revision to the information, or upon a request for updated information." However, 1 provider credentialing file showed

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						an *Ownership Disclosure* form that was dated 1½ years prior to the Credentialing Committee approval date, and 1 provider credentialing file showed an *Ownership Disclosure* form that was dated almost 3 years prior to the Credentialing Committee approval date. *Corrective Action: Implement the updated Provider Entity Disclosure of Ownership form presented in the previous EQR corrective action. Ensure Ownership Disclosure forms show current information at credentialing.*
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					
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 were organized and contained proper documentation. Any issues are discussed in the standards that follow.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
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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 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					

STANDARD	SCORE					COMMENTS
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4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration (NPPES);	X					
4.2.12 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					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure form.			X			In the previous EQR, *Ownership Disclosure* forms showed signatures from unauthorized signers. This contradicted the *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* document, which says "an individual must have the power to legally bind the entity." During the corrective action process, United presented an updated *Provider Entity Disclosure of Ownership* form that contained a statement regarding the signer having authority to legally bind the entity. However, the updated form was not implemented. *Policy Provider Disclosures/National Disclosure Program* received in the onsite requested materials states, "A contracted provider is

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						required to complete and submit a Disclosure Form upon enrolling, contracting, or credentialing and every three (3) years, or at any time there is a revision to the information, or upon a request for updated information." However, the following recredentialing files showed *Ownership Disclosure* forms that were outdated upon recredentialing: •1 BH file *Ownership Disclosure* form was dated 3½ years prior to the Credentialing Committee approval date. •8 provider files showed disclosure forms that were dated 1½ to 2+ years prior to the Credentialing Committee approval date. *Corrective Action: Implement the updated Provider Entity Disclosure of Ownership form presented in the previous EQR corrective action. Ensure Ownership Disclosure forms show current information at recredentialing.*
4.3 Provider office site reassessment for grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established grievance threshold has been met.	X					Processes are in place to regularly monitor office site quality for issues related to the physical accessibility, physical appearance, cleanliness, and adequacy of the waiting and exam room space. Once a threshold is met, a site visit is conducted within 45 calendar days of the receipt of the complaint as defined in *Policy QM-02, Timeframes for Ongoing Monitoring of Office Site Visit Quality* and *UnitedHealthcare Policy 5299, Ongoing Monitoring of Office Site Quality*.

STANDARD	SCORE					COMMENTS
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4.4 Review of practitioner profiling activities.	X					During the recredentialing process, the Credentialing Committee reviews the history of quality of care/quality of service concerns. If substantiated the applicant may be subject to denial of recredentialing. Evidence of quality of care/service review was found in the recredentialing files. *Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization* defines measures United uses to create provider profiles and monitor PCP over and under-utilization. The profiles are generated annually and are distributed to suitable identified network physicians and health plan staff. Samples of the provider profiles were received in the desk materials.
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					The *UnitedHealthcare Credentialing Plan 2019-2021* defines the process for evaluating potential quality of care concerns which could include suspension, restriction, or termination of a participating provider. This process includes Medical Director review, with possible referrals to the Peer Review Committee and Regional Peer Review Committee. Any appeal process related to the termination, suspension or non-renewal of practitioners will be communicated to the affected practitioner. *UnitedHealthcare Policy 5776, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions* details the process for investigating, evaluating, and reviewing

STANDARD	SCORE					COMMENTS
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						potential quality of care concerns which includes determining severity levels, improvement actions, disciplinary actions, and fair hearings as needed.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				Credentialing and recredentialing guidelines for organizational providers are addressed in the *UnitedHealthcare Credentialing Plan 2019-2021*. The plan addresses MS-specific credentialing criteria in the *Additional State and Federal Credentialing Requirements Addendum*. CCME's organizational file review showed proper documentation except for 3 recredentialing files that showed *Ownership Disclosure* forms dated 1½ to 2 years prior to the Credentialing Committee approval date. *Policy Provider Disclosures/National Disclosure Program* received in the onsite requested materials states, "A contracted provider is required to complete and submit a Disclosure Form upon enrolling, contracting, or credentialing and every three (3) years, or at any time there is a revision to the information, or upon a request for updated information." *Corrective Action: Ensure recredentialing files show current Ownership Disclosure forms.*
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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*, addresses the requirement that PCPs must be notified of members assigned to them, including notification of panel changes, within 5 business days of the date on which United receives the Member Listing Report from DOM. To notify providers of panel composition and keep them informed of any changes to their member panels, United makes member panel details available to all participating PCPs via the secure provider portal.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Participating providers can access member enrollment information via the secure, password-protected online provider portal and any provider may call the telephone number listed on the CAN or CHIP ID cards as defined in *Policy PS4, Member Enrollment Verification.*
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					PCPs communicate desired restrictions on member panel composition to United during initial credentialing or contracting setup as defined in *Policy PS10a, PCP Panel Notification*. If no panel restrictions are requested, it is understood that the PCP agrees to accept all members as assigned. If the PCP requests panel restrictions, these variables are applied to the provider setup and it is understood that the PCP will accept all member assignments in alignment with the desired panel profile.

STANDARD	SCORE					COMMENTS
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						When PCPs request a fully closed panel, that information is included in the provider profile and that PCP will not be considered in the assignment logic for new members. Member panel details are available to all providers via the secure provider portal. The *Provider Directory*, paper and online, indicates providers who are are accepting new patients.
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					*Policy PS3, Geographic Access Standards*, defines the PCP geographic access standards for the CAN and CHIP programs that comply with contract requirements. CHIP GeoAccess Reports show correct measurements for urban and rural PCP standards. The *CHIP 2018 Quality Improvement Program Evaluation* shows that ongoing assessments are conducted of the provider network and are reported quarterly and annually to DOM. The network for 2018 remained steady for primary care providers which includes family/general practice, internal medicine, and pediatrics. For PCPs, the goal of 90% of members having access was met for the urban and rural access standards. The health plan will continue to monitor availability of practitioners to future opportunities for improvement.
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	X					*Policy PS3, Geographic Access Standards*, defines the specialists geographic access standards for the CAN and CHIP programs that comply with contract requirements. CHIP

