2021 External Quality Review

UNITEDHEALTHCARE COMMUNITY PLAN - MISSISSIPPI

Submitted: November 16, 2021

Prepared on behalf of the
Mississippi Division of Medicaid

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies contracting 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 the results of the 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The goals of the review were to:

- Determine if United is in compliance with service delivery as mandated in the Coordinated Care Organization (CCO) contracts with DOM.
- Provide feedback for potential areas of continued 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 two-day onsite visit; a compliance review; validation of performance improvement projects (PIPs) and performance measures; evaluation of network adequacy; member satisfaction and provider satisfaction survey validations; and an Information System Capabilities Assessment (ISCA) review.

Provider Network Access Call Studies and Provider Directory Validations are conducted on a quarterly basis and are reported separately.

I. Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements are related to:

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*

- Confidentiality *(§ 438.224)*
- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards provides an overall snapshot of United's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Number of CAN and CHIP Standards	Number of CAN and CHIP Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	18	18	100%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	36	36	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	28	28	100%
• Provider Selection *(§ 438.214, § 457.1233)*	77	71	92.2%
• Confidentiality *(§ 438.224)*	2	2	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	40	37	92.5%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	4	4	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	20	20	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	8	8	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	38	38	100%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

To assess United's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration

42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457

United has policies and procedures in place to guide the operation of daily business activities. Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, defines procedures for the annual review and revision of policies and procedures. Operational relationships are clearly identified in United's Organizational Chart and are sufficient to ensure that all health care services required by the State of Mississippi are provided to members.

United has provided documentation indicating its information systems infrastructure is capable of meeting the requirements of Mississippi's contracts. The infrastructure is managed in accordance with policies that prioritize data security and system resilience. United regularly performs risk assessments to identify potential risks to its infrastructure and aid the organization in implementing preventative measures. Revision timestamps indicate the organization regularly reviews and updates its documentation.

Lines of communication are outlined in the 2021 Care Provider Manuals (Provider Manuals) and Member Handbooks and provide reporting options for Optum's Anti-Fraud and Recovery Solutions (AFRS) unit and DOM. The UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program 2020-2021 document (FWA Plan) outlines dedicated approaches to prevention, detection, reporting, corrective action, and best practices. The Group Code of Conduct emphasizes United's efforts made toward representing the highest level of personal and institutional integrity. The role and responsibilities of the Compliance Officer and the Compliance Oversight Committee are detailed in the Mississippi addendum to the FWA Plan. Training and education are provided to assess the state of the Compliance Program and to ensure that it effectively prevents, detects, and corrects violations of applicable laws, regulations, guidance, government contract requirements, company policies, and ethical guidelines.

The 2020-2021 UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program describes the process of scheduled and unscheduled FWA compliance and performance audits. Allegations and facts are reviewed by United and DOM on a case-by-case basis. United's CAN Investigative Process document outlines the steps developed to conduct consistent investigative processes for fraud investigations performed by United's Special Investigations Unit and implement sanctions in responses to identified offenses.

Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

Credentialing and recredentialing functions are conducted at the corporate level and credentialing decisions are communicated to the local Provider Advisory Committee (PAC), chaired by the Chief Medical Officer, for review and approval. Membership of the PAC includes participating Mississippi network providers with an array of specialties.

Processes and requirements for initial and ongoing credentialing are documented in the UnitedHealthcare Credentialing Plan 2021 – 2023, an addendum with state-specific requirements, and in policies and procedures. The process for collecting fingerprints for CHIP providers designated as high-risk by DOM was not identified in any of the credentialing documentation reviewed. Issues were noted in credentialing and recredentialing files for independent practitioners related to collection of collaborative agreements between nurse practitioners and collaborating physicians and query of the Mississippi State Board of Medical Licensure. Issues related to verification of CLIA certificates or certificates of waiver and querying the MS DOM Sanctioned Provider List were noted in credentialing and recredentialing files for organizational providers.

The current EQR revealed that issues in credentialing/recredentialing files related to queries of the MS DOM Sanction Provider List continue. In the response to the 2020 Corrective Action Plan, United indicated processes had been changed and staff had been educated regarding querying the MS DOM Sanctioned Provider List. United should implement a monitoring process to ensure credentialing and recredentialing files contain appropriate evidence of required queries.

United follows established processes for assessing its network for adequacy of access to and availability of providers. Action plans are implemented to address any identified issues. Geographic access standards for the CAN and CHIP provider networks are defined in policy and are compliant with contractual requirements. Quarterly Geo Access reports measure access by provider specialty and by rural and urban designations. Several methods are used to notify providers of assigned members, and providers can communicate desired panel restrictions at any time. Ongoing monitoring is conducted to ensure sufficient providers are accepting new patients.

Appointment access standards are defined in policy and are compliant with contractual requirements. Routine assessments are conducted of provider compliance to the standards and results are relayed to the Service Quality Improvement Subcommittee (SQIS) for monitoring, identification of improvement opportunities, and development of corrective action initiatives. Review of results of appointment access call studies indicated the percentage of providers requiring corrective action for appointment access is increasing for pediatrics and OBGYN. For after-hours access, the percentage of providers requiring corrective action is increasing for PCP, OBGYN, and pediatrics providers. The percentage for Behavioral Health (BH) providers has consistently been at or above 50%, most recently at 61.36%.

United's Multicultural Health Care Program includes various activities to ensure its network can serve members with special needs, foreign language, and cultural requirements.

Processes for new provider orientation and education are documented in policy. Provider Advocates are assigned to new providers and are responsible placing welcome calls to answer any immediate questions and to schedule an on-site orientation within 30 days of the contract effective date. United uses various methods and forums for initial and ongoing provider education, such as virtual forums, mailings, bulletins, one-to-one sessions, etc. The Provider Manuals are very detailed; however, a few issues were identified related to documentation of well child care benefits for CAN and peer support services for CAN and CHIP. Also, the CAN and CHIP Provider Manuals do not include the timeframe required for medical record retention, and the CHIP Provider Manual does not include the full requirement for BH appointment access after discharge from an acute psychiatric hospital. Provider contract templates revealed discrepancies in the timeframes for medical record retention by providers.

United reviews and adopts preventive guidelines (PHGs) and clinical practice guidelines (CPGs) that are nationally recognized and are pertinent to the member population.

The validation of the Provider Satisfaction surveys found the low response rate may not reflect the population of providers and results should be interpreted with great caution. The 2020 results indicate overall satisfaction has increased. Results were presented to the Quality Management Committee (QMC) during the March 2021 meeting.

Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Member rights and responsibilities are clearly outlined in policies and procedures as well as in the CAN and CHIP Member Handbooks, Provider Manuals, and United's website. Standards specific to Member Information Packets, ID Cards, service coverage and benefit limitations, 24-hour access to care, and information on disease management and chronic condition programs were met. Information is provided in the Member Handbook that defines and describes types of advanced directives. However, the 2021 CAN and CHIP Provider Manuals did not include information about Advance Directive and associated forms.

Agent training and scripts were provided demonstrating efforts to prepare Call Center staff on the management of urgent, emergent, and routine communication with members. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committees. The Call Center Reports, completed quarterly, documented trends were reviewed and were clear in the coverage of the outcome measures referenced in the Contract. Policies and procedures are in place regarding member enrollment, disenrollment, and re-enrollment. Preventive Health and Chronic Disease Management Education policies are in place and onsite discussion included this year's annual initiatives and steps taken to educate and provide resource information to assist members.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are conducted annually via a third-party vendor, SPH Analytics. The MY2020 survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, the Member Handbooks, Provider Manuals, and United's website define grievances and include options for filing a grievance. Information on timelines is outlined in policy and notes grievances will be acknowledged within five calendar days with a resolution within 30 calendar days of receipt of the grievance. United updated CAN and CHIP policies and documents to reflect accurately the amount of time that grievance information is to be retained to reflect the contractual language indicating that this will be done "during the entire term of this Contract and for a period of 10 years thereafter."

Randomly selected files were reviewed to evaluate compliance with policies and procedures for handling grievances. For the sample reviewed, all standards for timeliness and letters of acknowledgement and resolution were met. United tracks, analyzes, and reports grievance trends to the SQIS quarterly, as described in the Utilization Management and Quality Improvement Program Descriptions.

Quality Improvement

42 CFR §438.330, 42 CFR §457.1240(b), and 42 CFR Part 441, Subpart B

United has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided to all CAN and CHIP members. The QI program is managed at the health plan and no activities are delegated. Behavioral health services are administered by Optum Behavioral Health, a sister company of United. Several program descriptions were presented in the desk materials, including the 2021 Quality Improvement Program Description for the CAN program, the 2021 Quality Improvement Program Description for the CHIP program, and the 2021 Behavioral Health Quality Improvement Program Description. The QI program description is updated annually and presented to the Board of Directors, Quality Management Committee, and the Division of Medicaid for approval.

United develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. United presented the 2020 and 2021 QI Work Plans for review. Both were reviewed and updated at least quarterly. The work plans included the QI activities across several tabs, the responsible person(s), quarterly target dates and each activity's status.

The Quality Management Committee (QMC) is responsible for oversight of the QI program and for the implementation, coordination, and integration of all QI activities. Other committees charged with the responsibility of evaluating and monitoring the QI activities include the Provider Advisory Committee, Healthcare Quality and Utilization Management Committee, and the Service Quality Improvement Subcommittee. Each committee meets at least quarterly and has designated a quorum as 51 percent of the voting members present.

United's Provider Manuals include details regarding their Quality Management program. Providers are advised that United requires their participation in and compliance with the program and a copy of the QI program description is available upon request. United measures network provider performance and compliance with the adopted clinical and preventive health guidelines on an annual basis. For CAN, United selected the Comprehensive Diabetes Care and Weight Assessment and Counseling for Nutrition and Physical Activity measures to assess compliance. For CHIP, United selected the Antidepressant Medication Management and the Weight Assessment Counseling for Nutrition and Physical Activity measures to assess compliance.

United tracks EPSTD and Well Child services and screenings per their Standard Operating Procedures. Members identified with significant conditions receive additional outreach for case management and referrals, if needed.

United evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors, the Quality Management Committee, and to the Division of Medicaid. The 2020 QI Program Evaluation was provided for the CAN, CHIP, and Behavioral Health populations. The program evaluations included the results of all completed activities conducted in 2020.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by United for the CAN and CHIP populations. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted the validation following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2020, through December 31, 2020.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by United. Aqurate found that United's

information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2020.

All relevant HEDIS performance measures for the CAN and CHIP populations were compared for the current review year (MY 2020) to the previous year (MY 2019) and the changes from 2019 to 2020 are reported in the Quality Improvement section of this report. *Table 2: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have a substantial increased or decreased in rate from 2019 to 2020. Substantial increase or decrease is a change in rate of greater than 10%.

Table 2: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2019)	HEDIS MY 2020	Change from 2019 to 2020
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	42.24%	54.02%	11.78%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Statin Adherence 80% - 40-75 years (Female)	42.31%	52.73%	10.42%
Statin Therapy for Patients with Diabetes (spd)			
Statin Adherence 80%	41.04%	51.43%	10.39%
Substantial Decrease in Rate (>10% decrease)			
Adult BMI Assessment (aba)	90.75%	47.10%	-43.65%
Annual Dental Visit (adv)			
2-3 Years	55.01%	41.78%	-13.23%
4-6 Years	76.47%	60.11%	-16.36%
7-10 Years	77.51%	62.81%	-14.70%
11-14 Years	74.23%	61.8%	-12.43%
Total	70.67%	57.52%	-13.15%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	83.87%	62.5%	-21.37%

The CHIP HEDIS rates were also compared. *Table 3: CHIP HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with a substantial decrease in rate from 2019 to 2020. There were no measures noted with a substantial increase.

Table 3: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2019)	HEDIS MY 2020	Change from 2019 to 2020
Substantial Decrease in Rate (>10% improvement)			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (12-17)	48.84%	36.47%	-12.37%
Blood Glucose Testing (Total)	45.95%	34.36%	-11.59%
Annual Dental Visit (adv)			
2-3 Years	57.12%	45.15%	-11.97%
4-6 Years	77.54%	64.54%	-13.00%
7-10 Years	82.81%	70.36%	-12.45%
11-14 Years	78.34%	66.76%	-11.58%
15-18 Years	69.80%	59.17%	-10.63%
19-20 Years	55.20%	44.52%	-10.68%
Total	75.25%	63.37%	-11.88%

In addition, Aqurate conducted additional source code review, medical record review validation and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Aqurate found United was compliant with data integration, data control, and documentation of PM calculations. The Primary source verification demonstrated concerns in the reporting of the PQI-08 Heart Failure Admission rate and the CDF-AD: Screening for Depression and Follow-up Plan measure for the CAN population. Also, United did not report the Elective Delivery (PC-01) non-HEDIS measures (CAN) as required by DOM. For CHIP, Primary source verification demonstrated concerns in the reporting of the CDF-AD/CH: Screening for Depression and Follow-up Plan measure. Overall, United met the validation requirements.

The HEDIS and non-HEDIS measure rates for the CAN and CHIP populations reported by United for 2020 are listed in the Quality Improvement section of this report.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

CAN PIP Validation Results

DOM requires the CCOs to conduct performance improvement projects that address the following topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). For the previous EQR (2020), United submitted four PIPs for validation that addressed the DOM required topics. All four PIPS scored in the "High Confidence in Reported Results" range and met the validation requirements. CCME provided recommendations regarding the presentation of the results in the PIP documents.

For the current EQR, United provided the same four PIP documents for validation. It was noted that the recommendations from the previous EQR were implemented and included in the PIP documents provided. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions are also included.

Table 4: Behavioral Health Readmission PIP

Behavioral Health Readmissions	
The Behavioral Health Readmissions PIP aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five MS inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation the PIP showed improvement in the latest readmission rate from 19.2% to 17.7% and the enrollment indicator had a decline from 46% to 38%. Individual facility rates were reported as well for each of the five facilities.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	79/80=99% High Confidence in Reported Results
Interventions	
• Collaboration with high volume Hinds County outpatient and inpatient providers in order to schedule and facilitate meetings to discuss ways to improve readmissions rates by increasing the seven day-follow-up appointment. • Meds to Beds Program to provide transition solutions to coordinate care and discharge medications for members discharging from inpatient facilities. • Enhanced Case Management.	

Table 5: Improved Pregnancy Outcomes PIP

Improved Pregnancy Outcomes
The Improved Pregnancy Outcomes PIP goal is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth that received a prenatal care visit in the first trimester or within 42 days of enrollment. The baseline rate was 92.21% and the remeasurement

Improved Pregnancy Outcomes	
#1 rate was 91.48%. This rate reflects a decline in the prenatal care visit rate, although it was above the DOM's goal rate of 90.1%.	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	79/80=99% High Confidence in Reported Results
Interventions	
• Home visit care management services in seven underserved communities in MS. • Care management for high-risk pregnant members and their babies less than a year old. • The Optum Whole Person Care Program provides telephonic and/or face-to-face outreach to high-risk members to educate the member and help with establishing an obstetric practice. • Dedicated maternity Member Services Team for telephonic outreach to low-risk members or to members whose risk is unknown to identify any barriers such as transportation childcare and connect the member to support resources. • Member and provider education with the First Steps packets and the OB toolkits. • National Healthy Starts program to address social needs.	

Table 6: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28% and declined to 26.43% in 2020. This is improvement as a lower rate is better.	
Previous Validation Score	**Current Validation Score**
66/71=93% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Outreach to providers encouraging the use of hydroxyurea for patients who do not have a pharmacy claim for hydroxyurea. • Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients. • Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments. • Telehealth campaigns and after hour care newsletters	

Table 7: Respiratory Illness: COPD/Asthma

Respiratory Illness: COPD/Asthma	
The Respiratory Illness PIP examines the COPD exacerbations and pharmacotherapy management HEDIS rate and the AMR measure assessing controller medication to total medication ratio HEDIS rate. The bronchodilators baseline rate was 74.96% which improved to 75.13% although it was still below the goal rate of 84.71%. The corticosteroids baseline rate was 42.24% which improved to 54.02% at remeasurement one , but still below the goal rate of 71.05%. The AMR goal rate was 71.28% and the baseline was 70.70% with an improvement of remeasurement one of 74.08%.	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Clinical practice consultants visit high volume practices to discuss Clinical Practice Guidelines and evidence-based Quality Performance Guidelines and assist with interpreting patient care opportunity reports. • Pharmacy outreach to ensure members have educational materials, prescriptions are filled and assist with overrides or claims issues related to prescribed inhalers. • Communication with clinics regarding non-compliant members, patient care opportunity reports, and provider education.	

CHIP PIP Validation Results

United submitted the same four PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction, Follow Up After Hospitalization, and Obesity. Last year there were some recommendations regarding the documentation of statistical analysis, causal analysis, and the reporting of results. All of those recommendations were implemented and reflected in the PIP documentation submitted with the desk materials. All the CHIP PIPs for this EQR scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each project's status and the interventions are also included.

Table 8: Adolescent Well Child Visits / Child and Adolescent Well Care Visits PIP

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
The goal of the Adolescent Well Child Visits (AWC)/Child and Adolescent Well Care Visits (WCV) PIP is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year The AWC measure was retired and replaced with the WCV measures. This measure looks at the percentage of members completing at least one comprehensive wellness visit during the calendar year. For this review only the baseline rates were provided for the 12–17-year-old the baseline rate for 2020 was 36.37% and the 18–21-year-old baseline rate was 19.64%.	
Previous Validation Score	**Current Validation Score**

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
100/100=100% High Confidence in Reported Results	73/73/=100% Hight Confidence in Reported Results
Interventions	
• Phone calls to noncompliant members and after hour and weekend clinic days • Staff collaboration with participating clinics to close care gaps. • Clinical practice consultants and clinical transformation consultants conduct educational sessions with providers on HEDIS requirements. • Resumption of the Farm to Fork activities for members to receive educational materials regarding wellness visits and immunizations.	

Table 9: Follow Up After Hospitalization for Mental Illness PIP

Follow Up After Hospitalization for Mental Illness	
The goal for the Follow Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7 day and 30-day follow-up visits. For this review period the PIP documentation report showed that the 30-day follow up rate improved from 61.39% to 64.55% which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.15% to 37.27% in 2020, then improved to 39.31% for MY 2020/RY2021. The goal rate for United is 30.07% so it is above the United goal rate but below the NCQA rate of 46.22%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay. • Continue demographic workflow to improve capture of current contact numbers for enrollees. • Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCP to communicate relevant treatment information involving member care. • Network notes and Optum news and updates for UBH clinicians and facilities. • Case management initiates calls to schedule follow-up appointments.	

Table 10: Reducing Adolescent and Childhood Obesity PIP

Reducing Adolescent and Childhood Obesity
The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity. All rates declined from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate. Measure one declined slightly from 64.96% to 64.23%, but it is above

Reducing Adolescent and Childhood Obesity	
United's goal of 33.17%; and below the NCQA rate of 80.5%. Measure two declined from 55.96% in reporting year (RY) 2019 to 52.07% in RY2020. United's goal for measure two is 42.34%, so that goal has been exceeded; the NCQA goal is 71.55%, which was not exceeded. Measure three declined slightly from 50.12% in RY2020 to 49.15% in RY2021. United's goal for measure three is 34.25%, so the current rate exceeded the United goal rate, but it below the NCQA goal of 66.79%.	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	99/100 = 99% High Confidence in Reported Results
Interventions	
• Member and provider education • Phone calls to noncompliant members. • After hour and weekend clinic days • Member events such as health fairs and Farm to Fork events • Clinical Practice Consultants conduct routine visits to PCPs to provide education on HEDIS measures and appropriate coding and billing. • Community outreach activities such as the Farm to Fork program and health fairs.	

Table 11: Getting Needed Care CAHPS PIP

Getting Needed Care CAHPS	
For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question Getting Needed Care – easy to see a specialist and improve the rate to meet the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019 and then it reduced again slightly to 82.3%. This is below the NCQA 50th percentile rate and United's goal of 91.19%.	
Previous Validation Score	**Current Validation Score**
99/100=99% High Confidence in Reported Results	99/100=99% High Confidence in Reported Results
Interventions	
• Member education regarding the provider network and how to access care. • Clinical Practice Consultants make face to face visits with high volume clinics to discuss the CAHPS survey. • Provide member education during phone calls and town hall meetings regarding United's provider network. • Offer case management to providers to support or expedite referrals.	

Utilization Management

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c), 42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's assessment of United's CAN and CHIP Utilization Management (UM) Programs included reviews of the UM Program Description and the UM Program Description Mississippi Addendum, which describe and define collaboration between the UM Program and other UnitedHealthcare Clinical Services areas. The CAN and CHIP UM Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health services. Policies and procedures are well-written and clearly define how services are implemented and provided to members. However, minor documentation issues were noted and CCME offered recommendations to address them.

Service authorization requests are conducted by appropriate reviewers utilizing internal clinical guidelines or other established criteria. The Care Management Program has been updated and a new Care Management (CM) model will be implemented. The newly revised 2021 United Healthcare C&S Care Model Program Description and CM policies appropriately document CM processes and services.

CCME identified issues with CAN and CHIP appeal documentation and appeal processes, such as: appeal information is not available in Spanish on the website, the "Your Additional Rights" enclosure does not include all of the member's appeal rights, policy guidelines for appeal start times are not consistently followed, a discrepancy in documentation of the appeal "received dates," and incorrectly referencing the adverse benefit determination in the original service authorization request.