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may utilize an out-of-network specialist with no benefit penalty.						GeoAccess Reports show correct measurements for urban and rural specialist standards. The *CHIP 2018 Quality Improvement Program Evaluation* detailed the analysis results of geographic access standards for specialist, dental, emergency, urgent care, mental health, pharmacy, dialysis, and hospital providers. The goal is for 90% of members to have access to the specific practitioner types within the miles designated based on the population of the geographic area. All provider categories received met scores except pharmacy for the rural standard, which was not met for 24-hour pharmacy; and urgent care providers for the rural standard was coded as not applicable. United explained there were insufficient 24-hour pharmacies in the state to meet the 90% access goal and DOM waived this contract requirement.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					
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					

STANDARD	SCORE					COMMENTS
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2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				*Policy PS2, Access Standard – Appointment Availability Requirements* defines the appointment availability requirements for providers contracted by United to provide services to members enrolled in the CAN and CHIP programs. The standards comply with contract requirements. United performs quarterly assessments to gauge level of compliance among PCPs, OB/GYNs, and BH providers. United performs quarterly and annual assessments to gauge level of compliance among high-volume specialty providers. United submits these results to DOM and the United Service Quality Improvement Subcommittee. The subcommittee uses these results to monitor, track, trend, and promote identification of improvement opportunities and development of corrective action initiatives. United documents appointment standards in the *CHIP 2019 Care Provider Manual* and reinforces them through provider education. Failure to meet access requirements results in direct outreach to the provider. The following appointment standards listed in the *CHIP 2019 Care Provider Manual* do not match the standards defined in *Policy PS2* or the *CHIP Member Handbook:* •Specialty Care – Page 53 - Non-urgent "sick" visit within 48–72 hours of request, as clinically indicated

STANDARD	SCORE					COMMENTS
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						- Non-urgent care within 4 to 6 weeks of request •BH (Mental Health and Substance Use Disorder (SUD)) – Page 54 - Non-urgent problems within 2 weeks of member's request - Following an emergency room visit or hospitalization within 5 days, or as medically necessary •Assessments for the purpose of making recommendations regarding a recipient's services (LDSS) within 10 days of member's request The *CHIP 2018 Quality Improvement Program Evaluation* showed detailed monitoring for access and availability which included monitoring access via questions from the Consumer Assessment of Healthcare Providers and Systems Survey, member complaints and appeals, assessing claims data for behavioral health, and conducting practitioner telephonic surveys for PCP and High Volume Specialist/High Impact Specialist (HVS/HIS). Results show all areas demonstrated the goal of 80% access within the established timeframes with no opportunities identified. The health plan will continue to monitor access and availability to identify future opportunities for improvement. *Corrective Action: Ensure appointment standards documented in the CHIP 2019 Care Provider Manual are consistent with Policy PS2 and the CHIP Member Handbook.*

STANDARD	SCORE					COMMENTS
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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* CCME conducted shows improvement from the previous study's results. CCME conducted a modified review last year, so the most recent *Telephonic Provider Access and Availability Study* was conducted in the 2016 review and had a success rate of 41% (77 out of 189 calls). Since that review, CCME adjusted its definition of a successful call. Now, the success rate is based on an adjusted denominator instead of the total calls made. The denominator is the total calls made minus those answered with voicemail messages, since this is now standard for many provider offices. With the new formula, the success rate for the 2019 *Telephonic Provider Access Study* was 61% (111 out of 182 total calls).
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* was received in the desk materials as an active policy. However, minutes in the September 17, 2018 Service Quality Improvement Subcommittee meeting stated this policy was retired due to Provider Relations introducing a new provider orientation process. Onsite discussion confirmed the policy is outdated and omits information relating to a new Provider Orientation Program that includes offering online training. United meets with the provider if the online training is not completed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update Policy PS11, Provider Orientation Plan or create a new policy that addresses the current provider orientation process.
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 are issues or inconsistencies when comparing the benefits listed in the CHIP *2019 Care Provider Manual* to the CHIP *Member Handbook*: •Ambulance – Page 30 of the CHIP *Member Handbook* lists limitations that are not addressed in the CHIP *2019 Care Provider Manual*. •Organ Transplants – Page 37 of the CHIP *Member Handbook* says prior authorization is needed and this is not mentioned in the CHIP *2019 Care Provider Manual*. •Podiatry Services – Not mentioned on page 38 of the *CHIP Member Handbook* but palliative or cosmetic foot care is excluded. The CHIP *2019 Care Provider Manual* says covered 100% for podiatry services. •Routine Hearing – Page 32 of the CHIP *Member Handbook* includes coverage for 1 hearing aid per ear every 3 years, but this is not mentioned in the CHIP *2019 Care Provider Manual*.

STANDARD	SCORE					COMMENTS
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						Corrective Action: Update the CHIP 2019 Care Provider Manual and/or the CHIP Member Handbook to address benefit issues and inconsistencies.
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 Well-Baby and Well-Child screenings and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and member 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				The CHIP *2019 Care Provider Manual* does not include the emergency supply of medication information.

STANDARD	SCORE					COMMENTS
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						Corrective Action: Update the CHIP 2019 Care Provider Manual to include the emergency supply of medication information.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
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					
3. The CCO regularly maintains and makes available a Provider Directory that is	X					United maintains the *Provider Directory* as an online searchable directory and a PDF directory formatted for print production. Both versions