The review of UM approval and denial files provided evidence that appropriate processes are followed, and no issues were identified. Care Management files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

CCME's review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring processes, and documentation of oversight. Delegation agreements for 16 current delegates specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from substandard performance or noncompliance. Processes for vendor oversight and assessment are detailed in the Delegated Vendor Oversight Strategy and in the UnitedHealthcare Credentialing Plan 2021–2023.

Monitoring of delegated activities includes routine reporting by delegates to facilitate performance monitoring. The reporting assists in identifying operational trends or issues, and performance improvement initiatives are implemented as needed. Routine joint operating committee meetings are held with subcontractors to review performance and discuss any needed remediation. Evidence of the oversight conducted for non-credentialing delegates was submitted prior to the onsite visit; however, oversight documentation for United's credentialing delegates was requested three times before it

was finally submitted after completion of the onsite visit. No issues were identified during review of oversight documentation of the delegated entities.

Quality Improvement Plans and Recommendations from Previous EQR

For the previous EQR, there were nine standards scored as "Partially Met" for CAN and nine standards scored as "Partially Met" for CHIP. Also, one standard was scored as "Not Met" for both CAN and CHIP. The following is a high-level summary of those deficiencies:

- File review findings for CAN and CHIP organizational provider credentialing and recredentialing files included undated queries of the MS DOM Sanctioned Provider List, System for Award Management, and Office of Inspector General List of Excluded Individuals & Entities.
- An incorrect parameter was used for measuring access to rural emergency medicine providers for CAN and CHIP.
- Discrepancies were noted in the benefits information presented in the Provider Manuals and Member Handbooks for both CAN and CHIP. These were repeat findings from the previous EQR.
- The PCP Responsibilities section of the CHIP Provider Manual did not clearly state the provider's responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services.
- The font size requirements for member materials could not be found in policies.
- Discrepancies and errors in documentation of toll-free telephone numbers and hours of operation for Member Services and Provider Services Call Centers were noted for both CAN and CHIP.
- CCME did not identify grievance and appeal procedures and instructions on the non-secure section of the CAN and CHIP websites, as contractually required.
- The Member Appeal, State Fair Hearing, External Appeal and Grievance policy stated an incorrect timeframe for grievance acknowledgement and included incomplete information regarding the timeframe for grievance record retention.
- The timeframe for allowing a provider to submit additional information for a service authorization was not included in the 2020 UM Program Description Addendum for both CAN and CHIP, and the timeframe for notifying a member of the termination, suspension, or reduction of a previously authorized service was not included in the Initial Review Timeframes policy.
- The CAN appeal resolution notice template instructed members to file an independent external review instead of a State Fair Hearing.

After the 2020 EQR, United submitted its response to the Corrective Action Plan (CAP) on January 19, 2021. Additional documentation was submitted on February 8, 2021. The CAP was accepted on February 9, 2021. A follow-up of the CAP was initiated in April 2021 and completed in May 2021. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Corrective Action Plan related to querying the MS DOM Sanctioned Provider List at initial credentialing and/or recredentialing for organizational providers was not implemented.

Table 12, Scoring Overview—CAN, provides an overview of the scoring of the current annual review as compared to the results of the 2020 review. For 2021, 219 out of 224 standards received a score of "Met." There were five standards scored as "Partially Met."

Table 12: Scoring Overview—CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2020	31	0	0	0	0	31
2021	31	0	0	0	0	31
Provider Services						
2020	83	2	1	0	0	86
2021	80	4	0	0	0	84
Member Services						
2020	29	4	0	0	0	33
2021	33	0	0	0	0	33
Quality Improvement						
2020	19	0	0	0	0	19
2021	19	0	0	0	0	19
Utilization Management						
2020	51	3	0	0	0	54
2021	51	1	0	0	0	54
Delegation						
2020	2	0	0	0	0	2
2021	2	0	0	0	0	2
Totals						
2020	**215**	**9**	**1**	**0**	**0**	**225**
2021	**219**	**5**	**0**	**0**	**0**	**224**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

Table 13, Scoring Overview—CHIP, provides an overview of the scoring of the current annual review as compared to the results of the 2020 review. For 2021, 216 out of 223 standards received a score of "Met." Zero standards were scored as "Partially Met," and one standard was scored as "Not Applicable."

Table 13: Scoring Overview—CHIP

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2020	31	0	0	0	0	31
2021	31	0	0	0	0	31
Provider Services						
2020	81	3	1	0	0	85
2021	78	4	0	0	1	83
Member Services						
2020	28	4	0	0	0	32
2021	33	0	0	0	0	33
Quality Improvement						
2020	19	0	0	0	0	19
2021	19	0	0	0	0	19
Utilization Management						
2020	51	2	0	0	0	53
2021	53	2	0	0	0	55
Delegation						
2020	2	0	0	0	0	2
2021	2	0	0	0	0	2
Totals						
2020	**213**	**9**	**1**	**0**	**0**	**224**
2021	**216**	**6**	**0**	**0**	**1**	**223**

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

II. Conclusions

Overall, United met all the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330* except for the Provider Selection and the Grievance and Appeal standards. The 2021 Annual EQR shows that United achieved a "Met" score for 97.8% of the standards reviewed for CAN and 96.9% of the standards reviewed for CHIP. The charts that follow display the current review results.

Figure 1: 2021 Annual EQR Review Results for CAN

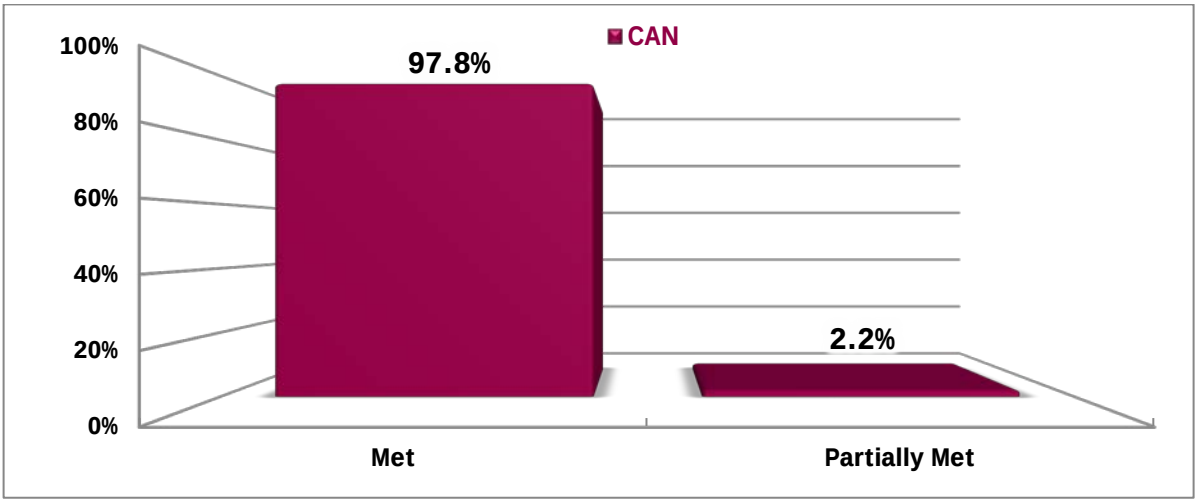
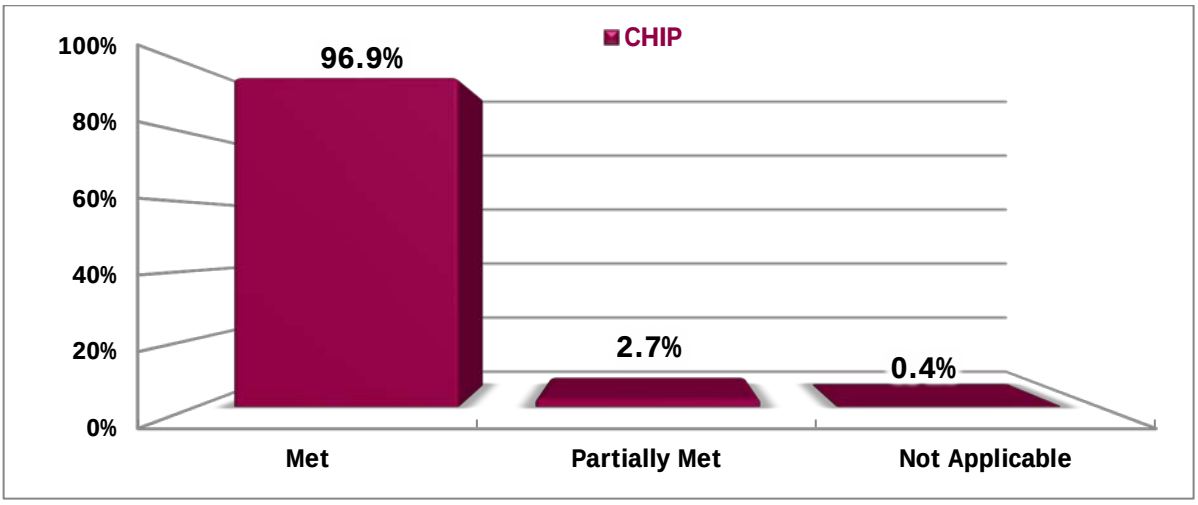


Figure 2: 2021 Annual EQR Review Results for CHIP



The following tables provide an overview of strengths, weaknesses, and recommendations related to the quality, timeliness, and access to care identified during this annual review of United.

Table 14: Evaluation of Quality

Strengths Related to Quality
• Staffing is in place for Member Services and Provider Relations teams, and in United's Call Center to enhance care access and provide education specific to service provision. • United processes provider claims at a rate that exceeds the State's requirements. • Fraud reporting options are available on United's website, internal and external handbooks, manuals, and newsletters. • The document entitled Investigative Process provides an overview of the investigative process and departmental steps for the timely review of fraud investigations performed by United and the Special Investigations Unit. • United's Provider Advisory Committee (PAC), which serves as the local Credentialing Committee, is chaired by the Chief Medical Officer and membership includes participating MS providers with an appropriate array of specialties to represent the network. • Although the corporate MTAC recommended removing the clinical practice guideline for Sickle Cell Disease in 2021, United successfully advocated for the guideline to be reimplemented. • Annual Disease Management goals are identified by United to reduce and prevent chronic health issues. • United uses the Multicultural Health Care Program to reduce health disparities. Specific goals have been identified to target for the CAN and CHIP populations. • United tracks EPSTD and Well Child services screenings per their Standard Operating Procedures. Members identified with significant conditions receive additional outreach for case management and referrals, if needed. • United was fully compliant with all information system standards and it was determined that the CCO submitted valid and reportable rates for all HEDIS measures in the scope of this audit. • Based on Aqurate's validation of PMs, there were no concerns with United's data processing, integration, and measure production for CMS Adult and Child Core Set measures that were reported. Aqurate determined that United followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs. • The following HEDIS MY 2020 CAN measure rates were strengths for United since their rates had a greater than 10% improvement: o Pharmacotherapy Management of COPD Exacerbation (PCE), the Systemic Corticosteroid indicator improved by 11.78 percentage points. o Statin Therapy for Patients with Cardiovascular Disease (spc), the Statin Adherence 80% - 40-75 years (Female) indicator improved by 10.42 percentage points. o Statin Therapy for Patients with Diabetes (spd), Statin Adherence 80% indicator improved by 10.39 percentage points. • All performance improvement projects scored within the High Confidence range for the reported results. • Adverse Benefit Determination notices include information written in Spanish directly within the body of the letter. • Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used.

Strengths Related to Quality
• Delegate oversight documentation indicates appropriate oversight is conducted of all delegated entities.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
• The process for collecting fingerprints for CHIP providers designated as high-risk by DOM was not identified in any of the credentialing documentation reviewed. Refer to the *CHIP Contract, Section 7 (E) 6*.	• Corrective Action: Develop and implement a process for collecting fingerprints for all CHIP providers designated as high risk by DOM at initial credentialing. The process must be detailed in a policy and evidence of fingerprint collection must be included in applicable provider credentialing files.
• The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians, and onsite discussion indicated this is United's practice. However, one CAN nurse practitioner initial credentialing file did not include the complete collaborative agreement. Two CAN recredentialing files for nurse practitioners did not include the complete collaborative agreement.	• Corrective Action: Ensure credentialing and recredentialing files for nurse practitioners contain the complete collaborative agreement between the nurse practitioner and the collaborating physician(s).
• For one independent practitioner recredentialing file for CAN, CCME was unable to determine the date of the board query conducted to verify active licensure on the screenshot included in the file.	• Recommendation: Ensure evidence of verification of active licensure conducted on the State Board of Examiners for the specific discipline includes an indication of the date of the verification.
• Issues identified in initial credentialing and recredentialing files for CAN and CHIP organizational providers regarding verification of CLIA certification included: o One file for a rural health clinic and one file for an inpatient hospice included a CLIA number on the provider's application but no verification of the CLIA in the file. Evidence of the verifications was submitted after completion of the onsite visit, but they were conducted on October 6, 2021. o One file for a hospital included a CLIA verification date on the credentialing checklist, but no other evidence of verification of the CLIA in the file. Evidence of the verification was submitted after completion of the onsite visit, but it was conducted on October 6, 2021.	• Corrective Action: Ensure verification of CLIA is conducted prior to issuing the credentialing or recredentialing determination and that evidence is included in the provider file.
• Issues identified in initial credentialing and recredentialing files for CAN and CHIP	• Corrective Action: Ensure queries of the MS DOM Sanctioned Provider List are included in each

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
organizational providers regarding verification of verification of the MS DOM Sanctioned Provider list included: o There was no evidence of querying the MS DOM Sanctioned Provider List for three providers. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted. o One file included a screenshot labeled as the query of the MS DOM Sanctioned Provider List, but there was no way to confirm as there was no identifying information on the screenshot. o Three files contained screenshots labeled as the query of the MS DOM Sanctioned Provider List, but they appeared to be general searches on DOM's main website and not queries of the MS DOM Sanctioned Provider List. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted.	organizational provider's file and that it is clearly identifiable and includes the date the query was conducted.
• The *CAN Contract, Exhibit C, Section K* and the *CHIP Contract, Exhibit D, Section J* indicate medical records must be retained for a period of no less than 10 years. However, the CAN and CHIP Provider Manuals do not include the medical record retention requirement. Additionally, errors were noted in the timeframes for medical record retention in the following CAN and CHIP provider contract/agreement templates: o Ancillary Provider Participation Agreement (6 years) o Facility Participation Agreement (6 years) o FQHC/RHC Participation Agreement (6 years) o Medical Group Participation Agreement (6 years) o MississippiCHIP Regulatory Requirements Appendix Downstream Provider (5 years) o Facility Contract (3 years) o Group Contract (3 years) o Individual Contract (3 years)	• Corrective Action: Update the CAN and CHIP Provider Manuals to include the required medical record retention timeframe. Revise the following documents to reflect the correct medical record retention timeframe: o Ancillary Provider Participation Agreement o Facility Participation Agreement o FQHC/RHC Participation Agreement o Medical Group Participation Agreement o MississippiCHIP Regulatory Requirements Appendix Downstream Provider o Facility Contract o Group Contract o Individual Contract
• Policy NQM-025 describes medical record audit processes. Onsite discussion confirmed additional review of providers who have failing scores is conducted during the next year's medical record audit. However, Policy NQM-025,	• Recommendation: Revise Policy NQM-025 to clearly indicate the timeframe during which an additional review is conducted for providers who fail the initial medical record review.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
as currently written, does not make this clear. For example, the information about the additional review is addressed prior to a statement that indicates final results may be presented to the applicable health plan committee upon final closure of the medical record review.	
• The response rate for the Provider Satisfaction Survey was 1.9% with 57 of 2,958 providers completing the survey. This very low response rate may not reflect the population of providers. Thus, results should be interpreted with great caution.	• Recommendation: Work on action plan steps including increasing email quality and survey advertisement to improve Provider Satisfaction Survey response rates.
• The CAN and CHIP Provider Manual does not provide information about Advance Directives.	• Recommendation: Edit the CAN and CHIP Provider Manual to include information about Advance Directives and associated forms.
• The generalizability of the Member Satisfaction Survey results is difficult to discern due to low response rates and small sample size.	• Recommendation: Work on action plan steps including increasing email quality and survey advertisement to improve response rates. Continue working with SPH Analytics to increase survey sample sizes and response rates for Adult and Child surveys.
• Some grievance resolutions letters did not contain language consistent with the grade level reading requirements outlined United's policy.	• Recommendation: Review the Grievances Resolution Letters containing the phrase "Quality and compliance unsubstantiated the complaint…." and consider verbiage to align with Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension.
• The process for monitoring provider compliance with the Clinical and Preventive Health Guidelines is outlined in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines. This policy was not specific regarding how providers receive the results of this monitoring.	• Recommendation: Include how results of the provider monitoring of Clinical and Preventive Health Guidelines are shared with network providers in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines.
• The HEDIS rates reported in the 2020 QI Program Evaluations for CAN and CHIP incorrectly listed some measures as not meeting the 50th percentile goal. However, the reported rates exceeded the 50th percentile goal.	• Recommendation: Correct the errors in the HEDIS results table in the QI Program Evaluations.
• The CAN and CHIP QI Program Evaluations listed the area United planned to target for improvements in 2021; however; they lacked the interventions United planned to use to improve those areas targeted.	• Recommendation: Include a summary of the interventions planned for 2021 in the QI Program Evaluations.
• Primary source verification demonstrated concerns in the reporting of the PQI-08 Heart Failure Admission rate and the CDF-AD:	• Recommendation: Improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
Screening for Depression and Follow-up Plan measure for the CAN population. • For CHIP, primary source verification demonstrated concerns in the reporting of the CDF-AD/CH: Screening for Depression and Follow-up Plan measure.	
• United did not report the Elective Delivery (PC-01) non-HEDIS measures (CAN) as required by DOM.	• Recommendation: Work proactively with DOM for clarification on the non-HEDIS measures that are required to be reported.
• The Pregnancy Outcomes and Behavioral Health Readmission CAN PIPs demonstrated no quantitative improvement in process or care. • The Getting Needed Care and the Reducing Adolescent and Childhood Obesity CHIP PIPs demonstrated no quantitative improvement in process or care.	• Recommendation: Continue working on provider and member interventions for the performance improvement projects that demonstrated no quantitative improvements in process or care.

Table 15: Evaluation of Timeliness

Strengths Related to Timeliness
• All grievance files reviewed were acknowledged and resolved per timeliness guidelines. • Service Authorization requests are completed within timeframe requirements according to policy guidelines and CAN and CHIP contract requirements.

Weaknesses Related to Timeliness	Corrective Actions / Recommendations Related to Timeliness
• For CAN and CHIP, documentation in appeals files reflected United did not consistently follow guidelines in Policy UCSMM.07.11, Appeal Review Timeframes, instructing that the appeal timeframe starts the day United receives the verbal or written request. The following issues were identified: o "Received dates" in the Resolution Letter and/or the Standard Acknowledgement Letter reflected the appeal start time began when the member's consent form was received instead of when the verbal request was received by the Call Center. o Discrepancies were noted in documentation of "received dates" between the Resolution Letter, the Standard Acknowledgement Letter, and the Verbal Acknowledgment Letter. o CAN and CHIP appeal resolution letters incorrectly use the term "previously	• Corrective Action: Ensure staff are following the guideline that appeal start times to begin when the verbal request was received by the Call Center, as outlined in Policy UCSMM.07.11, Appeal Review Timeframes. Ensure staff are consistently documenting the same "received date" on the Verbal Acknowledgement Letter, Standard Acknowledgement letter, and Resolution Letter. Ensure appeal Resolution Letters correctly reference the adverse benefit determination in the original service authorization as "previously denied" instead of "previously upheld."

Weaknesses Related to Timeliness	Corrective Actions / Recommendations Related to Timeliness
upheld" instead of "previously denied" when referencing the adverse benefit determination for the original service authorization request.	
• Policy MS021, Transitional Care Management, incorrectly indicates providers will be notified within 14 days of a member's discharge, instead of seven days.	• Recommendation: Correct Policy MS021, Transitional Care Management, to indicate United will notify providers within seven days of a member's discharge, instead of 14 days.

Table 16: Evaluation of Access to Care

Strengths Related to Access to Care
• Appropriate processes are in place for notifying affected providers and members when DOM terminates a provider's participation in Medicaid or United terminates a provider's participation in the health plan's provider network. • United is compliant with contractual provider geographic access and appointment availability standards. • United's Multicultural Health Care Program includes various activities to ensure its network can serve members with special needs, foreign language, and cultural requirements. • A new process was initiated by the Member Services and Marketing Teams to work with large provider groups to provide information to new members about the member portal to enhance access to care.