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consistent with the contract requirements.						are available to members, potential members, network providers, and all United staff. United continues to make hard copy *Provider Directories* available in State Medicaid Regional Offices, United's office, Women Infant and Children offices, and upon member request. During 2018, *Provider Directories* were sent in new member Welcome Kits. The *Provider Directory* is available on the general website. *Policy NQM-052, Web-based Directory Usability Testing*, describes the process for evaluating the accuracy of the online *Provider Directory*, which United does annually. United corrects inaccurate information on an ongoing basis. United trends ongoing issues, finds opportunities for improvements, and implements interventions when applicable. *NQM-052 MS Rider 1* provides state-specific requirements for the *Provider Directory* and addresses the contract requirement that changes to the web-based *Provider Directory* must be updated within 5 business days.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider education is accomplished through physician newsletters, webinars, and resource information available on the provider website portal such as pre-recorded training sessions, bulletins, *Care Provider Manuals* for CAN and CHIP, policies and clinical guidelines, and prior authorization guidelines.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The Medical Technology Assessment Committee and the National Medical Care Management Committee review and accept preventive health practice guidelines on a national level. The local PAC reviewed and approved the 2019 guidelines on July 22, 2019.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Preventive health and clinical practice guidelines (CPGs) are available on the website provider portal. Providers may also request that hard copies of the guidelines be sent to them by contacting the Provider Services Center. Additionally, when new guidelines are added or current guidelines are revised, United 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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Evidenced-based CPGs are used to monitor and improve the quality of care provided by participating providers. United clinical guidelines are annually reviewed and accepted by the Physician Advisory Committee, presented to the Quality Management Committee and distributed to the network providers. The CPGs are available on the provider portal of the website and provider education is also provided on the CPGs. United continues to create and update guidelines based on medical evidence, either by expert advice and/or recognized clinical publications.
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					Providers are educated about CPGs through information listed in the CAN *and* CHIP *Care Provider Manuals*, and all adopted guidelines are posted on the website. When new guidelines are added or current guidelines are revised, United notifies providers of these changes in the *Provider Newsletter*. The *2019 Clinical Practice Guidelines* document was posted to the website and providers may request that hard copies of the guidelines be sent to them by contacting the Provider Services Center.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					*Policy NQM-025 Ambulatory Medical Record Review Process* defines the procedures for ensuring that member medical records, both paper and electronic, are maintained in a manner that is current, detailed and organized, and permits effective and confidential patient

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						care and quality review. United explains medical record standards to Practitioners in the *Care Provider Manual* and other ad hoc communication documents. The record review is completed annually, unless required more frequently. If standards are not met, an Improvement Action Plan is implemented.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	X					During the 3rd quarter of 2018, the Medical Record Review audit was completed in-house by the Clinical Practice Consultants. The Clinical Practice Consultants audited 27 Primary Care Providers who rendered services to adults as well as children in their clinics. The results of the adult medical record review, all Primary Care Providers audited met the goal of 85%. Results for EPSDT/Well- Baby/Child showed only 67% of the clinics unclothed members while performing the exam (having the member unclothed is required). Another area not meeting the requirements for EPSDT/Well-Baby/Child was getting certain labs and immunizations at the correct age. The Clinical Practice Consultants educated the staff of the missing elements not found in the medical records before leaving the clinic.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					CCME performed *Provider Satisfaction Survey* validation using a validation worksheet based on the *CMS Survey Validation Protocol*. The *Provider Satisfaction Survey* had a low response rate (3%). This is well below the

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						National Council for Quality Assurance target response rate of 40% for surveys. The low response rate may impact the generalizability of the survey. The complete worksheet is available as an attachment in this report. *Recommendation: Focus on strategies that help increase response rates for the Provider Satisfaction Survey. Enlist the help of the survey vendor.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The health plan analyzed the survey.
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					United presented survey results to the Quality Management Committee in the December 2018 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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					United guarantees member rights and responsibilities as outlined in *Policy MBR4a, Notification of Rights* and as described *in the* CHIP *Member Handbook* and *Care Provider Manual*.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in *Policy MBR4a, Notification of Rights*, the *Member Handbook*, *Care Provider Manual*, and member website. See standards 2.1 – 2.4 for specific comments.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						Page 57 of the *Member Handbook* states the member can "refuse care and be told what you may risk if you do". This statement fails to include the member's right to participate in decisions regarding his or her health care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussions revealed member rights are listed in some issues of the *Health TALK* newsletter and in member handouts that are distributed at community events. *Recommendation: Edit the Member Rights and Responsibilities section of the CHIP Member Handbook to clearly address the requirement in CHIP Contract, Section 6 (D)(I).*
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;						
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 listed in *Policy MBR4a, Notification of Rights*, the *Member*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Handbook, *Care Provider Manual*, and the member website. See standards 3.1 – 3.5 for specific comments.
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.						*Policy MBR4a, Notification of Rights* does not indicate the member is responsible for informing the plan of changes in family size, address, or health care coverage. CCME did not find member responsibilities in the CHIP *Care Provider Manual* as required by *CHIP Contract, Section (D) (15) and Section (I)*. During the onsite United confirmed member responsibilities listed in the *Care Provider Manual* follow National Committee on Quality Assurance requirements. *Corrective Action: To be consistent with information in the Member Handbook and website, and to comply with the CHIP Contract,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Section 6 (J), edit Policy MBR4a, Notification of Rights to indicate members are responsible for informing the Coordinated Care Organization (CCO) of changes in family size, address changes, and other health care coverage. Revise the Care Provider Manual to include all member responsibilities required in the CHIP Contract, Section (D) (15) and Section (I).
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 entitled, including:	X					*Policy MBR 2a, Information Packets to Members (Prior to the first day of the month of their enrollment)* notes new members will receive an Information Packet, which contains a welcome letter, CHIP ID card, *Member Handbook*, and *Care Provider Manual*, within 14 days after United receives information of enrollment.
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 *Member Handbook* includes information that Women's Health Specialists are types of PCPs and female members may access a Women's Health Specialist for routine and preventive health services. However, it does not indicate members can have a Women's Health Specialist in addition to a PCP. Refer to the *CHIP Contract, Section 7(A)*. Onsite discussion confirmed female member are not restricted from seeing a Women's Health Specialist in addition to their PCP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit page 18 or 32 of the Member Handbook to clarify that female members may receive women's routine and preventive care from a Women's Health Specialist in addition to services by their designated PCP. Refer to the CHIP Contract, Section 7 (A).
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
1.9 A description of the member's identification card and how to use the card;						
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;						
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, and the member portal;						The *Member Handbook* provides correct toll-free contact information and descriptions for United CAN Member Services, the NurseLine, and secure website access to the member portal at myuhc.com/CommunityPlan.
1.13 A description of the Well-Baby and Well-Child services which include:						Information on Well-Baby/Well-Child Care services is provided on pages 20 and 35 of the *CHIP Member Handbook*, indicating the guidelines are from the American Academy of Pediatrics. Brief information is available on the website. *Recommendation: Edit the website to include complete descriptions of required Well-Baby/Well-Child services and age-appropriate periodic health screenings and immunizations.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						In the Member Handbook and on the website, reference the AAP Bright Futures Medical Periodicity schedule. Refer to CHIP Contract Section 5(D) and Section 6(D).
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
1.15 Procedures for filing complaints/grievances and appeals;						
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;						
1.17 Instructions on reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						*Policy MBR15a, Advanced Directives* describes information about advanced directives. Additionally, the *Member Handbook, Care Provider Manual,* and website describe two types of *Advance Directives*—Living Wills and Medical Powers of Attorney. The website provide links for two fillable electronic forms. Initially it was not clear that *Advance Directive* forms are located on the website because the links are named "Example1" and "Example2". During the onsite CCME discussed that