Weaknesses Related to Access to Care	Corrective Actions / Recommendations Related to Access to Care
• The benefits grid in the CAN Provider Manual, page 11, indicates "well child care" is not covered; but, the CAN Member Handbook, page 12, states "All well-child visits and immunizations are covered by your plan."	• Recommendation: Revise the CAN Provider Manual to indicate well child care services are covered benefits.
• Onsite discussion indicated Peer Support Services are covered as a behavioral health benefit; however, the benefit grids in the CAN Provider Manual, page 12, and in the CAN Member Handbook, page 39, do not indicate this as a covered service. Also, the CHIP Provider Manual, page 10, and the CHIP Member Handbook, page 32, do not indicate Peer Support Services as a covered service.	• Recommendation: Revise the CAN Provider Manual to indicate peer support services are covered benefits. Revise the CAN Member Handbook, CHIP Provider Manual, and the CHIP Member Handbook to indicate peer support services is a covered benefit.
• The CHIP Provider Manual, page 56, defines appointment access standards for behavioral health providers, but does not include the requirement that appointments after discharge from an acute psychiatric hospital are required within 7 days.	• Corrective Action: Revise the CHIP Provider Manual, page 56, to include the seven-day timeframe for appointments after discharge from an acute psychiatric hospital.
• Some provider entries in the printed and online CAN and CHIP provider directories do not include hours of operation, as required by the *CAN Contract Section 6 (E) (11)* and *the CHIP Contract Section 6*	• Recommendation: Develop and implement processes to gather information about providers'

Weaknesses Related to Access to Care	Corrective Actions / Recommendations Related to Access to Care
(E) (5). Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing also states provider directories must include "Identification of hours of operation including identification of Providers with non-traditional hours…"	hours of operation and include this information in the CAN and CHIP provider directories.
• Service Authorization requests are completed within timeframe requirements according to policy guidelines and CAN and CHIP contract requirements.	• Recommendation: Ensure the embedded links for the PDL and OTC medications on page 33 of the CAN Member Handbook are in working order.
• For CAN and CHIP, appeals instructions posted on the member website are not available in Spanish like other materials, such as the Member Handbook and member rights and responsibilities.	• Recommendation: Post appeals instructions in Spanish on the CAN and CHIP member website to be consistent with other member materials such as the Member Handbook and Member rights and responsibilities and to ensure information is readily accessible to Spanish-speaking members.
• For CHIP, the "Your Additional Rights" document enclosed with appeal resolution letter does not include information that members have the right to request and receive benefits while the Independent External Review is pending and that the member can be held liable for the cost.	• Corrective Action Plan: Edit the "Your Additional Rights" enclosure for CHIP appeal letters to include information that members have the right to request and receive benefits and can be held liable for the cost, according to requirements in the *CHIP Contract, Section E (14) (d).*

METHODOLOGY

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

On July 6, 2021, CCME sent notification of the initiation of the annual EQR to United (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN and CHIP Programs.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for purposes of providing United an opportunity to seek clarification on the review process and ask questions regarding any of the 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 10, 2021, for review at the CCME offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on October 4, 2021, and October 5, 2021. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with United's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*, and the Contract requirements between United and DOM. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

I. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

United has policies and procedures to guide business operations. Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, defines procedures for the annual review and revision of policies and

procedures. Operational relationships are clearly identified in United's Organizational Chart and are sufficient to ensure that all health care services required by the State of Mississippi are provided to members.

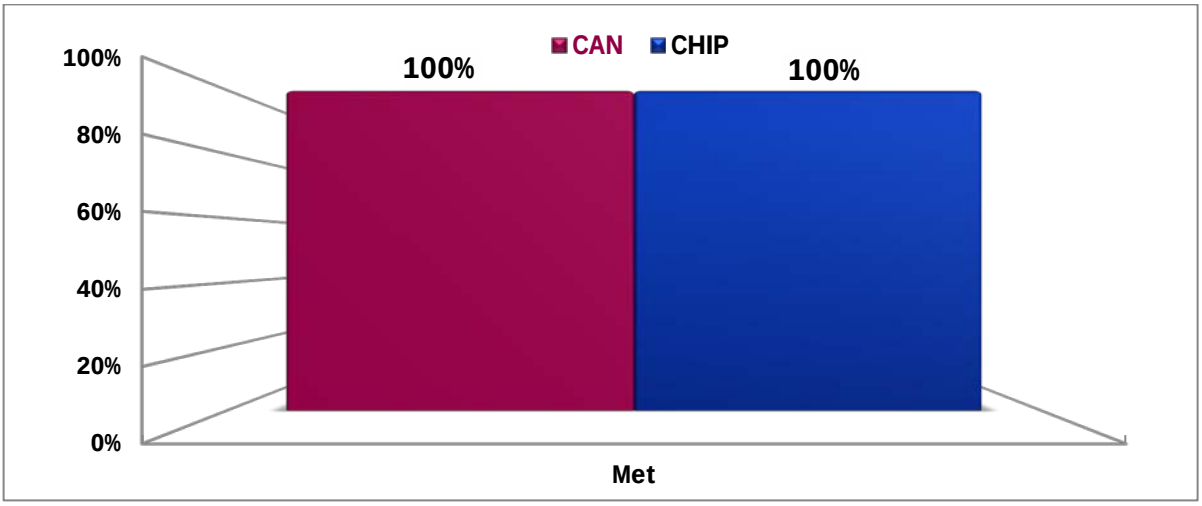
United has provided documentation indicating it has an Information System infrastructure capable of meeting the requirements of Mississippi's contracts. The infrastructure is managed in accordance with policies that prioritize data security and system resilience. Additionally, United regularly performs risk assessments to identify potential risks to its infrastructure and to aid the organization in implementing preventive measures. Finally, revision timestamps indicate the organization regularly reviews and updates its documentation.

Lines of communication are outlined in the Provider Manuals and Member Handbooks and provide reporting options for Optum's Anti-Fraud and Recovery Solutions (AFRS) unit and DOM. The UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2020-2021 outlines dedicated approaches to prevention, detection, reporting, corrective action, and best practices. The Group Code of Conduct emphasizes United's efforts made towards representing the highest level of personal and institutional integrity. The role and responsibilities of the Compliance Officer and the Compliance Oversight Committee are detailed in the Mississippi addendum to the Fraud, Waste, and Abuse Program. Training and education are provided to assess the state of the Compliance Program and to ensure that it effectively prevents, detects, and corrects violations of applicable laws, regulations, guidance, government contract requirements, company policies, and ethical guidelines.

The 2020-2021 UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program describes the process of scheduled and unscheduled FWA Program compliance and performance audits. Allegations and facts are reviewed by United and DOM on a case-by-case basis. The CAN Investigative Process document outlines the steps developed to conduct consistent investigations for fraud investigations performed by United's Special Investigations Unit and implemented sanction(s) in responses to identified offenses.

In the Administration section of the review, United received "Met" scores for 100% of the standards reviewed, as illustrated in *Figure 3: Administration Findings*.

Figure 3: Administration Findings



Strengths

- Staffing is in place for Member Services and Provider Relations teams, and in United's Call Center to enhance care access and provide education specific to service provision.
- United processes provider claims at a rate that exceeds the State's requirements.
- Fraud reporting options are available on United's website, internal and external handbooks, manuals, and newsletters.
- The document entitled Investigative Process provides an overview of the investigative process and departmental steps for the timely review of fraud investigations performed by United and the Special Investigations Unit.

II. Provider Services

42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260

The review of Provider Services focused on policies and procedures, provider education, provider network access and availability, credentialing and recredentialing processes and files, clinical practice and preventive health guidelines, and the provider satisfaction survey.

Provider Credentialing and Selection

42 CFR § 438.214, 42 CFR § 457.1233(a)

The corporate Board of Directors delegates responsibility and authority for credentialing and recredentialing to the National Credentialing Committee (NCC). The NCC communicates credentialing and recredentialing decisions to the health plan's Provider Advisory Committee (PAC), which serves as the local Credentialing Committee. The PAC, chaired by the health plan's Chief Medical Officer and reporting to the Quality

Management Committee, reviews and approves all credentialing decisions made by the NCC. Membership of the PAC includes participating Mississippi network providers with an array of specialties, and the committee meets at least four times yearly. The quorum is established as the presence of 51% of voting members.

Processes and requirements for initial and ongoing credentialing of providers for United's network are documented in the UnitedHealthcare Credentialing Plan 2021 – 2023 (Credentialing Plan), the State and Federal Regulatory Addendum Attachment E to the UnitedHealthcare Credentialing Plan, the United Behavioral Health (Optum) Clinician Credentialing Process policy, and in associated policies and procedures. The process for collecting fingerprints for CHIP providers designated as high-risk by DOM was not identified in any of the credentialing documentation reviewed. During onsite discussion , United staff were unable to verbalize the process for collecting fingerprints or who is responsible for this activity.

Review of initial credentialing and recredentialing files for independent practitioners revealed issues related to:

- Failure to collect the complete collaborative agreement between nurse practitioners and their collaborating physicians (CAN).
- Failure to include the date the query of the Mississippi State Board of Medical Licensure was conducted on the verification screenshot.

For organizational providers, issues were noted related to CLIA verification and queries of the MS DOM Sanctioned Provider List, including:

- Failure to include verification of providers' Clinical Laboratory Improvement Amendments (CLIA) certificates or certificates of waiver in three files. For these files, verification of the CLIA was submitted, but the verifications were dated October 6, 2021, which was after completion of the onsite visit.
- There was no evidence of querying the MS DOM Sanctioned Provider List for three CAN providers. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted.
- One CAN file included a screenshot labeled as the query of the MS DOM Sanctioned Provider List, but there was no way to confirm as there was no identifying information on the screenshot.
- Three CAN files contained screenshots labeled as the query of the MS DOM Sanctioned Provider List, but they appeared to be general searches on DOM's main website and not queries of the MS DOM Sanctioned Provider List. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted.

The current EQR revealed that issues in credentialing/recredentialing files related to queries of the MS DOM Sanction Provider List continue. In the response to the 2020 Corrective Action Plan, United indicated processes had been changed and staff had been educated regarding querying the MS DOM Sanctioned Provider List. See *Table 17: Previous Provider Credentialing and Selection CAP Items* below. United should implement a monitoring process to ensure credentialing and recredentialing files contain appropriate evidence of required queries.

Table 17: Previous Provider Credentialing and Selection CAP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing – CAN and CHIP	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	File review findings for CAN and CHIP organizational providers include: •All initial credentialing files for organizational providers contained evidence that the MS DOM Sanctioned Provider List was checked, but for three of the files, the date the MS DOM Sanctioned Provider List was updated was not captured on the document included in the file. During onsite discussion, United staff stated they would follow-up with CCME, but no additional information was provided. •All recredentialing files for organizational providers contained screenshots of the SAM query; however, four of the screenshots did not display the date the query was conducted. •Three recredentialing files for organizational providers included screenshots of the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) query; however, the screenshots did not display the date the query was conducted. •One recredentialing file for an organizational provider did not contain evidence of the query of the OIG LEIE. *Corrective Action: Ensure the date the MS DOM Sanctioned Provider List was updated is included on screenshots captured as evidence of query. Ensure primary source verification of the SAM includes the date the query was conducted. Ensure primary source verification of the OIG LEIE is included in all files and that it includes the date the query was conducted.*
United's Response: United enabled document printing properties for each credentialing processor to capture the date the query was conducted. Staff have been educated and shown how to automatically populate the source document date. United will capture screen shots of the date and time stamp on the computer screen for evidence.	

Policy PS13, Provider Terminations, addresses processes followed when United decides to terminate a provider from its network. The Credentialing Plan describes the roles of the National Peer Review and Credentialing Policy Committee, Regional Peer Review

Committees, and Medical Directors in suspending, restricting, or terminating a provider's participation in the network for quality of care concerns. It also addresses the role of the Hearing Panel when a provider appeals a decision to suspend, restrict, or terminate network participation. United's process for responding to notification that DOM has terminated a provider is included in United's Fraud, Waste and Abuse Program 2020-2021. When United is notified, the health plan immediately terminates the provider and provides written notification to the terminated provider within one day and to affected members within 48 hours.

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

United ensures CAN and CHIP members have consistent and convenient access to medical providers by annually assessing access to and availability of providers and, as necessary, implementing action plans to address identified issues. Geographic access standards for the CAN and CHIP provider networks are defined in Policy PS3, Geographic Access Standards, and are compliant with contractual requirements. Submitted Geo Access reports indicate quarterly geographic assessments are conducted. The reports provide a breakdown of member access by provider specialty and by rural and urban designations.

Primary care providers (PCPs) are notified of assigned members within five business days of the date United receives the Member Listing Report from DOM. United also makes member panel details available to all participating PCPs via its secure provider portal. PCPs can communicate desired panel restrictions to United during initial credentialing and/or contracting and can request changes to their panel at any time through the secure provider portal or by communicating with United. Quarterly reports are generated that indicate providers who are not accepting new patients. These are routinely reviewed to ensure there are sufficient providers in the network accepting new patients to meet member needs.

Appointment access standards are defined in Policy PS2, Access Standards – Appointment Availability Requirements, and are compliant with contractual requirements. United conducts quarterly assessments of PCP, OBGYN, and BH provider compliance to the standards. Quarterly and annual assessments are conducted to determine compliance by high-volume specialists. Results are reported to the SQIS for monitoring, tracking, trending, identification of improvement opportunities, and development of corrective action initiatives. Failure to meet access requirements results in direct outreach to providers.

Excel spreadsheets documenting results of appointment access and afterhours access call studies conducted by DialAmerica were submitted. Review of these documents indicated:

- For appointment access, the percentages of providers requiring corrective action are increasing for Peds (>35%) and OBGYN (>59%). The percentages for BH (>40%))and PCPs (>23%) are trending down from the previous quarter.
- For after-hours access, the percentages of providers requiring corrective action is increasing for PCPs (62.42%), OBGYNs (25.93%), and Peds (46.67%). The percentage for BH providers has consistently been at or above 50%, most recently at 61.36%.

Onsite discussion of these findings indicated that providers continue to face challenges related to the COVID-19 pandemic and that United reinforces requirements for appointment availability and after-hours access with providers during monthly "town hall" meetings, in provider bulletins, and during one-on-one sessions with providers.

United's CAN and CHIP websites include the "Find A Provider" function that allows users to search for providers by various parameters, including name, specialty, etc. The print versions of the CAN and CHIP Provider Directories are available for download from the health plan's website and are available upon request. Some provider entries in the printed and online provider directories do not include hours of operation, as stated in Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing, and as required by the *CAN Contract Section 6 (E) (11)* and the *CHIP Contract Section 6 (E) (5)*.

United's Multicultural Health Care Program includes various activities to ensure its network can serve members with special needs, foreign language, and cultural requirements. These activities include, but are not limited to:

- Assessments of race, ethnicity, and language demographics for members and providers at least every 3 years to identify language/cultural gaps and to determine if changes in language services are needed.
- Measurement of health care disparities using HEDIS data to identify opportunities and develop action plans.
- Measurement of member satisfaction via annual CAHPS surveys.

United does not have a formal, written Cultural Competency Plan; however, information is available on the provider portal, in Provider Manuals, newsletters, etc.

The current EQR confirmed United addressed items related to Availability of Services that were identified during the 2020 EQR. See *Table 18: Previous Availability of Services CAP Items*.

Table 18: Previous Availability of Services CAP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network – CAN	
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	Policy PS3, Geographic Access Standards, defines the specialist geographic access standards for United's provider network. The most recent Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CAN Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural. CCME noted the goal of 90% of members with access to various specialties is not met for some specialty types. During onsite discussion, United acknowledged this finding and confirmed they continue to target and work toward securing contracts with the needed specialty types. *Corrective Action: Ensure Geo access reports are run using the contractually-required standard for Emergency Care Providers.*
United's Response: The Geographic Access Report was updated to run the contractually required standard for Emergency Care Providers (see pages 3 and 5). Supporting Documentation: CAN 02_Attachment 1_UHC CAP_MSCAN GEO Access Reports	
II B. Adequacy of the Provider Network – CHIP	
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	Policy PS3, Geographic Access Standards, defines the specialist geographic access standards for United's provider network. The most recent Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CHIP Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural. CCME noted the goal of 90% of members with access to various specialties is not met for some specialty types. During onsite discussion, United acknowledged this finding and confirmed they continue to target and work toward securing contracts with the needed specialty types. *Corrective Action: Ensure Geo access reports are run using the contractually-required standard for Emergency Care Providers.*
United's Response: The Geographic Access Report was updated to run using the contractually required standard for Emergency Care Providers (see pages 3 and 5). Supporting Documentation: •CHIP 12_Attachment 1_UHC CAP_CHIP GEO Access Report	

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for new provider orientation and education are found in Policy PS14, Provider Orientation Plan, and in SOP-PS14, Standard Operating Procedure – Provider Orientation Plan Summary & Checklist. Provider Advocates are assigned to new providers and are responsible for placing welcome calls to answer any immediate questions and to schedule an on-site orientation within 30 days of the contract effective date. United uses various methods and forums for initial and ongoing provider education, such as virtual forums, mailings, bulletins, one-to-one sessions, etc.

United's website and its CAN and CHIP Care Provider Manuals (Provider Manuals) include essential information needed by providers for understanding the CAN and CHIP Programs and provider obligations as participants in the health plan's networks. The Provider Manuals are very detailed; however, a few issues were identified:

- The benefits grid in the CAN Provider Manual, page 11, indicates "well child care" is not covered; but, the CAN Member Handbook, page 12, states "All well-child visits and immunizations are covered by your plan."
- United confirmed that Peer Support Services are covered under the BH benefits for CAN and CHIP; however, the benefit grids in the CAN Provider Manual, page 12, the CAN Member Handbook, page 39, the CHIP Provider Manual, page 10, and the CHIP Member Handbook, page 32, do not indicate this as a covered service.
- The CAN and CHIP Provider Manuals do not include the timeframe required for medical record retention.
- The CHIP Provider Manual defines appointment access standards for BH providers but does not include the requirement that appointments after discharge from an acute psychiatric hospital are required within 7 days.

Related to the finding that the Provider Manuals do not specify the medical record retention timeframes, review of the provider contract templates revealed discrepancies in the timeframes for medical record retention by providers:

- The Ancillary Provider Participation Agreement, Facility Participation Agreement, FQHC/RHC Participation Agreement, and Medical Group Participation Agreement specify the timeframe as 6 years.
- The MississippiCHIP Regulatory Requirements Appendix Downstream Provider template indicated the medical record retention timeframe is not less than 5 years.
- The Facility Contract, Group Contract, and Individual Contract submitted for CHIP indicated the medical record retention timeframe is 3 years.

United reviews and adopts preventive guidelines (PHGs) and clinical practice guidelines (CPGs) that are nationally recognized and include recommendations for childhood, adult, and geriatric population preventive care and clinical care guidelines for a host of conditions and diagnoses pertinent to the member population. The Medical Technology Assessment Committee (MTAC) is responsible for reviewing the guidelines at least every 12 months. The Provider Manuals include information about the PHGs and CPGs, and states United endorses and monitors use of the guidelines.

The current EQR confirmed United addressed and corrected items related to Provider Education that were identified during the 2020 EQR. See *Table 19: Previous Provider Services CAP Items*.

Table 19: Previous Provider Education CAP Items

Standard	EQR Comments
II C. Provider Education – CAN	
2.3 Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CAN Provider Manual and CAN Member Handbook. When comparing the CAN Provider Manual and CAN Member Handbook information for the current EQR, CCME again noted numerous discrepancies, including: •The CAN Provider Manual states there is a limit of 25 home health services visits per calendar year for adults. The CAN Member Handbook states the limit is 36 visits per calendar year for adults. •The CAN Provider Manual says prior authorization is required for hospice. The CAN Member Handbook states no prior authorization is required. •The CAN Provider Manual states medical supplies are covered but lists limitations and states prior authorization is required to exceed those limitations. The CAN Member Handbook states medical supplies are covered with no prior authorization required. •The CAN Provider Manual states non-emergency transportation services are covered but lists limitations and states to call Member Services to arrange. The CAN Member Handbook does not include limitations and states to call MTM to arrange. •The CAN Provider Manual states prior authorization is required for outpatient PT/OT/ST when provided by home health agencies. The CAN Member Handbook states prior authorization is required.

Standard	EQR Comments
	•The CAN Provider Manual states human solid organ (heart, lung, liver, kidney) or bone marrow/stem cell transplants are covered with prior authorization. It does not include cornea transplant, which is included in the CAN Member Handbook. •The CAN Provider Manual lists skilled nursing facility coverage and requirements in the benefits grid. There is no information related to coverage for skilled nursing facilities in the CAN Member Handbook. •The CAN Provider Manual includes Physician Services for Long-Term Care Visits in the benefits grid, but the CAN Member Handbook does not. •The CAN Provider Manual lists Skilled Nursing Services along with Private Duty Nursing Services in the benefit grid but the CAN Member Handbook does not include Skilled Nursing Services. *Corrective Action: Update the 2020 CAN Provider Manual and/or the CAN Member Handbook to ensure correct and consistent information about member benefits is included in both.*

United's Initial Response 1/19/21:

•The CAN Provider Manual, CAN Member Handbook and CAN Member Benefit Grid were updated to include the requirements as outlined. Going forward, documents will be reviewed on a quarterly basis to ensure consistency.

•The CAN Provider Manual was updated to accurately represent 36 visits per calendar year for home health services (see page 13), remove nursing facility benefits as they are administered through the Division of Medicaid, and remove physician services for long-term care visits as they are administered through the Division of Medicaid.

•The CAN Member Handbook was updated to match the language in the CAN Provider Manual for hospice (see page 37), medical supplies (see page 38), non-emergency transportation services (see page 3), and outpatient PT/OT/ST (see page 39).