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						instructions for obtaining *Advance Directive* forms and receiving assistance to complete them are not clearly stated in the *Member Handbook*, *Care Provider Manual*, or website. United explained that health plan staff can provide members with assistance in completing forms if needed. *Recommendation: Edit Policy MBR15a, Advanced Directives, page 46 of the Member Handbook, page 59 of the Care Provider Manual, and websites to clarify how members can obtain Advance Directive forms and how to receive assistance completing it if needed.*
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					United notifies CHIP members by mail 30 days before the effective date of any material changes and 14 days prior to implementing changes to covered benefits/services as described in *Policy MBR8a, Proper notice to members on written notices in material changes*. *Policy MBR8b, 15 day written notices of termed provider* indicates members who received primary care from, or who were seen on a regular basis by, a terminated provider will be notified in writing within 15 days after United receives a provider's termination notice. CCME

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						did not identify how United includes information about selecting a new provider and a date after which members who are receiving an ongoing course of treatment cannot use the terminated provider, as required in *CHIP Contract*. During the onsite, United confirmed the written notice has a cutoff date and the member is given the option to choose another PCP. *Recommendation: Edit Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes and Policy MBR8b, 15 Day Written Notices of Termed Provider to reflect written notices of termed providers include a cutoff date and a statement that the member is given the option to choose another PCP. Refer to the CHIP Contract, Section 7 (D) (3).*
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.	X					*Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension* and *Policy MBR1b2, Notification of Oral Interpretation Services* confirm member materials are written at no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. Onsite discussions revealed materials are written using a minimum 12-point font and large print means items are printed in a font size no smaller than 18-point.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					United provides interpreter and translation services to members who speak another language or have limited English proficiency free of charge as described in the *Member Handbook* and *Policy MBR1b2, Notification of Oral Interpretation Services*. Written materials in alternative formats, such as large print or simple language, can be obtained by calling Member Services. The toll-free telephone number for CHIP Member Services and the 24-Hour NurseLine are located on the member's ID card, in the *Member Handbook*, and on the United website. Additionally, this information is located in member education materials such as the Fall 2018 *Health TALK* member newsletter.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	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					The CHIP toll-free telephone number for Member Services and the 24-Hour NurseLine are located on the member's ID card, in the *Member Handbook*, and in member education materials such as the Spring 2019 *Health TALK*. Additionally, members can access a 24-hour behavioral health hotline staffed with mental health professionals. CCME found the following issues:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•CCME could not determine the difference between the Mental Health Crisis Line, (referenced on page 16 of the *Member Handbook*) and the Crisis intervention/access, 24-hour hotline (referenced on page 34 of the *Member Handbook)*. During the onsite, United advised these refer to the same telephone line. •Page five of the CHIP *Care Provider Manual* lists the toll-free number for Provider Services; however, the hours of operation are not listed anywhere in the manual. The *CHIP Contract, Section 7 (H) (1)* requires hours from 8:00 am-5:00 pm CST. •On the CHIP website under "See more benefits and features," a phone number is not provided for the NurseLine or for Member Services; the Members Services section erroneously notes members can call "24/7"; and the NurseLine availability is written as "24/7" which this abbreviated format may not be understood by all readers. *Recommendation: Edit page 16 or page 34 of the Member Handbook to specify either Mental Health Crisis Line or Crisis intervention/access, 24-hour hotline. Include the operating hours for Provider Services on page 5 of the Care Provider Manual. Provide the toll-free number for Member Services and the NurseLine on the CHIP member website. Additionally, on the CHIP website, clearly state NurseLine availability as "24 hours a day, 7 days a week"*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						instead of "24/7". Refer to page 16 in the CHIP Member Handbook.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					United has an internal team that listens to calls and uses a call monitoring system, Nexidia, to collect data and perform monthly quality analysis on calls received. United annually reports Member Services Call Center performance analysis and metrics for All Calls Offered, All Calls Handled, Abandonment Rate Percentage, Average Speed of Answer, and the Service Level rate as noted in the 2018 CHIP QI Program Evaluation. All performance metrics were met in 2018. The ABN for 2018 was less than 5% as required by the *CHIP Contract, Section 6(A)(5)*.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					During the onsite United confirmed disenrollment requests are submitted to DOM for approval.
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about available preventive health and chronic disease management services and encourages members to utilize these benefits.	X					Members are informed of scheduled preventive health services, available case management programs, and how to obtain educational support for medical, BH, and pharmaceutical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						services through the *Member Handbook* and member newsletters; both are available on the website. Additionally, United mails postcards and sends email messages to eligible members reminding them of screenings and well visits.
2. 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* informs members about the Healthy First Steps™ program, where enrolled pregnant members receive services, support and education which can assist in achieving a healthy pregnancy. Case management staff provide information on the Women, Infant and Children Program and members are encouraged to visit the Women, Infant and Children website, www.nwica.org, for instructions to sign up. *Policy MBR9, Open Enrollment Period* describes how United uses claims data and submits a weekly CHIP Maternal report to DOM for members identified as pregnant within 7 days.
3. The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					Well-Child services and immunizations are tracked and managed through HEDIS monitoring as described in the 2018 CHIP QI Program Evaluation. United addresses barriers of low utilization by creating interventions to encourage members to use the services, such as reminder postcards and phone call campaigns and member incentive programs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