•The CAN Provider Manual and the CAN Member Handbook were updated to remove the notes for transplant services and update the information for skilled nursing services.

Supporting Documentation:
CAN 03_05_Attachment 1_UHC CAP_MS Provider Manual_MSCAN_DRAFT
CAN 03_Attachment 2_UHC CAP_CAN Member Handbook_DRAFT
CAN 03_Attachment 3_UHC CAP_Member Benefit Grid

United's Revised Response 2/8/21:

•United updated the Member Benefit Grid to account for CCME comments, which is included in the CAN Member Handbook (pages 35-36) and will be inserted into the CAN Provider Manual (pages 12-16).

•There are no limitations for hospice services, therefore that language was removed in both the CAN Member Handbook and CAN Provider Manual.

Standard	EQR Comments
•United updated the CAN Member Handbook (page 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the same language for medical supplies. •United updated the CAN Member Handbook (pages 14-15; 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the same language for non-emergency transportation. •United updated the CAN Member Handbook (page 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the same language for outpatient PT/OT/ST. •United updated the CAN Member Handbook (page 36) and the Member Benefit Grid which will be inserted into the CAN Provider Manual, to reflect the limitations for transplant services. •United updated the Member Benefit Grid which will be inserted into the CAN Provider Manual, to remove nursing facility benefits. •United updated the Member Benefit Grid which will be inserted into the CAN Provider Manual, to remove physician services for long-term care visits. •United updated the Member Benefit Grid which will be inserted into the CAN Provider Manual, to remove skilled nursing services. Supporting Documentation: CAN 03_Attachment 1_UHC CAP_Updated Member Benefit Grid CAN 03_Attachment 2_UHC CAP_Member Handbook_UPDATED CAN 03_Attachment 3_UHC CAP_MS CAN Provider Manual_UPDATED	
II C. Provider Education – CHIP	
2.3 Initial provider education includes: 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;	During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CHIP Provider Manual and Member Handbook. When comparing the CHIP Provider Manual and Member Handbook information for the current EQR, CCME again noted numerous discrepancies, including: •The CHIP Provider Manual does not include Parenting Education as a benefit, but the CHIP Member Handbook does. •For Prosthetic/Orthotic Devices, the CHIP Provider Manual does not include the coverage restrictions for orthotic shoes that are included in the CHIP Member Handbook. •For Speech Therapy, the CHIP Provider Manual does not include the restrictions on maintenance speech therapy that are found in the CHIP Member Handbook. *Corrective Action: Update the CHIP Provider Manual and/or the CHIP Member Handbook to ensure correct and consistent information about member benefits is included in both.*
United's Initial Response 1/19/21: •The CAN Provider Manual, CAN Member Handbook and CAN Member Benefit Grid were updated to include the requirements as outlined. Going forward, documents will be reviewed on a quarterly basis to ensure consistency.	

Standard	EQR Comments
•The CHIP Member Handbook was updated to match the CHIP Provider Manual for parenting education, prosthetic/orthotic devices. •The CHIP Provider Manual was updated to match the CHIP Member Handbook for speech therapy. Supporting Documentation: CHIP 13_14_16_Attachment 1_UHC CAP_MS Provider Manual_CHIP_ DRAFT CHIP 13_Attachment 2_UHC CAP_CHIP Member Handbook_DRAFT CHIP 13_Attachment 3_UHC CAP_Member Benefit Grid **United's Revised Response 2/8/21:** •United updated the Member Benefit Grid to account for CCME comments, which is included in the CHIP Member Handbook (see pages 29-30) and will be inserted into the CHIP Provider Manual (see pages 7-9). •United updated the CHIP Member Handbook (see page 29) and the Member Benefit Grid which will be inserted into the CHIP Provider Manual, to reflect Parenting Education. •United updated the CHIP Member Handbook (see page 30) and the Member Benefit Grid which will be inserted into the CHIP Provider Manual, to reflect maintenance speech therapy. Supporting Documentation: CHIP 13_Attachment 1_UHC CAP_Updated Member Benefit Grid CHIP 13_Attachment 2_UHC CAP_Member Handbook_UPDATED CHIP 13_Attachment 3_UHC CAP_CHIP Provider Manual_UPDATED	
2.7 Initial provider education includes: Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	The PCP Responsibilities section of the CHIP Provider Manual does not clearly state the responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule. Refer to CHIP Contract Section 7 (H) 2 (m). *Corrective Action: Revise the CHIP Provider Manual to include the PCP's responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule.*
United's Response: The CHIP Provider Manual was updated to include the PCP's responsibility to follow up as required. Supporting Documentation: CHIP 13_14_16_Attachment 1_UHC_CAP_ MS Provider Manual_CHIP_DRAFT	

Processes and requirements for provider medical record reviews are detailed in Policy NQM-025, Ambulatory Medical Record Review Process, and its associated attachments. The medical record review process is conducted to monitor and assess provider compliance with medical record documentation standards. The policy describes the processes followed when providers have a failing score for the medical record review, which include education, support, and a follow-up review. Onsite discussion confirmed

the additional review of providers who have failing scores is conducted during the next year's medical record audit. However, the timing of the additional review is not clear in Policy NQM-025 as currently written.

Provider Satisfaction Survey Validation

The provider satisfaction survey, revised in 2020 to include new questions to better understand the experience of providers and their perceptions of the health plan, was administered by Escalent, an independent research company, on behalf of United. The response rate was 1.9% with 57 providers completing the survey out of 2,958. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution.

The 2020 results indicate that overall satisfaction has increased, with significantly more providers rating United favorably in 2020 (80%) versus 63% in 2019. The domain areas with the highest ratings included specialty network, practice support, cultural competency and language assistance, customer service, and member support. Prior authorization, appeals, reimbursement, and pharmacy are the four domain areas with the opportunity for improvement. Results were presented to the QMC during the March 2021 meeting.

Table 20 below offers the section of the worksheet that needs improvement, the reason, and the recommendation.

Table 20: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 1.9% with 57 providers completing the survey out of the 2,958. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution.	Work on action plan steps per the report including increasing email quality and survey advertisement to improve response rates.

As noted in *Figure 4, Provider Services Findings*, United received "Met" scores for 95% of the Provider Services standards for CAN and 94% of the standards for CHIP.

Figure 4: Provider Services Findings

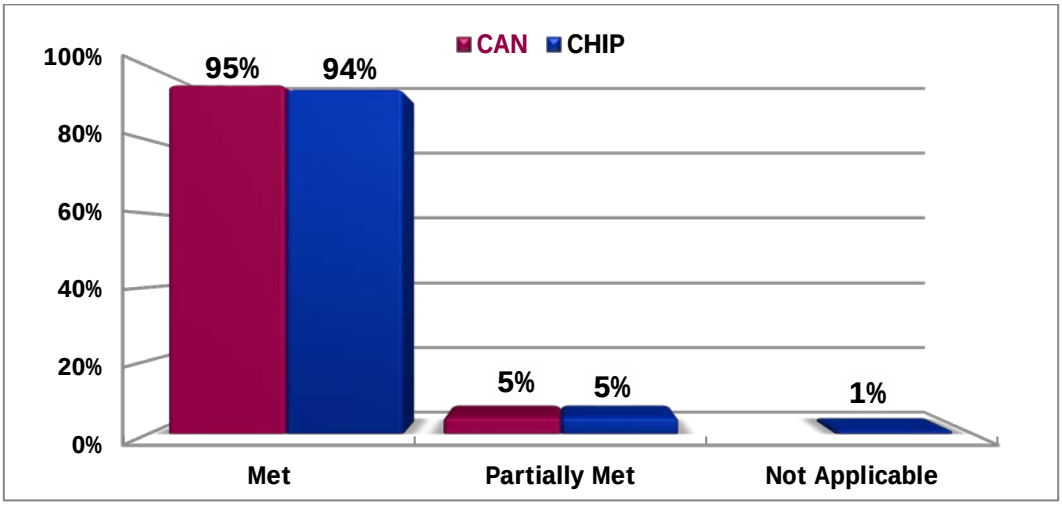


Table 21: Provider Services

Section	Standard	CAN 2021 Review	CHIP 2021 Review
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Partially Met	Met
	Recredentialing processes include all elements required by the contract and by the CCO's internal policies	Partially Met	Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met
Provider Education	Initial provider education includes: Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Partially Met
	Initial provider education includes: Medical record handling, availability, retention, and confidentiality	Partially Met	Partially Met

Strengths

- United's Provider Advisory Committee (PAC), which serves as the local Credentialing Committee, is chaired by the Chief Medical Officer and membership includes

participating MS providers with an appropriate array of specialties to represent the network.

- Appropriate processes are in place for notifying affected providers and members when DOM terminates a provider's participation in Medicaid or United terminates a provider's participation in the health plan's provider network.
- United is compliant with contractual provider geographic access and appointment availability standards.
- United's Multicultural Health Care Program includes various activities to ensure its network can serve members with special needs, foreign language, and cultural requirements.
- Although the corporate MTAC recommended removing the clinical practice guideline for Sickle Cell Disease in 2021, United successfully advocated for the guideline to be reimplemented.

Weaknesses

- The process for collecting fingerprints for CHIP providers designated as high-risk by DOM was not identified in any of the credentialing documentation reviewed. Refer to the *CHIP Contract, Section 7 (E) 6*.
- Issues identified in initial independent practitioner credentialing files included:
    - The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians, and onsite discussion indicated this is United's practice. However, one CAN nurse practitioner initial credentialing file did not include the complete collaborative agreement.
- Issues identified in independent practitioner recredentialing files included:
    - The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians, and onsite discussion indicated this is United's practice. However, two CAN recredentialing files for nurse practitioners did not include the complete collaborative agreement.
    - For one CAN provider file, CCME was unable to determine the date of the board query conducted to verify active licensure on the screenshot included in the file.
- Issues identified in initial credentialing and recredentialing files for CAN and CHIP organizational providers included:
    - One file for a rural health clinic and one file for an inpatient hospice included a CLIA number on the provider's application but no verification of the CLIA in the

file. Evidence of the verifications was submitted after completion of the onsite visit, but they were conducted on October 6, 2021.

- One file for a hospital included a CLIA verification date on the credentialing checklist, but no other evidence of verification of the CLIA in the file. Evidence of the verification was submitted after completion of the onsite visit, but it was conducted on October 6, 2021.
- There was no evidence of querying the MS DOM Sanctioned Provider List for three providers. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted.
- One file included a screenshot labeled as the query of the MS DOM Sanctioned Provider List, but there was no way to confirm as there was no identifying information on the screenshot.
- Three files contained screenshots labeled as the query of the MS DOM Sanctioned Provider List, but they appeared to be general searches on DOM's main website and not queries of the MS DOM Sanctioned Provider List. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted.

- The benefits grid in the CAN Provider Manual, page 11, indicates "well child care" is not covered; but, the CAN Member Handbook, page 12, states "All well-child visits and immunizations are covered by your plan."
- Onsite discussion indicated Peer Support Services are covered as a behavioral health benefit; however, the benefit grids in the CAN Provider Manual, page 12, and in the CAN Member Handbook, page 39, do not indicate this as a covered service. Also, the CHIP Provider Manual, page 10, and the CHIP Member Handbook, page 32, do not indicate Peer Support Services as a covered service.
- The CHIP Provider Manual, page 56, defines appointment access standards for behavioral health providers, but does not include the requirement that appointments after discharge from an acute psychiatric hospital are required within 7 days.
- The *CAN Contract, Exhibit C, Section K* indicates medical records must be retained for a period of no less than 10 years. However, the CAN Provider Manual does not include the medical record retention requirement. Additionally, errors were noted in the timeframes for medical record retention in the following CAN provider contract/agreement templates:
  - Ancillary Provider Participation Agreement (6 years)
  - Facility Participation Agreement (6 years)
  - FQHC/RHC Participation Agreement (6 years)
  - Medical Group Participation Agreement (6 years)

- The *CHIP Contract, Exhibit D, Section J* indicates medical records must be retained for a period of no less than 10 years. However, the CHIP Provider Manual does not include the medical record retention requirement. Additionally, errors were noted in the timeframes for medical record retention in the following CHIP provider contract/agreement templates:
    - Ancillary Provider Participation Agreement (6 years)
    - Facility Participation Agreement (6 years)
    - FQHC/RHC Participation Agreement (6 years)
    - Medical Group Participation Agreement (6 years)
    - MississippiCHIP Regulatory Requirements Appendix Downstream Provider (5 years)
    - Facility Contract (3 years)
    - Group Contract (3 years)
    - Individual Contract (3 years)
- Some provider entries in the printed and online CAN and CHIP provider directories do not include hours of operation, as required by the *CAN Contract Section 6 (E) (11)* and the *CHIP Contract Section 6 (E) (5).* Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing also states provider directories must include "Identification of hours of operation including identification of Providers with non-traditional hours…"
- Policy NQM-025 describes medical record audit processes. Onsite discussion confirmed additional review of providers who have failing scores is conducted during the next year's medical record audit. However, Policy NQM-025, as currently written, does not make this clear. For example, the information about the additional review is addressed prior to a statement that indicates final results may be presented to the applicable health plan committee upon final closure of the medical record review.
- The response rate for the Provider Satisfaction Survey was 1.9% with 57 of 2,958 providers completing the survey. This very low response rate may not reflect the population of providers. Thus, results should be interpreted with great caution.

Corrective Actions

- Develop and implement a process for collecting fingerprints for all CHIP providers designated as high risk by DOM at initial credentialing. The process must be detailed in a policy and evidence of fingerprint collection must be included in applicable provider credentialing files.
- Ensure credentialing and recredentialing files for nurse practitioners contain the complete collaborative agreement between the nurse practitioner and the collaborating physician(s).

- Ensure verification of CLIA is conducted prior to issuing the credentialing or recredentialing determination and that evidence is included in the provider file.
- Ensure queries of the MS DOM Sanctioned Provider List are included in each organizational provider's file and that it is clearly identifiable and includes the date the query was conducted.
- Revise the CHIP Provider Manual, page 56, to include the seven-day timeframe for appointments after discharge from an acute psychiatric hospital.
- Update the CAN and CHIP Provider Manuals to include the required medical record retention timeframe.
- Revise the following documents to reflect the correct medical record retention timeframe:
    - Ancillary Provider Participation Agreement
    - Facility Participation Agreement
    - FQHC/RHC Participation Agreement
    - Medical Group Participation Agreement
    - MississippiCHIP Regulatory Requirements Appendix Downstream Provider
    - Facility Contract
    - Group Contract
    - Individual Contract

Recommendations

- Ensure evidence of verification of active licensure conducted on the State Board of Examiners for the specific discipline includes an indication of the date of the verification.
- Revise the CAN Provider Manual, pages 11 and 12, to indicate well child care and peer support services are covered benefits. Revise the CAN Member Handbook, page 39, CHIP Provider Manual, page 10, and the CHIP Member Handbook, page 32, to indicate peer support services is a covered benefit.
- Develop and implement processes to gather information about providers' hours of operation and include this information in the CAN and CHIP provider directories.
- Revise Policy NQM-025 to clearly indicate the timeframe during which an additional review is conducted for providers who fail the initial medical record review.
- Work on action plan steps including increasing email quality and survey advertisement to improve Provider Satisfaction Survey response rates.

III. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Member Rights and Responsibilities are clearly outlined in United's policies and procedures as well as in the CAN and CHIP Member Handbooks, Provider Manuals, and the websites. Standards specific to Member Information Packets, ID Cards, service coverage and benefit limitations, 24-hour access to care, and information on disease and chronic condition programs were met. The Provider Manual did not include advanced directive information and associated forms.

The 2021 EQR review found that Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension was corrected based on the previous EQR findings, to include the verbiage on the requirement that written materials use a minimum 12-point font and items requiring large print are completed in 18-point font. *See Table 22: Previous Member CCO Program Education CAP Items.*

Table 22: Previous Member CCO Program Education CAP Items

Standard	EQR Comments
III B. Member CCO Program Education – CAN and CHIP	
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.	Policy MBR7, Member Materials/Sixth (6) Grade Level of Reading Comprehension and Policy MBR1b2, Notification of Oral Interpretation Services, describe and outline the processes United uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. CCME could not identify documentation of the requirement for member materials to have a minimum 12-point font for regular print items and 18-point font for large print items. During the onsite teleconference, United staff explained this requirement in documented in Policy MBR11a, Marketing Material. Upon review CCME still could not identify documentation of this requirement. This requirement was discussed during the 2019 EQR and a recommendation was made to address it. *Corrective Action Plan: Document the requirement to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font.*
United's Response: United's Member Materials Policy was updated to document the requirement to print written material using the correct font size. Supporting Documentation:	

Standard	EQR Comments
III B. Member CCO Program Education – CAN and CHIP	
CAN 04_Attachment 1_UHC CAP_Member Materials Policy CHIP 15_Attachment 1_UHC CAP_Member Materials Policy	

Training and scripts were provided demonstrating efforts to prepare Call Center staff to manage urgent, emergent, and routine communication with members. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committees. The Call Center Reports, completed quarterly, document that trends are reviewed and were clear in the coverage of the outcome measures referenced in the Contract standards. Policies and procedures are in place regarding member enrollment, disenrollment, and re-enrollment. The Preventive Health and Chronic Disease Management Education policies are in place, but also the onsite description of this year's annual initiatives and steps taken to educate and provide resource information to assist members was evident.

The 2021 EQR concluded that the CAN Member Handbook, CAN Provider Manual, and website were edited to reflect the correct hours of operations for Member Services and Provider Services call centers as discussed in the 2020 EQR. United has multiple toll-free contact numbers for members to call. These are labeled on the Member Services website, the "Have Questions?" section, and the CAN and CHIP Member Handbooks. As indicated in United's response to the 2020 EQR, United tracks calls generated from the website via a different phone number and the Member Services toll-free number is directed to the same call center.

Table 23: Previous Call Center CAP Items

Standard	EQR Comments
III C. Call Center – CAN	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	During the onsite teleconference, CCME discussed the following documentation issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services Call Centers: •The Member Services toll-free telephone number on the member website is not the same number that is listed in the CAN Member Handbook (1-877-743-8731) and in other materials. The CAN Contract, Section 6 (A) requires states that, "Members will be provided with one (1) toll free number, and the Contractor's automated system and call center staff will route calls as required to meet Members' needs."

Standard	EQR Comments
	•The Member Services hours in the Wellness Mailer are not consistent with hours in the Member Handbook on page 13. •The Provider Services hours on the CAN website are not consistent with operating hours in the CAN Member Handbook on page 13. •The Provider Services hours on page 5 of the CAN Provider Manual are not correct. •The Provider Services number in the Provider Manual (877-743-8734) is different than the number listed in the Spring 2020 Practice Matters newsletter (800-557-9933). *Corrective Action Plan: Edit the CAN Member Handbook, CAN Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services call centers as required in the CAN Contract, Section 6 (A) and Section 7 (H) (1) and ensure consistent documentation of such across the respective areas.*
United's Response: Updates were made to the Wellness Mailer and CAN Provider Manual as required by the contract to ensure consistent documentation. The Member Services toll-free telephone number is correct in the CAN Member handbook, CAN Provider Manual and other materials. United tracks calls generated from the website via a different phone number that is currently routed to member services. This website enhancement helps the health plan better support its Medicaid members. •The hours on the Wellness Mailer have been updated to match the Member Handbook. •The operating hours for member services listed on the website are consistent with the CAN Member Handbook on page 13. The Provider Services hours are not listed on the member services website. •The CAN Provider Manual was updated with correct hours of service (see page 8). Supporting Documentation: CAN 03_05_Attachment 1_UHC CAP_MS Provider Manual_MS CAN_DRAFT CAN_05_Attachment 2_UHC CAP_Wellness Mailer	
III C. Call Center – CHIP	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	United maintains a Member Services Call Center, Provider Services Call Center, and 24-Hour NurseLine. In addition, members can access a 24-hour behavioral health hotline staffed with mental health professionals and TTY 711 relay is communicated in several areas. During the onsite teleconference, CCME discussed the following documentation issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services: •The CHIP website, under the "See more benefits and features" section, informs members they can call Member Services and the NurseLine, however it does not provide the telephone number to call.

Standard	EQR Comments
	•The Member Services hours of operation listed in the CHIP Member Handbook are not consistent with the hours listed on the CHIP website. •The tollfree number for Provider Services is correctly listed on page 6 in the CHIP Provider Manual, but incorrectly on page 20 as 888-980-8728. •The CHIP Provider Manual does not have hours of operation for Provider Services Call Center listed. *Corrective Action Plan: Edit the CAN Member Handbook, CAN Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services call centers as required in CAN Contract, Section 6 (A) and Section 7 (H) (1) and ensure consistent documentation of such across the respective areas.*
United's Response: Updates were made to the CHIP Website and CHIP Provider Manual as required by the contract to ensure consistent documentation. •The CHIP website was updated to include the correct telephone number as required. •The CHIP website was updated to include the correct hours as required. •The section on page 20 of the CHIP Provider Manual lists the number 888-980-8728, which is for contacting the Utilization Management Team. Therefore, no update is required. •The CHIP Provider Manual was updated to include hours of operation for the Provider Services Call Center. Supporting Documentation: CHIP 13_14_16_Attachment 1_UHC CAP_MS Provider Manual_CHIP_DRAFT CHIP 16_Attachment 2_UHC CAP_Website Changes	

Grievances

42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Grievances are defined and members are provided with options for who may file a grievance orally or in writing as described in Policy POL2015-01, the Member Handbook, Provider Manual, and on the website. Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance captures the process for filing a grievance, which is reflected in the Member Handbook. Information on timelines is outlined in policy by acknowledging grievances within 5 calendar days with a resolution within 30 calendar days. United updated CAN and CHIP policies and documents to accurately reflect that grievance information will be retained "during the entire term of this Contract and for a period of 10 years thereafter."