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 CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. United contracts with DSS Research, a certified *CAHPS Survey* vendor, to conduct the Adult and Child Surveys. The actual sample sizes were adequate and met the National Committee for Quality Assurance minimum sample size and number of valid surveys (at least 411), but the response rates were below the National Committee for Quality Assurance target of 40%. For Child *CAHPS Survey*, generalizability of the survey results is difficult to discern due to low response rate (25.53%) for the total sample and 23.46% for general population. *Recommendation: In addition to the other ongoing interventions, continue working with DSS Research to increase response rates for Adult and Child surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the *Member Satisfaction Survey* to identify quality problems.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO reports the results of the member satisfaction survey to providers.	X					The CCO reports the results of the *Member Satisfaction Survey* to providers in the Summer/Fall 2018 *Provider Newsletter*.
4. The CCO reports the results of the member satisfaction survey and the impact of measures taken to address quality problems that were identified to the appropriate committee.	X					The CCO reports results of the *Member Satisfaction Survey* and the impact of measures taken to address any quality problems that were identified to the correct committee.
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (*POL2015-01*) is applicable to both the MSCAN and MS CHIP lines of business and describes operating procedures for processing member appeals and grievances. As of October 1, 2018, Optum is no longer delegated to conduct appeal and grievance functions for members.
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;			X			The timeframe for filing a grievance is correctly documented in all information sources reviewed. The timeframe for filing a complaint is included in policy and in the CHIP *2019 Care Provider Manual* but is not documented in the CHIP *Member Handbook*. Note: This is an uncorrected deficiency from the 2018 EQR. Also, the CHIP *Member Handbook* does not inform members that assistance is available for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the grievance filing process. Note: This is an uncorrected deficiency from the 2018 EQR. *Corrective Action: Revise the CHIP Member Handbook to include the filing timeframe for a complaint and that assistance can be provided in the grievance filing process.*
1.3 Timeliness guidelines for resolution of the grievance;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;	X					*Policy POL2015-01* states grievance records are retained for a minimum of 10 years and include a general description of the reason for the grievance; receipt date; the date of review or, if applicable, review meeting; resolution; date of resolution; and name of the covered person for whom the grievance was filed.
2. The CCO applies the grievance policy and procedure as formulated.	X					Grievance files reflected timely determinations and notifications. Two grievance files were noted with acknowledgement letters sent beyond the 5-calendar day acknowledgement timeframe specified in *Policy POL2015-01*. One grievance regarding billing for ambulance transportation for a medical emergency was inadequately resolved. According to file notes, the provider was contacted on several occasions and was sent a Cease Billing letter. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resolution letter only informed the grievant she could contact the service provider or the collections agency for more information. The grievant was not informed she should disregard the bill as ambulance transportation is a covered service under medical benefits for a medical emergency. *Recommendation: Ensure acknowledgement letters for grievances are sent within the required 5 calendar day timeframe from receipt of the grievance. Ensure correct information is provided in grievance resolution letters.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The CHIP *2019 Quality Improvement Program Description* states complaint and grievance data are collected, analyzed and monitored to identify opportunities for improvement. The Service Quality Improvement Committee (SQIC) responsibilities include monitoring member complaint and grievance trends. The Provider Advisory Committee also reviews summary data regarding quality of care complaints and grievances to identify trends, conducts barrier analysis, and recommends corrective actions as needed. Review of SQIC meeting minutes revealed very little evidence that the SQIC monitors member complaint and grievance trends, as stated in the CHIP *2019 Quality Improvement Program Description*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•For the February and June 2019 meetings, minutes indicated a report was not available and did not indicate a reason for this. •The remaining three meetings (June, September, and December 2018) do not clearly reflect discussion and monitoring of member complaint and grievance trends. United staff agreed during the onsite that the program description is inaccurate regarding the SQIC's responsibility for monitoring member complaint and grievance trends and should be revised. *Recommendation: Revise the CHIP 2019 Quality Improvement Program Description to include accurate information regarding the committee responsible for reviewing grievance data to find quality improvement opportunities.*
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
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					During the onsite, United confirmed Member Services assists members with PCP change requests for any reason including dissatisfaction. United investigates these requests.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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					During the onsite, United confirmed requests for PCP changes related to dissatisfaction are categorized and tracked.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. 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 *2019 Quality Improvement Program Description* for the CHIP program describes the program United has implemented to improve the quality and safety of clinical services provided to their Children's Health Insurance Program (CHIP) members.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					United has established the Multicultural Health Program (MHP) to reduce health disparity and improve culturally and linguistically appropriate services. To help reduce disparities for the CHIP population, United has chosen to improve the Health Effectiveness Data and Information Set (HEDIS®) rate for Adolescent Visits (age 12 – 21) by 5 percent in targeted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						counties. The description of the MHP appeared incomplete. *Recommendation: Update the Multicultural Health Program description in the QI Program description.*
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 program description does not specifically address how utilization data is used. United uses utilization data as part of their monitoring of network providers as descried in *Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization*. The Healthcare Quality and Utilization Management Committee is responsible for reviewing over and under-utilization data and recommends interventions as indicated.
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					United maintains a separate, comprehensive work plan for the CHIP Program. The performance improvement projects (PIPs) were addressed in the work plan; however, the projects listed were not the ongoing CHIP projects. The CAN projects were listed in error. *Recommendation: Update the CHIP workplan to include the current CHIP PIPs are tracked.*
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 QI activities for the CHIP population has been delegated to the Quality Management Committee (QMC). The Provider Advisory Committee and the Healthcare Quality