The 2021 EQR found information on grievance procedures was included on the non-secured section of the CAN website. This had been a deficiency identified during the 2020 EQR, which has since been resolved.

Table 24: Previous Grievances CAP Items

Standard	EQR Comments
III G. Grievances - CAN	
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: 1.2 The procedure for filing and handling a grievance;	CCME did not identify grievance procedures and instructions on the CAN website. During the onsite teleconference, United staff confirmed that grievance information is located on the Member Portal and not on the public website. However, the *CAN Contract, Section 6 (H)* requires the plan to provide specific up-to-date grievance information on a non-secure section of the website. The CAN Member Handbook and CAN Provider Manual correctly state grievances will be acknowledged in writing within 5 calendar days; however, the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) indicates acknowledgement in 10 calendar days. *Corrective Action Plan: Include information on grievance procedures on the non-secured section of the CAN website, as required in the CAN Contract, Section 6 (H). Correct the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) to indicate that grievances will be acknowledged in 5 calendar days.*
United's Response: United created a new link on the non-secure section of the website. UHC will review the non-secure section of the A&G website on a biannual basis, to ensure grievance procedures align with the contract. https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN Appeals_Grievance.pdf The A&G Policy (POL2015-01) contains the grievance acknowledgement of 5 calendar days (see page 18). Supporting Documentation: CAN 06_Attachment 1_UHC CAP_ Web A&G CAN 06_Attachment 2_UHC CAP_ MS A&G Policy POL2015-01	
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.	The POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, indicates grievance records are retained for a minimum of 10 years, however it does not specify that grievance records will be retained, "during the entire term of this Contract and for a period of 10 years thereafter," as required by the *CAN Contract Section 11 (A).* *Corrective Action Plan: Edit the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy to include the complete grievance requirement in the CAN Contract, Section 11(A).*

Standard	EQR Comments
United's Response: United's A&G Policy (POL2015-01) was revised to include the complete grievance requirement as stated in the CAN Contract. Supporting Documentation: CAN 07_Attachment 1_UHC CAP_MS A&G Policy POL2015-01_DRAFT	
III G. Grievances – CHIP	
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: 1.2 The procedure for filing and handling a grievance;	The procedure for filing a grievance is correctly described in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, and CHIP Provider Manual. CCME did not identify grievance procedures or instructions on the CHIP website. During the onsite teleconference, United staff confirmed that grievance information is located on the Member Portal and not on the public website. However, the *CHIP Contract, Section 6 (H)* requires the plan to provide specific up-to-date grievance information on a non-secure section of the website. The CHIP Member Handbook and CHIP Provider Manual correctly state grievances will be acknowledged in writing within 5 calendar days; however, the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) indicates 10 calendar days. *Corrective Action Plan: Include information on grievance procedures on the non-secured section of the CHIP website, as required in the CHIP Contract, Section 6 (H). Correct the Member Appeal, State Fair Hearing, External Appeal, and Grievance Policy (POL2015-01) to indicate that grievances will be acknowledged in 10 calendar days.*
United's Response: United created a new link on the non-secure section of the website and will review the non-secure section of the A&G website on a biannual basis, to ensure grievance procedures align with the contract. https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN-Appeals_Grievance.pdf The A&G Policy (POL2015-01) contains the grievance acknowledgement of 5 calendar days (see page 18). Supporting Documentation: CHIP 17_Attachment 1_UHC CAP_ Web A&G CHIP 17_Attachment 2_UHC CAP_ MS A&G Policy POL2015-01	
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;	The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy indicates grievance records are retained for a minimum of 10 years; however, it does not specify that grievance records will be retained "during the entire term of this Contract and for a period of 10 years thereafter," as required by the *CHIP Contract, Section 11 (A).*

Standard	EQR Comments
	Corrective Action Plan: Edit the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy to include the complete grievance requirement in the CHIP Contract, Section 11 (A).
United's Response: United's A&G Policy (POL2015-01) was revised to include the complete grievance requirement as stated in the CHIP Contract. Supporting Documentation: CHIP 18_Attachment 1_UHC CAP_MS A&G Policy POL2015-01_DRAFT	

Randomly selected files were reviewed to evaluate compliance with policies and procedures. For the sample reviewed, all standards for timeliness and letters of acknowledgement and resolution were met for the 2021 EQR review. United tracks, analyzes, and reports results of grievance trends to the SQIS quarterly, as described in the Utilization Management and Quality Improvement Program Description documents.

Member Satisfaction Survey

Member Satisfaction Survey validation for United CAN and CHIP was performed based on the CMS Survey Validation Protocol. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. United contracts with SPH Analytics Research, a certified Consumer Assessment of Healthcare Providers and Systems survey vendor, to conduct the Adult and Child Surveys. The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS.

For United CAN Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (14.7%) which included 237 completed surveys out of a sample of 1,614. For the Child CCC survey, generalizability of the survey results is also difficult to discern due to low response rates (10.8%) which included 214 completed surveys out of 1,973 sampled.

For United CHIP, the generalizability of the Child CCC survey results is difficult to discern due to low response rate of 15.9% (315 completed surveys out of 1,979 sampled). This is a decrease from last year's response rates although it was higher than the average United CHIP general population response.

The tables below offer the section of the worksheets that need improvement, the reasons, and the recommendations.

Table 25: ADULT CAHPS Survey Section, Reasons, and Recommendations (CAN)

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 14.7% - 237 completed surveys out of the sample of 1614. This is the same as the previous year. There were 234 completed in 2020.	Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts); oversample of 20% is still not impacting the response rate.

Table 26: CHILD CCC CAHPS Survey Section, Reasons, and Recommendations (CAN)

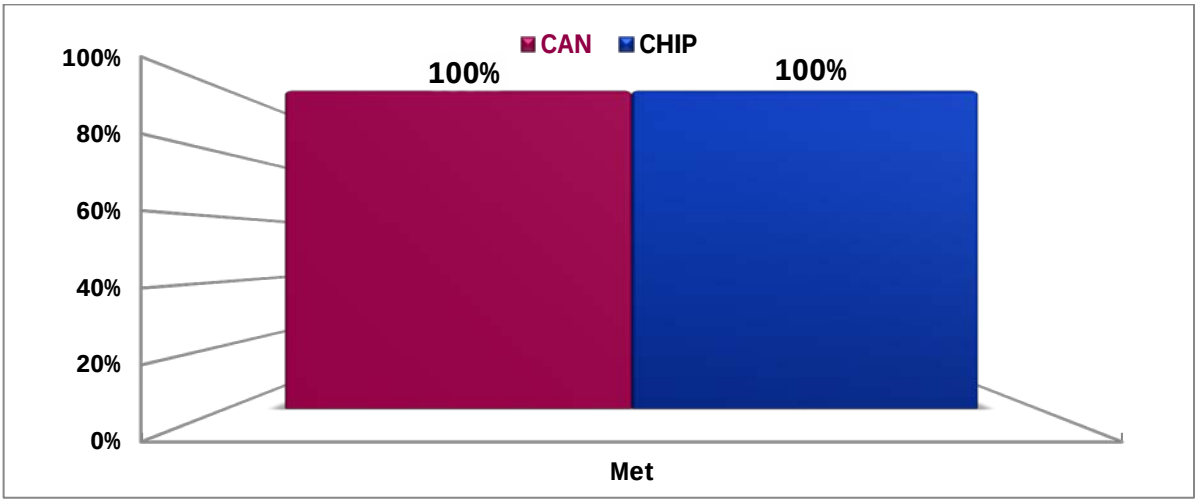
Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rates for general population and total population. The response rate was 10.8% (214 surveys out of 1,973 sample size). The previous rate for 2020 was 12.7%, so the response rate has declined from last year's survey.	Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts). The response rate has declined the past 3 years from 17.2% in 2019, to 12.7% in 2020, to 10.8% in 2021.

Table 27: CHILD CCC CAHPS Survey Section, Reasons, and Recommendations (CHIP)

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	The sample size for the general population was 1,979 with 315 completed surveys for a response rate of 15.9%. The response rates are below the NCQA target rate is 40%, but higher than the average national response rate of 12.6%. The 2021 response rate was lower than previous surveys which had 16.9% response rate in 2020 and 20.4% in 2019.	Continue to assess barriers that occur for completion of surveys for the Child CCC member population. Continue to work with SPH Analytics to improve response rates.

As noted in *Figure 5: Member Services Findings,* United achieved "Met" scores for 100% of the Member Services Standards.

Figure 5: Member Services Findings



Strengths

- Annual Disease Management goals are identified by United to reduce and prevent chronic health issues.
- All grievance files reviewed were acknowledged and resolved per timeliness guidelines.
- A new process was initiated by the Member Services and Marketing Teams to work with large provider groups to provide information to new members about the member portal to enhance access to care.

Weaknesses

- The CAN and CHIP Provider Manual does not provide information about Advance Directives.
- The generalizability of the Member Satisfaction Survey results is difficult to discern due to low response rates and small sample size.
- Some grievance resolutions letters did not contain language consistent with the grade level reading requirements outlined United's policy.

Recommendations

- Edit the CAN and CHIP Provider Manual to include information about Advance Directives and associated forms.
- Work on action plan steps including increasing email quality and survey advertisement to improve response rates. Continue working with SPH Analytics to increase survey sample sizes and response rates for Adult and Child surveys.

- Review the Grievances Resolution Letters containing the phrase "Quality and compliance unsubstantiated the complaint…." and consider verbiage to align with Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension.

IV. Quality Improvement

42 CFR §438.330, 42 CFR §457.1240(b), and 42 CFR Part 441, Subpart B

United has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided to all CAN and CHIP members. The QI program is managed at the health plan and no activities are delegated. Behavioral health services are administered by Optum Behavioral Health, a sister company of United. Several program descriptions were presented in the desk materials: the 2021 Quality Improvement Program Description for the CAN program, the 2021 Quality Improvement Program Description for the CHIP program, and the 2021 Behavioral Health Quality Improvement Program Description. The QI Program Description is updated annually and presented to the Board of Directors, Quality Management Committee, and the Division of Medicaid for approval.

The QI program description describes United's efforts to reduce health disparities through the Multicultural Health Care program. Three of the goals specific to the CAN population include improving the rates for breast cancer screenings, eye exams for diabetics, and member satisfaction. The specific goals for CHIP included improving the rates for adolescent well child exams and member satisfaction. The 2021 Health Disparities Action Plan was presented to the Quality Management Committee for review and approval.

United develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. United presented the 2020 and 2021 QI Work Plans for review. Both are reviewed and updated at least quarterly. The work plans included the QI activities across several tabs, the responsible person(s), quarterly target dates, and each activity's status.

The Quality Management Committee (QMC) is responsible for oversight of the QI program and for the implementation, coordination, and integration of all QI activities. Other committees charged with evaluating and monitoring the QI activities include the Provider Advisory Committee, Healthcare Quality and Utilization Management Committee, and the Service Quality Improvement Subcommittee. Each committee meets at least quarterly and has designated a quorum as 51 percent of the voting members present. The Utilization Management activities are handled by the Healthcare Quality and Utilization Management Committee. The Board of Directors/Executive Committee is the governing body for the organization. The Quality Management Committee reports to the Board at least annually.

The Chief Medical Officer chairs the QMC, the Provider Advisory Committee and the Healthcare Quality and Utilization Management Committee. The Service Quality

Improvement Subcommittee is chaired by the Chief Operations Officer. Network primary care and subspecialty physicians are included as voting members for the Provider Advisory Committee. Their specialties include Pediatrics, OBGYN, Internal Medicine, Psychiatry, Dentistry, and Family Medicine.

The Quality Management Committee and the Provider Advisory Committee meet at least quarterly as required by the DOM contract. Copies of the committee minutes provided by United demonstrated the committees met at quarterly intervals. The minutes contained the meeting attendees, the activities, the decisions or recommendations, any follow-up needed, and responsible party.

United's Provider Manual includes details regarding the Quality Management Program. Providers are advised that United requires their participation in and compliance with the program. A copy of the QI program description is available upon request. United measures network provider performance and compliance with the adopted clinical and preventive health guidelines. Per Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, on an annual basis, United measures Provider Performance against at least two of the clinical guidelines. For CAN, United selected the Comprehensive Diabetes Care and Weight Assessment and Counseling for Nutrition and Physical Activity measures to assess compliance. For CHIP, United selected the Antidepressant Medication Management and the Weight Assessment Counseling for Nutrition and Physical Activity measures to assess compliance. The results are provided to DOM with a summary of any corrective actions taken to ensure compliance with the guidelines. This policy was not specific regarding how providers receive the results of this monitoring.

United tracks EPSTD and Well Child services screenings per their Standard Operating Procedures. Members identified with significant conditions receive additional outreach for case management and referrals, if needed. During the previous EQR, CCME recommended that United update the EPSDT and Well-Baby or Well-Child exam tracking reports and include the date of the exam, the ICD 10 or CPT codes, treatment/referral, if provided, and members who received additional outreach for case management referrals. The tracking reports were updated, and the recommendations were implemented.

United evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors, the Quality Management Committee, and to the Division of Medicaid. The 2020 QI Program Evaluation was provided for the CAN and CHIP populations. The program evaluations included the results of all completed activities conducted in 2020. Pages eight and nine of the CAN evaluation included a three-year trend of HEDIS rates and if the 2020 rate met the goal established by United (Quality Compass ® 50th percentile). There were three measures noted as not meeting the 50th percentile goal, however; the reported rates exceeded the 50th percentile goal. Those measures included Follow-up for Children Prescribed ADHD Medications (Continuation), Follow-up for Children Prescribed ADHD Medications (Maintenance Phase), and the Use of

Opioids from Multiple Providers – Multiple Prescribers and Multiple Pharmacies. Also, page 105 listed the area United planned to target for improvements in 2021. However, this section lacked the interventions United planned to use to improve those areas targeted.

For CHIP, pages seven through nine included a three-year trend of HEDIS rates and if the 2020 rate met the goal established by United (Quality Compass ® 50th percentile). There were two measures noted as not meeting the 50th percentile goal, however; the reported 2020 rates exceeded the 50th percentile goal. Those measures included Annual Dental Visits (Total Rare) and Asthma Medication Ratio (Total Rate). Also, pages 84 and 85 listed the area United planned to target for improvements in 2021. However, this section lacked the interventions United planned to use to improve those areas targeted.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by United for the CAN and CHIP populations. DOM has selected a set of PMs to evaluate the quality of care and services delivered by United to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2020, through December 31, 2020.

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, DOM required each CCO to undergo an NCQA HEDIS Compliance Audit. United contracted with an NCQA-licensed organization to conduct the HEDIS Compliance Audit. Aqurate reviewed the CCOs' final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by United. Aqurate found that United's information system and processes were compliant with the applicable standards and the HEDIS reporting requirements for HEDIS Measure Year (MY) 2020.

All relevant CAN HEDIS performance measures were compared for the current review year (MY 2020) to the previous year (MY 2019), and the changes from 2019 to 2020 are reported in *Table 28: CAN HEDIS Performance Measure Results*. The rate changes shown in green indicate a substantial (>10%) improvement, and the rates shown in red indicate a substantial (>10%) decline.

Table 28: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	90.75%	47.10%	-43.65%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	69.10%	68.61%	-0.49%
Counseling for Nutrition	54.74%	55.96%	1.22%
Counseling for Physical Activity	54.99%	51.82%	-3.17%
Childhood Immunization Status (cis)			
DTaP	77.62%	81.27%	3.65%
IPV	93.43%	95.38%	1.95%
MMR	89.54%	93.92%	4.38%
HiB	88.08%	90.02%	1.94%
Hepatitis B	90.27%	96.11%	5.84%
VZV	91.48%	93.19%	1.71%
Pneumococcal Conjugate	83.70%	82.24%	-1.46%
Hepatitis A	76.16%	81.75%	5.59%
Rotavirus	79.08%	82.48%	3.40%
Influenza	32.85%	34.06%	1.21%
Combination #2	72.75%	79.08%	6.33%
Combination #3	72.26%	76.4%	4.14%
Combination #4	62.77%	68.61%	5.84%
Combination #5	66.18%	70.56%	4.38%
Combination #6	29.93%	30.41%	0.48%
Combination #7	57.91%	63.75%	5.84%
Combination #8	28.22%	28.95%	0.73%
Combination #9	27.01%	27.74%	0.73%
Combination #10	25.30%	26.28%	0.98%
Immunizations for Adolescents (ima)			
Meningococcal	58.64%	61.56%	2.92%
Tdap/Td	78.10%	80.05%	1.95%
HPV	24.57%	25.79%	1.22%
Combination #1	56.93%	61.56%	4.63%
Combination #2	22.87%	24.82%	1.95%
Lead Screening in Children (lsc)	72.81%	74.21%	1.40%
Breast Cancer Screening (bcs)	46.17%	45.54%	-0.63%
Cervical Cancer Screening (ccs)	56.69%	50.85%	-5.84%
Chlamydia Screening in Women (chl)			
16-20 Years	46.92%	45.72%	-1.20%
21-24 Years	59.70%	58.9%	-0.80%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Total	48.74%	47.78%	-0.96%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	70.48%	73.89%	3.41%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	28.30%	25.68%	-2.62%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	42.24%	54.02%	11.78%
Bronchodilator	74.96%	75.13%	0.17%
Asthma Medication Ratio (amr)			
5-11 Years	81.04%	82%	0.96%
12-18 Years	68.84%	74.79%	5.95%
19-50 Years	44.66%	52.36%	7.70%
51-64 Years	50.00%	51.16%	1.16%
Total	70.70%	74.08%	3.38%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	53.53%	50.61%	-2.92%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA	76.92%	NA
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	71.16%	73.25%	2.09%
Statin Adherence 80% - 21-75 years (Male)	52.49%	61.43%	8.94%
Received Statin Therapy - 40-75 years (Female)	68.42%	73.73%	5.31%
Statin Adherence 80% - 40-75 years (Female)	42.31%	52.73%	10.42%
Received Statin Therapy - Total	69.80%	73.48%	3.68%
Statin Adherence 80% - Total	47.53%	57.22%	9.69%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.18%	81.27%	-2.91%
HbA1c Poor Control (>9.0%)	58.88%	51.82%	-7.06%
HbA1c Control (<8.0%)	34.55%	37.47%	2.92%
Eye Exam (Retinal) Performed	57.42%	57.91%	0.49%
Blood Pressure Control (<140/90 mm Hg)	49.39%	53.77%	4.38%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	54.66%	57.83%	3.17%
Statin Adherence 80%	41.04%	51.43%	10.39%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	41.72%	46.77%	5.05%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Effective Continuation Phase Treatment	25.64%	30.43%	4.79%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	53.69%	55.63%	1.94%
Continuation and Maintenance (C&M) Phase	66.81%	73.18%	6.37%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	62.00%	60.2%	-1.80%
6-17 years - 7-Day Follow-Up	38.82%	35.88%	-2.94%
18-64 years - 30-Day Follow-Up	52.33%	56.72%	4.39%
18-64 years - 7-Day Follow-Up	27.77%	33.73%	5.96%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	57.92%	58.61%	0.69%
7-Day Follow-Up	34.17%	34.9%	0.73%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	51.09%	47.30%	-3.79%
6-17 years - 7-Day Follow-Up	31.52%	32.43%	0.91%
18-64 years - 30-Day Follow-Up	39.39%	37.41%	-1.98%
18-64 years - 7-Day Follow-Up	25.42%	22.73%	-2.69%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	43.36%	40.69%	-2.67%
Total- 7-Day Follow-Up	27.49%	25.98%	-1.51%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NA	2.94%	NA
7-Day Follow-Up: 13-17 Years	NA	2.94%	NA
30-Day Follow-Up: 18+ Years	6.06%	5.96%	-0.10%
7-Day Follow-Up: 18+ Years	3.64%	3.64%	0.00%
30-Day Follow-Up: Total	5.87%	5.65%	-0.22%
7-Day Follow-Up: Total	3.35%	3.57%	0.22%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	73.09%	66.52%	-6.57%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	67.91%	63.61%	-4.30%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	72.22%	77.78%	5.56%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	55.13%	59.45%	4.32%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Blood Glucose Testing (1-11)	35.85%	28.51%	-7.34%
Cholesterol Testing (1-11)	26.03%	21.27%	-4.76%
Blood Glucose and Cholesterol Testing (1-11)	23.22%	18.21%	-5.01%
Blood Glucose Testing (12-17)	44.30%	39.27%	-5.03%
Cholesterol Testing (12-17)	26.97%	23.73%	-3.24%
Blood Glucose and Cholesterol Testing (12-17)	24.46%	21.62%	-2.84%
Blood Glucose Testing (Total)	40.61%	34.87%	-5.74%
Cholesterol Testing (Total)	26.56%	22.73%	-3.83%
Blood Glucose and Cholesterol Testing (Total)	23.92%	20.23%	-3.69%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.09%	1.47%	0.38%
Appropriate Treatment for Upper Respiratory Infection (uri)	69.24%	69.35%	0.11%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	44.42%	42.73%	-1.69%
Use of Imaging Studies for Low Back Pain (lbp)	71.45%	71.78%	0.33%
Use of Opioids at High Dosage (hdo)	1.50%	0.98%	-0.52%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	18.37%	15.58%	-2.79%
Multiple Pharmacies	3.74%	2.41%	-1.33%
Multiple Prescribers and Multiple Pharmacies	2.07%	1.44%	-0.63%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	7.38%	4.69%	-2.69%
18-64 years - >=31 Days covered	3.87%	3.47%	-0.40%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	7.39%	4.68%	-2.71%
Total - >=31 Days covered	3.87%	3.46%	-0.41%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.13%	83.74%	-2.39%
45-64 Years	90.08%	88.95%	-1.13%
65+ Years	86.84%	79.17%	-7.67%
Total	87.82%	85.79%	-2.03%
Annual Dental Visit (adv)			
2-3 Years	55.01%	41.78%	-13.23%
4-6 Years	76.47%	60.11%	-16.36%
7-10 Years	77.51%	62.81%	-14.70%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
11-14 Years	74.23%	61.8%	-12.43%
15-18 Years	64.17%	54.72%	-9.45%
19-20 Years	43.71%	39.58%	-4.13%
Total	70.67%	57.52%	-13.15%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	83.87%	62.5%	-21.37%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%	0.00%	0.00%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-7 Years	63.59%	65.97%	2.38%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.35%	4.71%	0.36%
Total: Initiation of AOD Treatment: 13-17 Years	63.37%	62.56%	-0.81%
Total: Engagement of AOD Treatment: 13-17 Years	3.96%	4.27%	0.31%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	43.95%	40.08%	-3.87%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	5.16%	5.16%	0.00%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	26.11%	29.76%	3.65%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	9.76%	11.9%	2.14%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	41.42%	41.65%	0.23%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.96%	4.91%	-0.05%
Total: Initiation of AOD Treatment: 18+ Years	35.88%	37.56%	1.68%
Total: Engagement of AOD Treatment: 18+ Years	6.10%	6.95%	0.85%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.45%	41.24%	-4.21%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.97%	4.9%	-0.07%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	26.25%	30.32%	4.07%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	9.70%	11.73%	2.03%

Measure/Data Element	HEDIS 2020 (MY 2019) CAN Rates	HEDIS MY 2020 CAN Rates	Change
Other drug abuse or dependence: Initiation of AOD Treatment: Total	44.08%	44.84%	0.76%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.88%	4.88%	0.00%
Total: Initiation of AOD Treatment: Total	37.88%	39.65%	1.77%
Total: Engagement of AOD Treatment: Total	5.94%	6.73%	0.79%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	92.21%	91.48%	-0.73%
Postpartum Care	73.24%	72.51%	-0.73%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	63.39%	58.44%	-4.95%
12-17 years	66.67%	64.71%	-1.96%
Total	65.33%	62.2%	-3.13%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	60.10%	51.3%	8.8%
15 Months-30 Months		65.25%	NA
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years		38.6%	NA
12-17 Years		32.61%	NA
18-21 Years		17.24%	NA
Total		34.83%	NA

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

As shown, three measures had substantial improvement of greater than 10%. Those included: Pharmacotherapy Management of COPD Exacerbation (pce) Systemic Corticosteroid, Statin Therapy for Patients with Cardiovascular Disease (spc) Statin Adherence 80% - 40-75 years (Female), and Statin Therapy for Patients with Diabetes (spd) Statin Adherence 80%.

The following HEDIS MY 2020 CAN measure rates had a substantial decline (greater than 10%) from the previous HEDIS rate (2019):

- The Adult BMI Assessment (aba) measure declined by over 40 percentage points. This can be attributed to the fact that the measure is no longer a HEDIS measure. The HEDIS measure was a hybrid measure, and the data was collected administratively and via medical record abstraction. The state measure specifications require only administrative data. This is a significant difference, and the measure rates should be compared with caution.

- The Annual Dental Visit had a greater than 10 percentage point decline for nearly all indicators.
- The Initiation and Engagement of AOD Dependence Treatment (iet), Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years indicator had more than a 21-percentage point decline.

All relevant CHIP HEDIS performance measures were compared for MY 2020 and the previous year (2019), and the change from 2019 to 2020 are reported in the table that follows. The rate changes shown in green indicate a substantial (>10%) improvement and the rates shown in red indicates a substantial (>10%) decline.

Table 29: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2020 (MY 2019) CHIP Rates	HEDIS MY 2020 CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	64.96%	64.23%	-0.73%
Counseling for Nutrition	55.96%	52.07%	-3.89%
Counseling for Physical Activity	50.12%	49.15%	-0.97%
Childhood Immunization Status (cis)			
DTaP	85.89%	85.89%	0.00%
IPV	93.92%	96.11%	2.19%
MMR	93.67%	94.40%	0.73%
HiB	90.75%	92.94%	2.19%
Hepatitis B	94.40%	97.08%	2.68%
VZV	92.94%	93.67%	0.73%
Pneumococcal Conjugate	86.86%	90.51%	3.65%
Hepatitis A	79.81%	82.24%	2.43%
Rotavirus	84.43%	86.37%	1.94%
Influenza	39.90%	43.07%	3.17%
Combination #2	84.91%	85.16%	0.25%
Combination #3	83.45%	84.43%	0.98%
Combination #4	72.26%	74.70%	2.44%
Combination #5	76.40%	77.13%	0.73%
Combination #6	36.74%	40.88%	4.14%
Combination #7	67.15%	68.86%	1.71%
Combination #8	34.55%	38.44%	3.89%
Combination #9	34.55%	38.44%	3.89%
Combination #10	32.60%	36.50%	3.90%

Measure/Data Element	HEDIS 2020 (MY 2019) CHIP Rates	HEDIS MY 2020 CHIP Rates	Change
Immunizations for Adolescents (ima)			
Meningococcal	56.20%	60.83%	4.63%
Tdap/Td	80.78%	83.94%	3.16%
HPV	19.71%	22.38%	2.67%
Combination #1	55.96%	60.34%	4.38%
Combination #2	18.73%	21.17%	2.44%
Lead Screening in Children (lsc)	65.94%	68.13%	2.19%
Chlamydia Screening in Women (chl)			
16-20 Years	39.78%	37.92%	-1.86%
21-24 Years	NA	NA	NA
Total	39.78%	37.92%	-1.86%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	76.24%	77.8%	1.56%
18-64 years	62.79%	71.12%	8.33%
65+ years	NA	NA	NA
Total	75.74%	77.55%	1.81%
Asthma Medication Ratio (amr)			
5-11 Years	86.85%	83.50%	-3.35%
12-18 Years	73.68%	75.11%	1.43%
19-50 Years	NA	NA	NA
51-64 Years	NA	NA	NA
Total	80.47%	79.21%	-1.26%
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	NA	NA	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	41.94%	NA	NA
Effective Continuation Phase Treatment	19.35%	NA	NA
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	52.09%	46.44%	-5.65%
Continuation and Maintenance (C&M) Phase	66.00%	66.22%	0.22%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	65.58%	67.52%	1.94%
6-17 years - 7-Day Follow-Up	37.67%	40.76%	3.09%
18-64 years - 30-Day Follow-Up	20.00%	NA	NA
18-64 years - 7-Day Follow-Up	20.00%	NA	NA

Measure/Data Element	HEDIS 2020 (MY 2019) CHIP Rates	HEDIS MY 2020 CHIP Rates	Change
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	64.55%	65.90%	1.35%
Total-7-day Follow-Up	37.27%	39.31%	2.04%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NA	NA	NA
6-17 years - 7-Day Follow-Up	NA	NA	NA
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	NA	NA	NA
Total-7-day Follow-Up	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	39.29%	30.34%	-8.95%
Cholesterol Testing (1-11)	26.79%	23.60%	-3.19%
Blood Glucose and Cholesterol Testing (1-11)	25.00%	21.35%	-3.65%
Blood Glucose Testing (12-17)	48.84%	36.47%	-12.37%
Cholesterol Testing (12-17)	27.91%	23.53%	-4.38%
Blood Glucose and Cholesterol Testing (12-17)	25.58%	20.59%	-4.99%
Blood Glucose Testing (Total)	45.95%	34.36%	-11.59%
Cholesterol Testing (Total)	27.57%	23.55%	-4.02%
Blood Glucose and Cholesterol Testing (Total)	25.41%	20.85%	-4.56%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.78%	1.02%	0.24%
Appropriate Treatment or Children with URI (uri)			
3 months-17 Years	67.70%	67.17%	-0.53%
18-64 Years	59.05%	53.69%	-5.36%
65+ Years	NA	NA	NA
Total	67.13%	66.71%	-0.42%
Use of Imaging Studies for Low Back Pain (lbp)	59.38%	NA	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	1.23%	0.00%	-1.23%
18-64 years - >=31 Days covered	0.00%	0.00%	0.00%
65+ - >=15 Days covered	NA	NA	NA
65+ - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	1.23%	0.00%	-1.23%

Measure/Data Element	HEDIS 2020 (MY 2019) CHIP Rates	HEDIS MY 2020 CHIP Rates	Change
Total - >=31 Days covered	0.00%	0.00%	0.00%
Access/Availability of Care			
Annual Dental Visit (adv)			
2-3 Years	57.12%	45.15%	-11.97%
4-6 Years	77.54%	64.54%	-13.00%
7-10 Years	82.81%	70.36%	-12.45%
11-14 Years	78.34%	66.76%	-11.58%
15-18 Years	69.80%	59.17%	-10.63%
19-20 Years	55.20%	44.52%	-10.68%
Total	75.25%	63.37%	-11.88%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Total Initiation of AOD Treatment: 13-17 years	64.44%	64.10%	-0.34%
Total Engagement of AOD Treatment: 13-17 years	8.89%	5.13%	-3.76%
Total Initiation of AOD Treatment: 18+ years	NA	NA	NA
Total Engagement of AOD Treatment: 18+ years	NA	NA	NA
Alcohol Abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA
Alcohol Abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA
Opioid Abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA
Opioid Abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	58.33%	53.57%	-4.76%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	8.33%	7.14%	-1.19%
Initiation of AOD Treatment: Total	53.33%	53.85%	0.52%
Engagement of AOD Treatment: Total	6.67%	6.15%	-0.52%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	NA	NA	NA
Postpartum Care	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	60.53%	59.52%	-1.01%
12-17 Years	58.33%	60.87%	2.54%
Total	59.09%	60.36%	1.27%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	73.48%	64.93%	-8.55%

Measure/Data Element	HEDIS 2020 (MY 2019) CHIP Rates	HEDIS MY 2020 CHIP Rates	Change
15 Months-30 Months		72.09%	NA
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years		40.02%	NA
12-17 Years		36.37%	NA
18-21 Years		19.64%	NA
Total		36.97%	NA

NA: Indicates denominator was too small or data were not available; NR: Not reported

There were no measures found to have a substantial improvement of greater than 10%. The following measures had a greater than 10 percentage point decline:

- Annual Dental Visit, all indicators
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm), indicators Blood Glucose Testing (12-17) and Blood Glucose Testing (Total) both had a decline of nearly 12 percentage points.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. Aqurate conducted additional source code review, medical record review validation and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Several aspects crucial to the calculation of PM data included: data integration, data control, and documentation of PM calculations. The following are some of the main steps included in Aqurate's validation process:

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by United, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined that the data integration processes for United were acceptable.

Data Control—United's organizational infrastructure must support all necessary information systems; its quality assurance practices, and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated the United's data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by United. Aqurate reviewed all related documentation, which

included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by United was acceptable.

The measure rates for the CAN population reported by United for 2020 are listed in *Table 30*: *CAN Non-HEDIS Performance Measure Rates*.

Table 30: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate
Adult Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)	
Ages 18 - 64	0.50%
Ages 65+	0.47%
Total	0.50%
Maternal and Perinatal Health	
PC-01: ELECTIVE DELIVERY (PC-01)	
Women with elective vaginal deliveries or elective cesarean sections	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)	
Most or moderately effective contraception – 3 days	13.51%
Most or moderately effective contraception – 60 days	46.22%
LARC - 3 Days	0.58%
LARC - 60 Days Reported	8.54%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)	
Most or moderately effective contraception rate	25.13%
LARC rate	3.37%
Care of Acute and Chronic Conditions	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)	
Ages 18 - 64	26.06%
Ages 65+	0.00
Total	26.01%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)	
Ages 40 - 64	39.01%
Ages 65+	115.61%
Total	39.34%
HEART FAILURE ADMISSION RATE (PQI-08)	
Ages 18 - 64	44.35%

Measure	MY 2020 Rate
Ages 65+	115.61%
Total	44.46%
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)	
Ages 18 - 39	0.88%
HIV VIRAL LOAD SUPPRESSION (HVL - AD)	
Ages 18 - 64	12.00%
Ages 65+	NA
Total	11.79%
Behavioral Health Care	
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)	
Ages 18 - 64	1.03%
Ages 65+	NA
Total	1.03%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)	
Ages 18 - 64	4.82%
Ages 65+	NA
Total	4.82%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)	
Overall	54.63%
Prescription for Buprenorphine	53.24%
Prescription for Oral Naltrexone	2.31%
Prescription for Long-acting, injectable naltrexone	0.00%
Prescription for Methadone	0.00%
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)	
Ages 12 - 17	0.79%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	25.75%
Age 2 Screening	41.74%
Age 3 Screening	42.13%
Total Screening	35.96%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA
Maternal and Perinatal Health	
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	

Measure	MY 2020 Rate
Most or moderately effective contraception – 3 days	2.00%
Most or moderately effective contraception – 60 days	51.59%
LARC - 3 Days	0.47%
LARC - 60 Days Reported	12.13%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception rate	30.09%
LARC Rate	2.66%
Dental and Oral Health Services	
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)	
Numerator 1 At Least One Sealant	34.80%
Numerator 2 All Four Molars Sealed	20.85%
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1 – 20	46.44%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate

The primary source verification demonstrated concerns in the reporting of the PQI-08 Heart Failure Admission rate and the CDF-AD Screening for Depression and Follow-up Plan measure for the CAN population. Also, United did not report the Elective Delivery (PC-01) non-HEDIS measures (CAN) as required by DOM.

The table for the CHIP population follows *(Table 31: CHIP Non-HEDIS Performance Measure Rates).*

Table 31: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)	
Ages 12 - 17	0.71%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	NA
Age 2 Screening	48.41%
Age 3 Screening	43.78%
Total Screening	46.04%
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA

Measure	MY 2020 Rate
Maternal and Perinatal Health	
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or moderately effective contraception – 3 days	NA
Most or moderately effective contraception – 60 days	NA
LARC - 3 Days	NA
LARC - 60 Days	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception rate	29.82%
LARC Rate	2.49%
Dental and Oral Health Services	
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)	
Numerator 1 At Least One Sealant	35.32%
Numerator 2 All Four Molars Sealed	21.12%
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1 - 20	55.36%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate

For CHIP, Primary source verification demonstrated concerns in the reporting of the CDF-AD/CH Screening for Depression and Follow-up Plan measure.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

CAN PIP Validation Results

DOM requires the CCOs to conduct performance improvement projects that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). For the previous EQR (2020), United submitted four PIPs for validation that addressed the DOM required topics. All four PIPS scored in the "High Confidence in Reported Results" range and met the validation requirements. CCME provided recommendations regarding the presentation of the results in the PIP documents. For the current EQR, United provided the same four PIP documents for validation. It was noted that the recommendations from the previous EQR were implemented and included in the PIP documents uploaded. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest readmission rate from 19.2% to 17.7% and the enrollment indicator had a decline from 46% to 38%. Individual facility rates were reported as well for each of the five facilities.

Table 32: Behavioral Health Readmissions PIP

Behavioral Health Readmissions	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	79/80=99% High Confidence in Reported Results
Interventions	
• Collaboration with high volume Hinds County outpatient and inpatient providers in order to schedule and facilitate meetings to discuss ways to improve readmissions rates by increasing the seven day-follow-up appointment. • Meds to Beds Program to provide transition solutions to coordinate care and discharge medications for members discharging from inpatient facilities. • Enhanced Case Management.	

The Improved Pregnancy Outcomes PIP goal is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment. The baseline

rate was 92.21% and the remeasurement #1 rate was 91.48%. This rate reflects a decline in the prenatal care visit rate, although it was above the DOM goal rate of 90.1%.

Table 33: Improved Pregnancy Outcomes PIP

Improved Pregnancy Outcomes	
Previous Validation Score	**Current Validation Score**
73/74=99% High Confidence in Reported Results	79/80=99% High Confidence in Reported Results
Interventions	
• Home visit care management services in seven underserved communities in MS. • Care management for high-risk pregnant members and their babies less than a year old. • The Optum Whole Person Care Program provides telephonic and/or face-to-face outreach to high-risk members to educate the member and help with establishing an obstetric practice. • Dedicated maternity Member Services Team for telephonic outreach to low-risk members or to members whose risk is unknown to identify any barriers such as transportation childcare and connect the member to support resources. • Member and provider education with the First Steps packets and the OB toolkits. • National Healthy Starts program to address social needs.	

The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28% and declined to 26.43% in 2020. This is improvement as a lower rate is better.

Table 34: Sickle Cell Disease Outcomes PIP

Sickle Cell Disease Outcomes	
Previous Validation Score	**Current Validation Score**
66/71=93% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Outreach to providers encouraging the use of hydroxyurea for patient who do not have a pharmacy claim for hydroxyurea. • Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients. • Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments. • Telehealth campaigns and after hour care newsletters.	

The Respiratory Illness PIP examines the COPD exacerbations and pharmacotherapy management HEDIS rate and the AMR measure assessing controller medication to total medication ratio HEDIS rate. The bronchodilators baseline rate was 74.96% which improved to 75.13% although it was still below the goal rate of 84.71%. The corticosteroids baseline rate was 42.24% which improved to 54.02% at remeasurement one, but still below the goal rate of 71.05%. The AMR goal rate was 71.28% and the baseline was 70.70% with an improvement of remeasurement one of 74.08%.

Table 35: Respiratory Illness: COPD/Asthma PIP

Respiratory Illness: COPD/Asthma	
Previous Validation Score	**Current Validation Score**
72/72=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Clinical practice consultants visit high volume practices to discuss Clinical Practice Guidelines and evidence-based Quality Performance Guidelines and assist with interpreting patient care opportunity reports. • Pharmacy outreach to ensure members have educational materials, prescriptions are filled and assist with overrides or claims issues related to prescribed inhalers. • Communication with clinics regarding non-compliant members, patient care opportunity reports, and provider education.	

CCME provided recommendations for the Improved Pregnancy Outcomes and the Behavioral Health Readmission PIPs. They are displayed in *Table 36: CAN Performance Improvement Project Recommendations.*

Table 36: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate declined from baseline to remeasurement 1. The rate declined from 92.21% to 91.48%. However, the rate is above the DOM goal rate and the NCQA rate.	Continue member focused interventions to enhance trust and case management outreach to provide needed maternity care.
Behavioral Health Readmissions	Was there any documented, quantitative improvement in	The enrollment indicator had a decline from 46% to 38%.	Focus on interventions to improve enrollment in case management for readmitted members.

Project	Section	Reason	Recommendation
	processes or outcomes of care?		

CHIP PIP Validation Results

United submitted the same four PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction, Follow Up After Hospitalization, and Obesity. Last year there were some recommendations regarding the documentation of statistical analysis, causal analysis, and the reporting of results. All of those recommendations were implemented and reflected in the PIP documentation submitted with the desk materials. All the CHIP PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each project's status and the interventions are also included.

The Adolescent Well Child Visits (AWC)/Child and Adolescent Well Care Visits (WCV) PIP goal is to improve and sustain adolescent well care visits for ages 12 – 21 with a PCP or OB/GYN each calendar year. The AWC measure was retired and replaced with the WCV measures. This measure looks at the percentage of members completing at least one comprehensive wellness visit during the calendar year. For this review only the baseline rates were provided for the 12–17-year-olds. The baseline rate for 2020 was 36.37% and the baseline rate for 18–21-year-olds was 19.64%.

Table 37: Adolescent Well Child Visits / Child and Adolescent Well Care Visits PIP

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	73/73/=100% Hight Confidence in Reported Results
Interventions	
• Phone calls to noncompliance members and after hour and weekend clinic days. Staff collaborated with participating clinics to close care gaps. • Clinical practice consultants and clinical transformation consultants conduct educational sessions with providers on HEDIS requirements. • Resumption of the Farm to Fork activities for member to receive educational materials regarding wellness visits and immunizations.	

The goal for the Follow-Up After Hospitalization for Mental Illness PIP is to improve the number of post hospitalization 7-day and 30-day follow-up visits. For this review period

the PIP documentation report showed that the 30-day follow up rate improved from 61.39% to 64.55% which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.15% to 37.27% in 2020, then improved to 39.31% for MY 2020/RY2021. The goal rate for United is 30.07% which is above the goal rate but below the NCQA rate of 46.22%.