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Utilization Management Committee is also responsible for monitoring of QI activities and providing recommendations as appropriate.
2. The composition of the QI Committee reflects the membership required by the contract.	X					There was an adequate representation of senior leadership, department managers, and network providers for all the QI committees. CCME found issues about who chairs the QMC. The issues were as follows: •According to the QI Program Description, the committee is chaired by the health plan's Chief Medical Officer. •The committee Charter received with the desk materials indicates the committee is chaired by the health plan's Chief Executive Officer. •Meeting minutes for June 2018, December 2018, and March 2019 indicates the meeting was Chaired by the Director, Clinical Quality. •The September 2018 meeting minutes indicated the meeting was chaired by Dr. Phillips however, the minutes were signed by the Director, Clinical Quality. *Recommendation: Correct the Quality Management Committee Charter to reflect the chair of the committed is the Chief Medical Officer.*
3. The QI Committee meets at regular intervals.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					United was found to be "Fully Compliant" and met all the requirements for the HEDIS measures as per the report by Attest Health Care Advisors. There were no measures that had substantial improvement of greater than 10%, although many rates improved. The measures of Antidepressant Medication Management and Follow-Up After Hospitalization for Mental Illness declined substantially. Details of the validation activities for the performance measures may be found in *Attachment 3, CCME EQR Validation Worksheets*.
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					For CHIP, United submitted four projects for desk material review. As per the contract, the topic of obesity should be selected annually for study providing continuous evaluation.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All four PIPs also scored in the "High Confidence in Reported Results" range, although there are several recommendations that apply to the most recent reports submitted. Details of the PIP validation activities, and specific outcomes related to each activity may

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be found in *Attachment 3, CCME EQR Validation Worksheets*.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					United collects physician profile reports at the group and individual level for the CHIP providers and uses these reports to measure provider performance and educate the provider.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per Policy *QM-01, Monitoring of Clinical and Preventive Health Guidelines,* United annually monitors provider compliance with the clinical and preventive health guidelines.
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						United's Standard Operating Procedure titled *Well Child Services - Tracking Process* was provided.
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					United's Standard Operating Procedure titled *Well Child Services - Tracking Process* indicates that providers use claims submission forms to document diagnosis, treatment, and/or referrals. Any problems identified during the Well-Child exam that require referrals are tracked quarterly through a supplemental report. United provided a sample of the results of this tracking report onsite. However, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						report appeared to include encounters not related to a diagnosis found on the Well-Child exam such as emergency room visits. According to United staff the tracking report is run for members who had a Well-Child exam and had an encounter for a service received after the exam, not necessarily related to a diagnosis found on the exam. The tracking reports are sent to the Case Management Department for follow-up with the member to ensure referrals are provided if needed. *Recommendation: The tracking reports should only include the problems or diagnoses identified during the Well-Child exam that required referrals.*
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	Not Applicable	Not Evaluated	
V A. 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 *Mississippi Utilization Management Program Description Addendum* outlines the objectives, scope, staff roles for physical health, behavioral health (BH), and pharmaceutical services. Several policies, such as *Policy UCSMM.06.10,Clinical Review Criteria*, *Policy UCSMM.06.13, Non-Clinical Intake and Initial Screening*, and *Policy UCSMM.06.16, Initial Review Timeframes* provide guidance on utilization management (UM) processes and requirements.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description Addendum* shows the Chief Medical Officer, Amit Prasad, MD, oversees the UM Program and responsibilities include supervising medical necessity decisions, conducting reviews, chairing the Healthcare Quality and Utilization Management Committee (HQUM) and Physician Advisory Committee, and co-chairing the Quality Management Committee (QMC) with the Chief Executive Officer. Operating authority is delegated to the UnitedHealthcare Health Services Director.
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 UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the National Medical Care Management Committee, the Community and State National Quality Management Oversight Committee, and the HQUM for approval. Additionally, Utilization Management reports and activities are reported to the Physician Advisory Committee.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					The *CHIP UM Program Description Addendum* states United uses external and internal clinical review criteria that are based upon applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as Milliman Care Guidelines. During the onsite, United staff confirmed procedures for determining service authorization requests

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						follow the clinical hierarchy noted in *Policy UCSMM.06.10 Clinical Review Criteria Rider 1.*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files reflect consistent decision making using evidenced base criteria and relevant medical information, as described in the *UM Program Description Addendum* and *Policy UCSMM.06.10, Clinical Review Criteria*. Member-specific needs are appropriately considered.
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					United conducts annual inter-rater reliability testing, which includes BH and pharmaceutical segments, to evaluate consistency in application of UM criteria and guidelines among reviewers. Staff scoring below 90% will receive remediation and retesting. Results are reported in the *2018 UM Program Evaluation*.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					United's member website states the *Preferred Drug List (PDL)* is a list of prescription drugs considered coverable by DOM. United adheres to DOM's policy for generic substitution and therapeutic interchange, quantity limits, and step therapy as noted in the *PDL Quick Reference Guide*. Page 27 in the CHIP *Member Handbook* describes over-the-counter medications are covered and lists examples of drugs that may be covered.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Some steps to access the PDL on the website and information in the *Member Handbook* are not clear. The following issues are identified: •Instructions on page 27 of the *CHIP Member Handbook* indicate the list is found on United's website when it is located on DOM's website. •When CCME attempted to access the link, an error message, "page not found," returned. •To view the PDL from United's website requires several clicks before receiving the message "You are leaving this site." This message may discourage the reader from proceeding to DOM's website, where the PDL is located. *Recommendation: On page 27 in the CHIP Member Handbook and the website, provide clearer information describing the PDL is located on DOM's website. Ensure the embedded link, on page 27 in the CHIP Member Handbook is in working order. Consider editing the links on United's website to land directly to the PDL on DOM's website.*
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					The *UM Program Description Addendum* shows United has policies and procedures that follow DOM's prior authorization criteria for drugs listed on the PDL and for drugs not listed. *Policy RX-036, Emergency Medication Supply / Temporary Coverage Override* shows United allows for a 3-day emergency supply of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medication that requires authorization when there is immediate need for the drug.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description Addendum* and policies such as *UCSMM.06.14, Initial Clinical Review and Non-Clinical Intake and Initial Screening* describe the role of licensed and unlicensed staff who are trained to perform physical and BH reviews. Clinical reviews are performed by a Registered Nurse, Licensed Practical Nurse, or appropriate licensed health professional, and a MS-licensed physician makes all clinical denials or adverse decisions.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization time frames for approval files are consistent with *Policy UCSMM.06.16, Initial Review Timeframes*, the UM Program Description, and *CHIP Contract* requirements.
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					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialist as outlined in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy UCSMM.06.16 Initial Review Timeframes.
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					Review of denial files reveal denial decisions are made according to the processes described in *Policy UCSMM.06.16 Initial Review Timeframes*.
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 adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					The *Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01*) describes operating procedures for processing member appeals and grievances.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				The terms "adverse benefit determination" and "appeal" are appropriately defined in: •*Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy* •CHIP *Member Handbook* •CHIP 2019 *Care Provider Manual* United's CHIP website glossary appropriately defines the term "appeal, but incompletely defines the term "adverse benefit determination." The following components of the definition are missing: •For residents in a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii) •The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						coinsurance, and other enrollee financial liabilities. *Corrective Action: Revise the CAN website glossary definition of the term "adverse benefit determination" to include the full definition as stated in 42 CFR § 438.400 (b).*
1.2 The procedure for filing an appeal;		X				*Policy POL2015-01* and the CHIP *Member Handbook* correctly show the timeframe to file an appeal is 60 calendar days from the date of receipt of the adverse benefit determination notice, as allowed by *42 CFR §438.402 (c) (ii) (2) (ii)*. Page 33 of the CHIP *2019 Care Provider Manual* contains information in a table about appeal filing timeframes. Identified issues include: •The information references an appeal filing timeframe of within 60 calendar days of the notice of adverse benefit determination for members but fails to specifically show the timeframe begins with the member's receipt of the notice. •The information references a timeframe of within 30 calendar days of the notice of adverse benefit determination for providers to file an appeal. Onsite discussion confirmed the timeframe for providers to file an appeal refers to provider disputes and not appeals of adverse benefit determinations. (CCME noted the CHIP *2019 Care Provider Manual* addresses provider disputes elsewhere, and therefore, including