Table 38: Follow Up After Hospitalization for Mental Illness PIP

Follow Up After Hospitalization for Mental Illness	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay. • Continue demographic workflow to improve capture of current contact numbers for enrollees. • Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCP to communicate relevant treatment information involving member care. • Network notes and Optum news and updates for UBH clinicians and facilities. • Case management initiates calls to schedule follow-up appointments.	

The goal of the Reducing Adolescent and Childhood Obesity PIP is to decrease childhood obesity through improved communication between the provider and member regarding counseling for weight, physical activity, and nutritional counseling. This PIP has three HEDIS indicators: body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity. All rates declined from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate. Measure one declined slightly from 64.96% to 64.23%, but it is above United's goal of 33.17%; and below the NCQA rate of 80.5%. Measure two declined from 55.96% in reporting year (RY) 2019 to 52.07% in RY2020. United's goal for measure two is 42.34%, so that goal has been exceeded; the NCQA goal is 71.55% which was not exceeded. Measure three declined slightly from 50.12% in RY2020 to 49.15% in RY2021. United's goal for measure three is 34.25%, so the current rate exceeded the United goal rate, but it below the NCQA goal of 66.79%.

Table 39: Reducing Adolescent and Childhood Obesity PIP

Reducing Adolescent and Childhood Obesity	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	99/100 = 99% High Confidence in Reported Results
Interventions	
• Member and provider education. • Phone calls to noncompliant members. • After hour and weekend clinic days. • Member events such as health fairs and Farm to Fork events. • Clinical Practice Consultants conduct routine visits to PCPs to provide education on HEDIS measures and appropriate coding and billing. • Community outreach activities such as the Farm to Fork program and health fairs.	

For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019 and then it reduced again slightly to 82.3%. This is below the NCQA 50th percentile rate and the United goal of 91.19%.

Table 40: Getting Needed Care CAHPS PIP

Getting Needed Care CAHPS	
Previous Validation Score	**Current Validation Score**
99/100=99% High Confidence in Reported Results	99/100=99% High Confidence in Reported Results
Interventions	
• Member education regarding the provider network and how to access care. • Clinical Practice Consultants make face to face visits with high volume clinics to discuss the CAHPS survey. • Provide member education during phone calls and town hall meetings regarding United's provider network. • Offer case management to providers to support or expedite referrals.	

CCME provided recommendations for the Getting Needed Care and the Reducing Adolescent and Childhood Obesity PIPs. They are displayed in *Table 41: CHIP Performance Improvement Project Recommendations.*

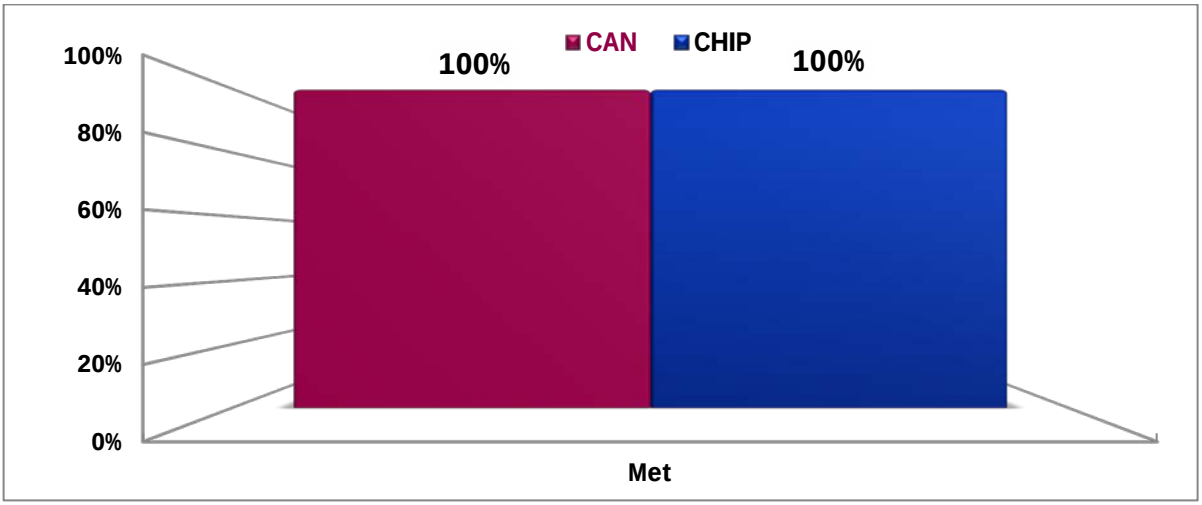
Table 41: CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Member Satisfaction/Getting Needed Care	Was there any documented, quantitative improvement in processes or outcomes of care?	For the member satisfaction PIP, the goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019 and then it reduced again slightly to 82.3%-- this is below the NCQA 50th percentile rate and the United goal of 91.19%.	Continue working on provider and member interventions to improve the composite score on Getting Needed Care.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity)	Was there any documented, quantitative improvement in processes or outcomes of care?	Measure one declined slightly from 64.96% to 64.23%, but it was above the United goal of 33.17%; and below the NCQA rate of 80.5%. Measure two declined from 55.96% in RY2019 to 52.07% in RY2020. The United goal was 42.34% so that goal has been exceeded; however; the NCQA goal is 71.55% which was not exceeded. Measure three declined slightly from 50.12% in RY2020 to 49.15% in RY2021. United's goal was 34.25%, so it exceeded that goal rate, but is below the NCQA goal of 66.79%.	Consider implementing additional member focused interventions and provider education programs to improve 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*.

For this review period, United met all the requirements in the Quality Improvement section for the CAN and CHIP populations as noted in *Figure 6: Quality Improvement Findings*.

Figure 6: Quality Improvement Findings



Strengths

- United uses the Multicultural Health Care Program to reduce health disparities. Specific goals have been identified to target for the CAN and CHIP populations.
- United tracks EPSTD and Well Child services screenings per their Standard Operating Procedures. Members identified with significant conditions receive additional outreach for case management and referrals, if needed.
- United was fully compliant with all information system standards and it was determined that the CCO submitted valid and reportable rates for all HEDIS measures in the scope of this audit.
- Based on Aqurate's validation of PMs, there were no concerns with United's data processing, integration, and measure production for CMS Adult and Child Core Set measures that were reported. Aqurate determined that United followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.
- The following HEDIS MY 2020 CAN measure rates were strengths for United since their rates had a greater than 10% improvement:
    - Pharmacotherapy Management of COPD Exacerbation (PCE), the Systemic Corticosteroid indicator improved by 11.78 percentage points.
    - Statin Therapy for Patients with Cardiovascular Disease (spc), the Statin Adherence 80% - 40-75 years (Female) indicator improved by 10.42 percentage points.
    - Statin Therapy for Patients with Diabetes (spd), Statin Adherence 80% indicator improved by 10.39 percentage points.

- All performance improvement projects scored within the High Confidence range for the reported results.

Weaknesses

- The process for monitoring provider compliance with the Clinical and Preventive Health Guidelines is outlined in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines. This policy was not specific regarding how providers receive the results of this monitoring.
- The HEDIS rates reported in the 2020 QI Program Evaluations for CAN and CHIP incorrectly listed some measures as not meeting the 50th percentile goal. However, the reported rates exceeded the 50th percentile goal.
- The CAN and CHIP QI Program Evaluations listed the area United planned to target for improvements in 2021; however; they lacked the interventions United planned to use to improve those areas targeted.
- The following HEDIS MY 2020 CAN measure rates were determined to be areas of opportunity for United since their rates had a greater than 10% decline:
    - The Adult BMI Assessment (aba) measure declined by over 40 percentage points. This can be attributed to the fact that the measure is no longer a HEDIS measure. The HEDIS measure was a hybrid measure, and the data was collected administratively and via medical record abstraction. The state measure specifications require only administrative data. This is a significant difference, and the measure rates should be compared with caution.
    - The Annual Dental Visit measure had a greater than 10 percentage point decline for nearly all indicators.
    - The Initiation and Engagement of AOD Dependence Treatment (iet), Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years indicator had more than a 21-percentage point decline.
- The following HEDIS MY 2020 CHIP measure rates were determined to be areas of opportunity for United since their rates had a greater than 10% decline:
    - The Annual Dental Visit measure had a greater than 10 percentage point decline for nearly all indicators.
    - The Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) indicators for Blood Glucose Testing (12-17) and Blood Glucose Testing (Total) both had a decline of nearly 12 percentage points.
- Primary source verification demonstrated concerns in the reporting of the PQI-08 Heart Failure Admission rate and the CDF-AD: Screening for Depression and Follow-up Plan measure for the CAN population.

- For CHIP, primary source verification demonstrated concerns in the reporting of the CDF-AD/CH: Screening for Depression and Follow-up Plan measure.
- United did not report the Elective Delivery (PC-01) non-HEDIS measures (CAN) as required by DOM.
- The Pregnancy Outcomes and Behavioral Health Readmission CAN PIPs demonstrated no quantitative improvement in process or care.
- The Getting Needed Care and the Reducing Adolescent and Childhood Obesity CHIP PIPs demonstrated no quantitative improvement in process or care.

Recommendations

- Include how results of the provider monitoring of Clinical and Preventive Health Guidelines are shared with network providers in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines.
- Correct the errors in the HEDIS results table and include a summary of the interventions planned for 2021 in the QI Program Evaluations.
- Work proactively with DOM for clarification on the non-HEDIS measures that are required to be reported.
- Improve processes around calculation, reporting and verification of the rates reported for the DOM required Adult and Child Core set measures.
- Continue working on provider and member interventions for the performance improvement projects that demonstrated no quantitative improvements in process or care.

V. Utilization Management

42 CFR § 438.210 (a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)

CCME's review of United's CAN and CHIP Utilization Management (UM) Programs include various UM documents**,** medical necessity determination processes, pharmacy requirements, the Care Management Program, websites, and a review of approval, denial, appeal, and care management files.

The UM Program Description and policies provide guidance to staff conducting UM activities for physical health, BH, and pharmaceutical services for members in Mississippi. Additionally, they outline the program's structure, lines of responsibility, and standards used to make UM decisions. Onsite discussion confirmed United ensures network practitioners can provide input in UM activities, such as appeals, grievances, and UM guidelines and criteria, during quarterly Physician Advisory Meetings.

Service authorization requests are conducted utilizing Milliman Care Guideline (MCG), InterQual, and internal clinical review criteria such as medical policies or other

established criteria. Onsite discussion revealed United transitioned from MCG to InterQual guidelines in May 2021. United assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing for physician reviewers and clinical reviewers for medical and BH services. All reviewers received passing scores at or above the benchmark of 90%.

Review of CAN and CHIP approval and denial files reflect consistent decision-making using appropriate criteria. Physical health, BH, and pharmaceutical utilization decisions are determined by appropriate staff within required timeframes. Approval notices were faxed to providers and contained all required information. Adverse Benefit Determination notices were written in clear language for a layperson to understand.

OptumRx is the pharmacy benefit manager (PBM) and is responsible for implementing pharmaceutical services. United uses the most current version of the MS Medicaid Program Preferred Drug List (PDL) to fulfill pharmacy requirements. The PDL is accessible from both the CAN and CHIP websites. However, links provided in the CAN Member Handbook to access the listing of over-the-counter (OTC) medicines and for the PDL results in an error message indicating "page not found."

United has a Care Management Program and a Population Health Management Program for CAN and CHIP. Onsite discussion revealed the Care Management Program has been updated across United's enterprise. The plan is transitioning to a new model of care management in November 2021 that will allow for a simplified process to providing case management services. The changes are reflected in the revised 2021 United Healthcare C&S Care Model Program Description. The program description defines and outlines United's approach to providing medical and BH CM services and CM policies provide direction and guidance to staff.

CM files reflect staff are providing the appropriate level of case management services according to the member's risk level and needs. CAN Transition of Care files reflect outreach to providers within seven days to confirm the member's post-discharge follow-up appointment as required in the *CAN Contract, Section (9) (B) (1) (d)*. However, Policy MS021, Transitional Care Management, indicates providers will be notified within 14 days of a member's discharge, instead of seven days.

As noted in *Table 42*, United CAN and CHIP had deficiencies during the 2020 EQR period related to timeliness of UM decisions, in which the UM Program Description did not meet all service authorization timeframe requirements in the *CAN Contract, Section 5 (J) (6)* and the *CHIP Contract, Section 5 (I) (4)*. Additionally, Policy UCSMM.06.16, Initial Review Timeframes, did not include all timeframe requirements for denial notices, according to CAN Contract, Section 5 (L) (1) and CHIP Contract, Section 5 (K).

United adequately addressed these issues by revising the UM Program Description and Policy UCSMM 06.16 Initial Review Timeframes to align with the contract.

Table 42: Previous Utilization Management (UM) Program CAP Items

Standard	EQR Comments
V A. Utilization Management (UM) Program – CAN	
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	The timeframe for allowing a provider to submit additional information for a service authorization noted in the *CAN Contract, Section 5 (J) (6)* and in Policy UCSMM.06.16, Initial Review Timeframes, page 9, was not included in the 2020 UM Program Description Addendum. The timeframe for notifying a member of the termination, suspension, or reduction of a previously authorized service listed in the *CAN Contract, Section 5 (L) (1)* and on page 14 of the 2020 UM Program Description Addendum was not included in Policy UCSMM.06.16, Initial Review Timeframes. *Corrective Action: Edit the UM Program Description to meet all service authorization timeframe requirements in the CAN Contract, Section 5 (J) (6) and to be consistent with Policy UCSMM.06.16, Initial Review Timeframes. Edit Policy UCSMM.06.16, Initial Review Timeframes, to include all timeframe requirements for denial notices, as noted in CAN Contract, Section 5 (L) (1).*
United's Response: United updated the UM Program Description and the UCSMM 06.16 Initial Review Timeframes Policy to align with the contract. Future updates will have a second staff review of documents for thoroughness and accuracy. Supporting Documentation: CAN 08_Attachment 1_UHC CAP_UCSMM 06.16 Initial Review Timeframes Policy_Corrected CAN 08_Attachment 2_UHC CAP_2020 UM PD Addendum_Corrected	
V A. Utilization Management (UM) Program – CHIP	
The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	The following service authorization timeframe requirement is found in Policy UCSMM.06.16, Initial Review Timeframes, but is omitted from the 2020 CHIP UM Program Description Addendum: "Contractor will notify the requesting provider of additional medical information needed and Contractor must allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If Contractor does not receive the additional medical information, Contractor shall make a second attempt to notify the requestor of the additional medical information needed and Contractor must allow one (1) business day or three (3) calendar days for the requestor to submit medical information to Contractor." Refer to the *CHIP Contract, Section 5 (I) (4)*. The following timeframe requirement for denial notices is found in the 2020 CHIP UM Program Description Addendum, but is omitted from Policy UCSMM.06.16, Initial Review Timeframes: "For

Standard	EQR Comments
	termination, suspension or reduction of previously authorized Medicaid-covered services, within 10 calendar days of the date of the Action for previously authorized services as permitted under 42 C.F.R. § 431, Subpart E." Refer to the *CHIP Contract, Section 5 (K)*. *Corrective Action Plan: Edit the UM Program Description to meet all service authorization timeframe requirements in the CHIP Contract, Section 5 (I) (4), and to be consistent with Policy UCSMM.06.16, Initial Review Timeframes. Edit Policy UCSMM.06.16, Initial Review Timeframes, to include all timeframe requirements for denial notices, as noted in the CHIP Contract, Section 5 (K).*
United's Response: 1/19/2021 – INITIAL RESPONSE: United updated the UM Program Description and the UCSMM 06.16 Initial Review Timeframes Policy to align with the contract. Future updates will have a second staff review of documents for thoroughness and accuracy. Supporting Documentation: OCHIP 19_Attachment 1_UHC CAP_UCSMM 06.16 Initial Review Timeframes Policy_Corrected OCHIP 19_Attachment 2_UHC CAP_2020 UM PD Addendum_Corrected 2/8/2021 - REVISED RESPONSE: United identified updates to the 2020 UM Program Description with yellow highlighting (see page 17). Supporting Documentation: OCHIP 19_Attachment 1_UHC CAP_2020 UM PD Addendum_2.8.2021	

Appeals

42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260

For CAN and CHIP, United has established policies describing processes for handling appeals of adverse benefit determinations that are consistent with contractual requirements and Federal Regulations. Definitions of the terms "adverse benefit determination" and "appeal," and information about who may file an appeal, are correctly documented. CAN and CHIP procedures for filing an appeal are clearly provided and consistently documented in policies, the Member Handbooks, the Provider Manuals, and websites. However, appeals information posted on the respective website is not available in Spanish like other materials, such as the Member Handbook and Member rights and responsibilities. It is recommended that appeals information be posted in the Spanish language to ensure accessibility to Spanish-speaking members.

Appeals notices are written clearly and provide instructions for CAN members to request a State Fair Hearing and CHIP members to request an Independent External Review. However, the "Your Additional Rights" enclosure with CHIP appeals notices does not include the requirement that members have the right to request and receive benefits

while the Independent External Review is pending and that the member can be held liable for the cost.

Review of appeal files reflect timely acknowledgements, resolution, and notification of determinations. Determination letters are written in language that is easily understood by a layperson and instructions for State Fair Hearings are provided. However, staff did not consistently follow appeals processes outlined in Policy UCSMM.07.11, Appeal Review Timeframes, and documentation errors were noted. The following issues were identified in CAN and CHIP appeal files:

- Policy UCSMM.07.11, Appeal Review Timeframes, indicates that the appeals timeframe starts the day United receives the verbal request or the written request. However, files reflected the appeal start time began when the member's consent form was received instead of when the verbal request was made with the Call Center.
- Discrepancies were noted in documentation of the appeal "received dates."
- The term "previously upheld" instead of "previously denied" was used to reference the adverse benefit determination for the original service authorization request.

The CAN and CHIP UM Programs are evaluated at least annually to assess strengths and effectiveness. The evaluations are presented to the Healthcare Quality and Utilization Committee (HQUM) and the Quality Management Committee (QMC) for approval.

As noted in Table 43, during the 2020 EQR period United had deficiencies in standards related to procedures for filing an appeal and the written notice of the appeal resolution. Deficiencies identified included issues with the non-secured sections of the CAN and CHIP websites did not have information on appeal processes and procedures and the CAN appeal resolution notice template indicated that members can request a State Fair Hearing instead of an Independent External Review. United has revised the websites and the documents to address these deficiencies.

Table 43: Previous Appeals CAP Items

Standard	EQR Comments
V C. Appeals – CAN	
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 procedure for filing an appeal is correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CAN Member Handbook, and CAN Provider Manual. However, CCME did not identify information for the appeal process or procedure on the CAN website. During the onsite teleconference, United staff confirmed that appeals information is located on the Member Portal, not on the public website. However, the CAN

Standard	EQR Comments
1.2 The procedure for filing an appeal;	Contract, Section 6 (H) requires the plan to provide specific, up-to-date appeals information on a non-secure section of the website. *Corrective Action Plan: Include information on appeal processes and procedures on the non-secured section of the CAN website, as required by the CAN Contract, Section 6 (H).*
United's Response: United created a new link on the non-secure section of the website and will review the non-secure section of the A&G website on a biannual basis, to ensure appeal processes and procedures align with the contract. https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN-Appeals_Grievance.pdf Supporting Documentation: CAN 09_Attachment 1_UHC CAP_Web A&G	
1.6 Written notice of the appeal resolution as required by the contract;	The CAN appeal resolution notice template, MS Member Admin or Clinical Uphold, instructs members to file an independent external review instead of a State Fair Hearing as required by the *CAN Contract, Exhibit D*. During the onsite teleconference, United staff reported the template was previously corrected and forwarded the correct version to CCME. Upon review of the resubmitted template CCME identified the language remains uncorrected. *Corrective Action Plan: Correct the appeal resolution notice template, MS Member Admin or Clinical Uphold, to reflect members can request a State fair Hearing instead of an independent external review.*
United's Response: United's Clinical Uphold template was updated to reflect members can request a State Fair Hearing. Supporting Documentation: CAN 10_Attachment 1_UHC CAP_MS Member Clinical Uphold	
V C. Appeals – CHIP	
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: 1.2 The procedure for filing an appeal;	The procedure for filing an appeal is correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CHIP Member Handbook, and CHIP Provider Manual. However, CCME did not identify information for appeals processes and procedures on the CHIP website. During the onsite teleconference, United staff confirmed that appeals information is located on the Member Portal, not on the public website. However, the *CHIP Contract, Section 6 (H)* requires the plan to provide specific, up-to-date appeals information on a non-secure section of the website. *Corrective Action Plan: Include information on appeals processes and procedures on the non-secured section of the CHIP website, as required in the CHIP Contract, Section 6 (H).*
United's Response: United created a new link on the non-secure section of the website and will review the non-secure section of the A&G website on a biannual basis, to ensure appeal processes and procedures align with the contract. https://www.uhccommunityplan.com/content/dam/uhccp/plandocuments/memberinformation/MS-CAN-Appeals_Grievance.pdf Supporting Documentation:	

Standard	EQR Comments
CHIP 20_Attachment 1_UHC CAP_Web A&G	

As noted in *Figure 7: Utilization Management Findings*, United achieved a "Met" score for 98.2% of the Utilization Management standards for CAN and 96.4% of the standards for CHIP. The plan received "Partially Met" scores for 1.8% of the standards for CAN and 3.6% of the standards for CHIP.