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the filing timeframe for provider disputes in this table could confuse the reader.) *Corrective Action: Revise the information about appeal filing timeframes in the table on page 39 of the CHIP 2019 Care Provider Manual to include the filing timeframe for member appeals begins with receipt of the initial notice of adverse benefit determination and to remove the filing timeframe for provider appeals (provider disputes).*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal;		X				Page 30 of the CHIP *2019 Care Provider Manual* does not clearly convey the 72-hour timeframe for expedited appeal resolution. It states United "makes reasonable efforts to give prompt verbal notice of an expedited appeal decision and follows-up with a written notice within two calendar days." *Corrective Action: Revise the CHIP 2019 Care Provider Manual to clarify the expedited*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appeal resolution timeframe is 72 hours from receipt of the appeal.
1.6 Written notice of the appeal resolution;	X					
1.7 Other requirements as specified in the contract.		X				Page 54 of the CHIP *Member Handbook* addresses continuation of benefits pending an Independent External Review but does not address continuation of benefits pending an initial appeal. *Corrective Action: Revise the CHIP Member Handbook to include full information about continuation of benefits for an initial appeal.*
2. The CCO applies the appeal policies and procedures as formulated.	X					Review of appeal files confirmed timely acknowledgement, resolution and notification of resolution. Appropriate physicians rendered appeal determinations. Three appeal resolution letters list 2 different physicians as reviewing the appeal. This could result in confusion for the reader. Onsite discussion confirmed a MS-licensed physician signs off on appeal determinations rendered by physicians in other states and this is the reason two physician's names are listed in the letter. Several resolution letters, when referencing the initial denial of services, used the word "upheld," which could confuse the reader. Onsite discussion confirmed this was an error and the letters should have used the word "denied" when referencing the outcome of the initial authorization review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise letter contents to clearly show the physician who actually rendered the determination and the MS-licensed physician who signed off on the determination. Ensure correct terminology is used in appeal resolution letters when referencing the initial prior authorization review outcome.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The CHIP 2019 *Quality Improvement Program Description* states appeal data are collected, analyzed, and monitored to identify opportunities for improvement, and the Service Quality Improvement Committee (SQIC) responsibilities include monitoring appeal activities. The Provider Advisory Committee also reviews summary data about appeals to identify trends, conducts barrier analysis, and recommends corrective actions as needed. Review of documentation in SQIC meeting minutes revealed very little evidence that the SQIC monitors member appeal activities, as stated in the CHIP 2019 *Quality Improvement Program Description*: •For the February and June 2019 meetings, minutes show a report was not available and there was no explanation given. •The remaining three meetings (June, September, and December 2018) do not clearly reflect discussion and monitoring of member appeal data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the CHIP 2019 Quality Improvement Program Description to include accurate information about the committee responsible for reviewing appeal data to identify quality improvement opportunities.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management Program.	X					The 2019 *CHIP Care Management Program Description/Whole Person Care Program Description* and *Addendum* outline the framework for Whole Person Care (WPC) Management Program goals, scope, and lines of responsibility, and shows the WPC Program is integrated within the United Care Management (CM) Program. The scope of the WPC Management program spans the continuum of care and includes treating inpatient and outpatient practitioners, member (or caregiver) engagement and education, member self-management, and community resource linkage. The program is National Committee for Quality Assurance case management accredited.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The goal of the WPC Management Program is to focus interventions on members who are persistent super-utilizers, those with emerging risks, and those with complex medical,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						behavioral, social, pharmacy, and specialty needs. The Health Risk Assessment tool is primarily used to screen and identify eligible members into case management. Other methods include review of clinical claims, medical records, and utilization management data. Identified members are stratified into low risk, medium risk, and high-risk categories based on results from United's predictive modeling software and stratification algorithms.
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 Rider2, Case Management Process* adequately addresses that a health risk assessment will occur within 30 calendar days for members newly assigned to medium and high-risk categories and the treatment plan will be completed within 30 calendar days after the assessment, as required in *CAN Contract, Section 8 (A) (1).*
4. The detailed health risk assessment includes all required elements:						*2019 WPC Program Description Addendum* adequately describes the requirements to complete a detailed health risk assessment.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 assessment.	X					A person-centered plan of care (POC) is developed by a Care Manager or Behavioral Health Advocate, caregiver/family, and the interdisciplinary care team in collaboration with the member. Qualifications for Care Managers include requirements such as holding an unrestricted Registered Nurse license and CM certification; and Behavioral Health Advocate qualifications include holding a Master's degree or Ph.D. and unrestricted license in their state. Review of Care Management (CM) files reflect qualified health professionals conducting health risk assessments and other CM services.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Member risk levels could not be identified or were difficult to identify in CM files, however, during the onsite United staff confirmed documentation of risk levels of reviewed files. Discussions further revealed risk levels are documented in other systems outside of care plans and care management notes in which the format is understood internally by United's staff. *Recommendation: Include clear documentation of member risk levels into CM documents such as care plans and care notes.*
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 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;						
7.7 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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract.	X					The *WPC Program Description Addendum* states, "United shall provide members assigned to the high risk level all the services included in the low risk and medium risk levels as required in the CHIP Contract."
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					*2019 WPC Program Description Addendum* states United will transfer the member's care management history, six months of claims history, and other pertinent information to DOM when a member disenrolls. If a member transfers to another health plan, the CM will provide the member's utilization information and care plan data to the new health plan upon request.
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 deficit hyperactivity disorder, and organ transplants.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					*Policy MS021, Transitional Care Management* shows United monitors and evaluates physician/practitioner performance in coordinating care and ensuring continuity of care by tracking activities such as member complaints and appeals, medical record audits, and *Member* and *Provider Satisfaction Surveys*. The 2019 *Care Management Program Description* describes the Transitional Care Management program as a subgroup of the WPC Management Program and aspects of the program are measured annually or quarterly and reported to quality committees.
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					*Policy MS021, Transitional Care Management* adequately outlines transition of care services before, during, and after members are discharged from an institutional clinic or inpatient setting back to the member's home or other community setting. As described in the CM Program Description, the four main focus areas for the Transitional Care Management Program are medication self-management, personal health record/My Health Snapshot, provider and specialist follow-up visits, and knowledge of red flags.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements the transition of care plan, and provides oversight to the transition process.	X					*Policy MS021, Transitional Care Management* and the *WPC Program Description Addendum* describe the transition of care team will consist of Transitional Care Nurses in addition to any staff necessary to enhance services for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members and provide support for their return to the home or other community setting. Additionally, the team consists of Medical Directors, Inpatient Care Managers, Discharge Planners, Pharmacy, Community Health Workers, Behavioral Care Advocates, and Care Managers.
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The 2018 *CAN Utilization Management Program Evaluation* provides an overall assessment of the effectiveness of the Utilization Management Program as well as analysis on program-specific outcomes. The evaluation notes the UM Program was effective in meeting its objectives. Program strengths include criteria development and approval, and improved member satisfaction. The UM process and recommendations for 2019 were also listed. An evaluation of the overall effectiveness of the UM Program is conducted annually and presented to the National Medical Care Management Committee, the Community and State National Quality Management Oversight Committee, and the HQUM for approval.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2018 *CAN Utilization Management Program Evaluation* was reviewed and approved by the HQUM on May 23, 2019 and by QMC on June 27, 2019.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	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					United ensures all delegation arrangements are governed by written agreements between the delegate and the health plan. The agreements contain the following: •Roles and responsibilities of the health plan and the delegated entity •Delegated activities and reporting requirements to the health plan •Process by which the health plan evaluates the delegated entity's performance •Terms for revoking delegation United has delegation agreements with the following entities: •OptumHealth - Behavioral health services •OptumRX - Pharmacy benefit administration services •Dental Benefit Providers - Dental network services and third-party dental administration •eviCore National - Radiology and cardiology management services and prior authorizations •MARCH Vision Care - Vision and eye care services •National MedTrans - Non-emergency transportation benefit services •Hattiesburg Clinic - credentialing •River Region Health System - credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•HubHealth - credentialing •University Physicians, PLLC - credentialing •HCA Physician Services - credentialing •Health Choice, LLC - credentialing •North Mississippi Medical Clinic- credentialing •Ochsner - credentialing •Premier Health, Inc. - credentialing
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				*Policy DCO-01, Delegated Vendor Oversight Strategy* outlines the ways United measures and monitors delegated vendor compliance and performance. United develops monitoring tools that are tailored to the vendor's delegated services. Vendors must report their performance monthly. United uses standing joint operating committee monthly meetings to conduct performance reviews, identify trends or areas of concern, and to develop performance improvement needs. CCME reviewed evidence of monthly oversight monitoring for the corporate delegated entities. *Policy UCSMM 03.14, Delegated Credentialing Oversight Policy & Procedure* provides guidelines for all delegated entities. These guidelines apply to entities delegated to credential and recredential licensed independent practitioners and organizational providers (hospitals, ancillaries). The guidelines cover pre-assessment audits for potential delegates, annual oversight, and ongoing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monthly and quarterly report monitoring. When United finds deficiencies, the health plan implements Improvement Action Plans with follow-up, as needed. As defined in the *2019 Quality Improvement Program Description*, the executive level Delegation Oversight Governance Committee monitors and approves delegated activities for care providers. The committee also monitors and approves delegated activities for intersegment partners related to claims, credentialing, and medical management. This may include complex care management, disease management, population management, observation/inpatient hospital review, appeals, and grievances if contractually agreed upon. The regional Delegation Oversight Committee handles ongoing oversight of delegation activities for claims/credentialing, and medical management including disease management and complex care management. The Provider Advisory Committee provides local delegation oversight. CCME reviewed proof of annual oversight for all delegated entities. For credentialing and recredentialing oversight, United conducted annual audits to assess compliance to with defined standards. The tool is comprehensive and included file review. However, the delegated credentialing and recredentialing tools omit the requirement for ensuring the entities collect *Ownership Disclosure* forms and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						query the Social Security Death Master File (SSDMF). *Corrective Action: Monitor the entities where credentialing and recredentialing is delegated to ensure Ownership Disclosure forms are collected and the SSDMF is queried. The delegation oversight tools should be updated to include monitoring the delegate for Ownership Disclosure forms and querying the SSDMF.*