Figure 7: Utilization Management Findings

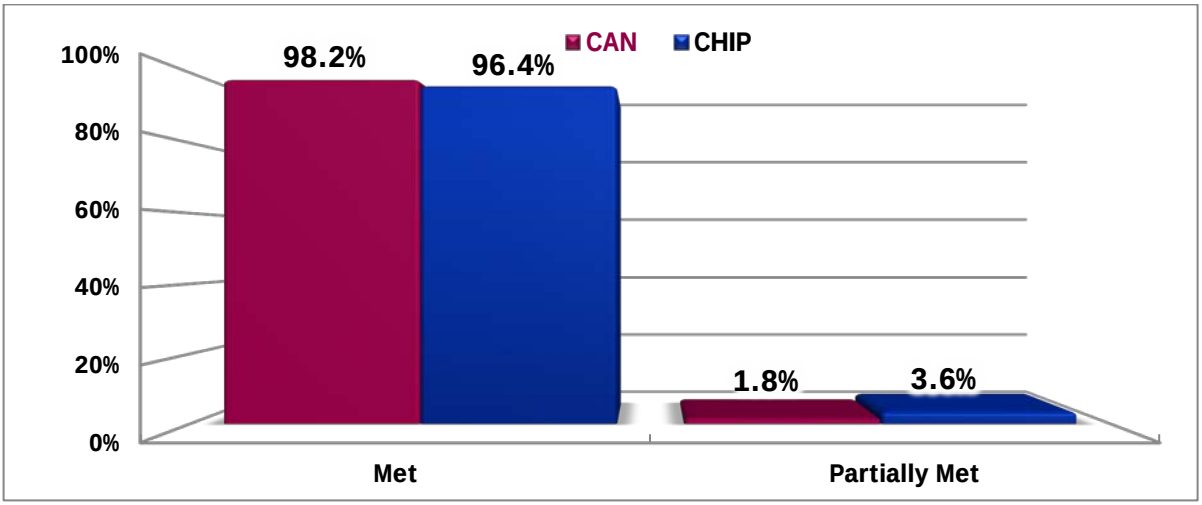


Table 44: Utilization Management

Section	Standard	CAN 2021 Review	CHIP 2021 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: Written notice of the appeal resolution as required by the contract	Met	Partially Met
	The CCO applies the appeal policies and procedures as formulated	Partially Met	Partially Met

Strengths

- Adverse Benefit Determination notices include information written in Spanish directly within the body of the letter.
- Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used.
- Service Authorization requests are completed within timeframe requirements according to policy guidelines and CAN and CHIP contract requirements.

Weaknesses

- For CAN, links provided in the Member Handbook to access the listing of OTC medicines and the PDL result in an error message indicating "page not found."
- For CAN and CHIP, appeals instructions posted on the member website are not available in Spanish like other materials, such as the Member Handbook and member rights and responsibilities.
- For CAN and CHIP, documentation in appeals files reflected United did not consistently follow guidelines in Policy UCSMM.07.11, Appeal Review Timeframes, instructing that the appeal timeframe starts the day United receives the verbal or written request. The following issues were identified:
    - "Received dates" in the Resolution Letter and/or the Standard Acknowledgement Letter reflected the appeal start time began when the member's consent form was received instead of when the verbal request was received by the Call Center.
    - Discrepancies were noted in documentation of "received dates" between the Resolution Letter, the Standard Acknowledgement Letter, and the Verbal Acknowledgment Letter.
    - CAN and CHIP appeal resolution letters incorrectly use the term "previously upheld" instead of "previously denied" when referencing the adverse benefit determination for the original service authorization request.
- Policy MS021, Transitional Care Management, incorrectly indicates providers will be notified within 14 days of a member's discharge, instead of seven days.
- For CHIP, the "Your Additional Rights" document enclosed with appeal resolution letter does not include information that members have the right to request and receive benefits while the Independent External Review is pending and that the member can be held liable for the cost.

Corrective Actions

- For CAN and CHIP, ensure staff are following the guideline that appeal start times to begin when the verbal request was received by the Call Center, as outlined in Policy UCSMM.07.11, Appeal Review Timeframes.
- For CAN and CHIP, ensure staff are consistently documenting the same "received date" on the Verbal Acknowledgement Letter, Standard Acknowledgement letter, and Resolution Letter.
- For CAN and CHIP, ensure appeal Resolution Letters correctly reference the adverse benefit determination in the original service authorization as "previously denied" instead of "previously upheld."
- Edit the "Your Additional Rights" enclosure for CHIP appeal letters to include information that members have the right to request and receive benefits and can be held liable for the cost, according to requirements in the *CHIP Contract, Section E (14) (d)*.

Recommendations

- Ensure the embedded links for the PDL and OTC medications on page 33 of the CAN Member Handbook are in working order.
- Post appeals instructions in Spanish on the CAN and CHIP member website to be consistent with other member materials such as the Member Handbook and Member rights and responsibilities and to ensure information is readily accessible to Spanish-speaking members.
- Correct Policy MS021, Transitional Care Management, to indicate United will notify providers within seven days of a member's discharge, instead of 14 days.

VI. Delegation

42 CFR § 438.230 and 42 CFR § 457.1233(b)

The review of Delegation activities examined the submitted list of delegates, delegation agreements, delegation monitoring processes, and documentation of oversight conducted for each delegated entity.

United reported 16 current delegation agreements, as shown in *Table 45, Delegated Entities and Services*. The delegation agreements in place with each of the entities specify the activities and functions that are delegated, reporting responsibilities, performance expectations, and consequences that may result from substandard or noncompliant performance.

Table 45: Delegated Entities and Services

Delegated Entities	Delegated Services
OptumHealth (United Behavioral Health)	Behavioral health case management, utilization management, quality management, network contract management, and claims processing
Dental Benefit Providers	Dental network services and 3rd party dental administrator
Medical Transportation Management	Non-Emergency Transportation (NET) benefit services broker, provider network, claims processing, quality management, and call center operations
eviCore National	Radiology and cardiology management services and prior authorizations
MARCH Vision Care	Vision and eye care benefit administration services, network contract management, call center operations, and claims processing
Optum RX	Pharmacy benefit administration services
Hattiesburg Clinic River Region Health System HubHealth University Physicians, PLLC HCA Physician Services Health Choice, LLC North Mississippi Medical Center Ochsner Premier Health Memorial Hospital at Gulfport	Credentialing and recredentialing activities

Processes for vendor oversight and assessment are detailed in Policy DOV-01, Delegated Vendor Oversight Strategy. The UnitedHealthcare Credentialing Plan 2021–2023 includes processes for delegation of credentialing and recredentialing functions and oversight of delegated entities. It addresses delegation agreements, sub-delegation, preassessments, annual evaluation, oversight and monitoring, and required follow-up.

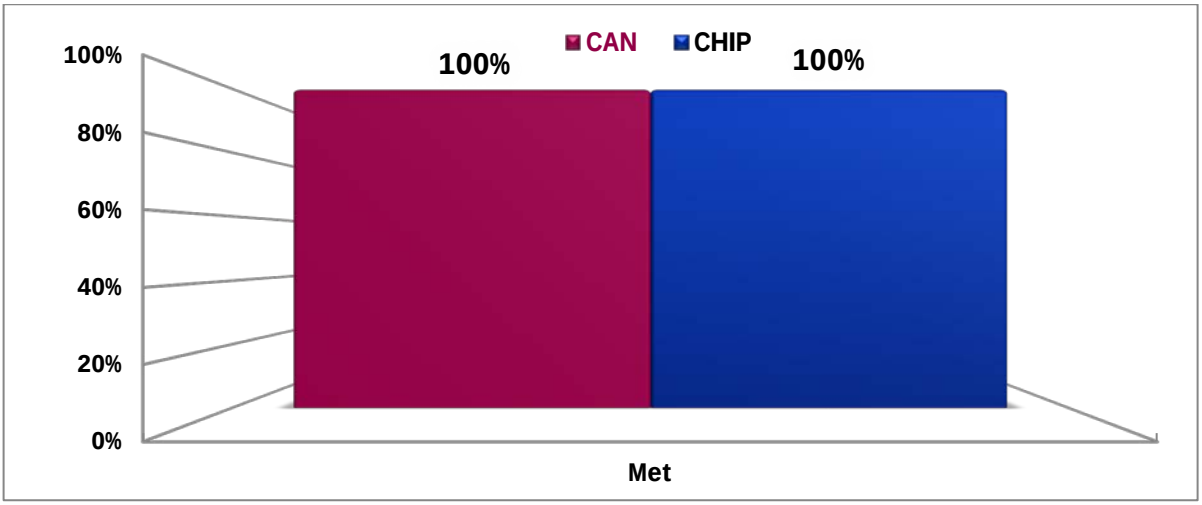
Monitoring of delegated activities includes routine reporting by delegates to facilitate performance monitoring. The reporting assists in identifying operational trends or issues so that performance improvement initiatives may be implemented as needed. Routine joint operating committee meetings are held with subcontractors to review performance and to discuss any needed remediation.

Evidence of the oversight conducted for non-credentialing delegates was submitted prior to the onsite visit. Oversight documentation for all credentialing delegates was requested

three times and was submitted after completion of the onsite; therefore, findings for the credentialing delegates were not discussed with the plan during the onsite visit. No issues were identified during review of oversight documentation of the delegated entities.

As indicated in *Figure 8, Delegation Findings*, 100% of the standards in the Delegation section were scored as "Met."

Figure 8: Delegation Findings



Strengths

- Delegate oversight documentation indicates appropriate oversight is conducted of all delegated entities.

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

I. 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 6, 2021

Scott Waulters
Interim CEO
UnitedHealthcare Community Plan - Mississippi
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Mr. Waulters:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2021 External Quality Review (EQR) of UnitedHealthcare Community Plan – Mississippi is being initiated. The review will include the MississippiCAN Program (MSCAN) and MississippiCHIP Program (MSCHIP) 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 on October 4, 2021, through October 5, 2021 for the MississippiCAN and Mississippi CHIP Programs.

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 5, 2021.

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 2021 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. 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.

6. A current provider list/directory as supplied to MSCAN members.

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

8. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for MSCAN. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

9. The Quality Improvement work plans for MSCAN for 2020 and 2021.

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

11. 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.

12. 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.

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

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

15. Copies of the most recent physician profiling activities for the MSCAN program conducted to measure contracted provider performance.

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

17. Provide reports for measuring provider adherence to medical record standards for 2020 and 2021.

18. A complete list of all MSCAN members enrolled in the Care Management program from July 2020 through July 2021. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the MSCAN program and changes.

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

21. A report of findings from the most recent member and provider satisfaction surveys for the MSCAN program with a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and any other documentation of the requested scope of work.

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

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

24. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of July 2020 through July 2021.

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

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

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

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

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

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

31. A sample provider contract for the MSCAN program.

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

g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of July 2020 through July 2021.

33. For the MSCAN program, 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.

34. Contracts for all delegated entities.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

36. Please provider the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS MY 2020 (Measurement Year 2020) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the HUDIS MY 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN.
c.	HEDIS MY 2020 Final Audit Report (from Licensed Organization) for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.

Folder	Requested Document	Description
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide the vendor's name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production.
f.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 f) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite review.*
g.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.*
h.	Rate reporting template populated with data for non-HEDIS measure rates	CCME will provide the rate reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.
1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA. 2. HEDIS Certified Measures SM is a service mark of the NCQA.		

37. Provide a complete list of all services that require prior authorization.

38. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (including 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 files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the MSCAN program made in the months of July 2020 through July 2021. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions.

Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of July 2020 through July 2021, 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 2021 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. 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.

6. A current provider list/directory as supplied to the CHIP members.

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

8. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for CHIP. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

9. The Quality Improvement work plans for CHIP for 2020 and 2021.

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

11. 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.).

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.

12. 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.

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

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

15. Copies of the most recent physician profiling activities for the CHIP program conducted to measure contracted provider performance.

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

17. Provide reports for measuring provider adherence to medical record standards for 2020 and 2021.

18. A complete list of all CHIP members enrolled in the Care Management program from July 2020 through July 2021. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the CHIP program and changes.

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

21. A report of findings from the most recent member and provider satisfaction surveys for the CHIP program with a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and any other documentation of the requested scope of work.

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

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

24. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of July 2020 through July 2021.

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

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

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

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

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

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

31. A sample provider contract for the CHIP program.

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

f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
h. A copy of the Information Security Plan & Security Risk Assessment.
i. A copy of the claims processing monitoring reports covering the period of July 2020 through July 2021.

33. For the CHIP program, 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.

34. Contracts for all delegated entities.

35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

36. Please provider the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS MY 2020 (Measurement Year 2020) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the HEDIS MY 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCHIP	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCHIP.
c.	HEDIS MY 2020 Final Audit Report (from Licensed Organization) for MSCHIP	Please submit the CHIP Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM,] to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.

Folder	Requested Document	Description
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide the vendor's name and contact information so that the EQR reviewer may contact the vendor to review the source code/process flow for measure production.
f.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 f) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite review.*
g.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.*
h.	Rate reporting template populated with data for non-HEDIS measure rates	CCME will provide the rate reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.
1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA. 2. HEDIS Certified Measures [SM] is a service mark of the NCQA.		

37. Provide a complete list of all services that require prior authorization.

38. Provide electronic copies of the following files for the CHIP program:
    a. Credentialing files (<u>including provider office site visits as appropriate</u>) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the CHIP program made in the months of July 2020 through July 2021. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.

d. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP program made in the months of July 2020 through July 2021, 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.**

II. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copies of the following policies:
    a. NM-31-UHCS - UnitedHealthcare Community and State, Provider Initiated (Voluntary and UnitedHealthcare Initiated (Involuntary) Terminations
    b. DOV-01, Delegated Vendor Oversight Strategy
    c. Policy UCSMM 06.10 Rider 1, Clinical Review Criteria

3. A copy of the 2020 CHIP UM Program Evaluation. The copy submitted for review has a CHIP file name but does not include CHIP contents.

4. A copy of the 2021 Health Disparties Action Plan for CHIP.

5. A copy of United's Cultural Competency Plan, if applicable.

6. Copies of the Addendum 1 - 2020 Annual MississippiCAN Performance Measures Report:, Addendum 2 - 2020 Annual MississippiCAN Multicultural Health Care QI Evaluation, and Addendum 3 - 2020 Annual MississippiCAN/CHIP Population Health Management Report noted in the **2020 CAN QI Program Evaluation**.

7. Copies of the Addendum 1 - 2020 Annual CHIP Performance Measures Report and Addendum 2 - 2020 Annual CHIP Multicultural Health Care QI Evaluation noted in the **2020 CHIP QI Program Evaluation**.

8. The most recent monitoring result of provider compliance with the clinical and preventive health guidelines for CAN and CHIP (Per policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, on an annual basis, United measures Provider Performance).

9. A copy of any reports from the 2020 Provider Medical Record Review for CAN and CHIP.

10. Copies of delegation agreements and oversight documentation for any entities delegated to conduct credentialing and recredentialing functions, if not previously submitted (CAN and CHIP).

11. Copy of CHIP CAHPS – Child survey report for 2021.

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

III. 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
- PIP Validation CHIP

CCME EQR Survey Validation Worksheet

Plan Name	**United Healthcare CAN/CHIP**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2020
Review Performed	2021

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 (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.

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 identified. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
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:* United Healthcare Provider Satisfaction Survey Results report- December 2020.

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 response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability is documented. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 1.9% with 57 providers completing the survey out of the 2,958. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2020. ***Recommendation**: Work on action plan steps as per the report including increasing email quality and survey advertisement to improve response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* United Healthcare Provider Satisfaction Survey Results report-December 2020.
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* United Healthcare Provider Satisfaction Survey Results report-December 2020.

CCME EQR Survey Validation Worksheet

Plan Name	**United Healthcare CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2020
Review Performed	2021

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. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

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 identified. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
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:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

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 response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability is documented. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 14.7% - 237 completed surveys out of the sample of 1614. This response rate was lower than the NCQA target rate of 40 and may introduce bias into the generalizability of the findings. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid. ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates and advertise the survey to members.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* 2021 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid.

CCME EQR Survey Validation Worksheet

Plan Name	**United Healthcare CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2020
Review Performed	2021

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. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

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 identified. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
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:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

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 response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
7.2	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. The response rate was 10.8% (214 surveys out of 1,973 sample size). The previous rate for 2020 was 12.7%, so the response rate declined from last year's survey. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H. ***Recommendation:*** *Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts). The response rate has declined the past 3 years from 17.2% in 2019, to 12.7% in 2020, to 10.8% in 2021.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* 2021 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H.

CCME EQR Survey Validation Worksheet

Plan Name	**United Healthcare CHIP**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2020
Review Performed	2021

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. (updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

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 identified. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
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:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

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 response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability is documented. *Documentation*: SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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 data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size for the general population was 1,979 with 315 completed surveys for a response rate of 15.9%. The response rates were below the NCQA target rate of 40%, but higher than the average national response rate of 12.6%. The 2021 response rate was lower than previous surveys which had 16.9% response rate in 2020 and 20.4% in 2019. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report **Recommendation:** Continue to assess barriers that occur for completion of surveys for the Child CCC member population. Continue to work with SPH Analytics to improve response rates.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics MY2020/RY2021 CAHPS 5.1H Medicaid Child with CCC Report

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
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**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)**
Reporting Year:	**2021**
Review Performed:	**10/5/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	During the United CHIP PSV, a case was identified where the member had an outpatient visit during the measurement year (which qualifies for the denominator) and a positive screening (identified for the numerator with code G8431) in the period that includes 14 days prior to the encounter. The technical specifications define the numerator as "Beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter." Therefore, if a member is identified with a positive screen (using G8431), their visit must be on the date of the denominator encounter. Only when the screening is negative (G8510) can the screening be identified in the 14-day period prior to the encounter. This guidance applies to both the CAN and CHIP submissions.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**	**4**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

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	**74**
Measure Weight Score	**75**
Validation Findings	**98.7%**

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:	**United Healthcare - MSCAN**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)**
Reporting Year:	**2021**
Review Performed:	**10/6/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**PC-01: ELECTIVE DELIVERY (PC-01)**
Reporting Year:	**2021**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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.	**Not Applicable**	This measure was not reported.

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.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
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.	**Not Applicable**	This measure was not reported.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Not Applicable**	This measure was not reported.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Not Applicable**	This measure was not reported.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			Not Applicable

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Not Applicable	
D1	10	Not Applicable	
D2	5	Not Applicable	
N1	10	Not Applicable	
N2	5	Not Applicable	
N3	5	Not Applicable	
N4	5	Not Applicable	
N5	5	Not Applicable	
S1	5	Not Applicable	
S2	5	Not Applicable	
R1	10	Not Applicable	

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	**N/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

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:	**United Healthcare - MSCAN**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Adult Core Set Measures Specifications

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**	

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**	
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**	During PSV for United CAN it was identified that a member was included in the measure that did not meet denominator criteria which states: Total number of months of Medicaid enrollment for beneficiaries age 18 and older during the measurement period. Since the member was not enrolled during the measurement period, the member would not be included in the denominator.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	During PSV for United CAN it was identified that a member was included in the measure that did not meet denominator criteria which states: Total number of months of Medicaid enrollment for beneficiaries age 18 and older during the measurement period. Since the member was not enrolled during the measurement period, the member would not be included in the denominator and therefore not be counted in the numerator.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			Met

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	4
N1	10	Met	10
N2	5	Met	4
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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	**73**
Measure Weight Score	**75**
Validation Findings	**97.3%**

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:	**United Healthcare - MSCAN**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	During the United CHIP PSV, a case was identified for the CDF-AD measure where the member had an outpatient visit during the measurement year (which qualifies for the denominator) and a positive screening (identified for the numerator with code G8431) in the period that includes 14 days prior to the encounter. The technical specifications define the numerator as "Beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter." Therefore, if a member is identified with a positive screen (using G8431), their visit must be on the date of the denominator encounter. Only when the screening is negative (G8510) can the screening be identified in the 14-day period prior to the encounter. This guidance applies to both the CAN and CHIP submissions for CDF-CH as well.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**	**4**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

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	**74**
Measure Weight Score	**75**
Validation Findings	**98.7%**

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:	**United Healthcare - MSCAN**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
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**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**
R1	**10**	**Met**	**10**

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCAN**
Name of PM:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	10	Met	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
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**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	During the United CHIP PSV, a case was identified for the CDF-AD measure where the member had an outpatient visit during the measurement year (which qualifies for the denominator) and a positive screening (identified for the numerator with code G8431) in the period that includes 14 days prior to the encounter. The technical specifications define the numerator as "Beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter." Therefore, if a member is identified with a positive screen (using G8431), their visit must be on the date of the denominator encounter. Only when the screening is negative (G8510) can the screening be identified in the 14-day period prior to the encounter. This guidance applies to both the CAN and CHIP submissions for CDF-CH as well.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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**	4
N3	**5**	**Met**	5
N4	**5**	**Met**	5
N5	**5**	**Met**	5
S1	**5**	**Met**	5
S2	**5**	**Met**	5
R1	**10**	**Met**	10

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	**74**
Measure Weight Score	**75**
Validation Findings	**98.7%**

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:	**United Healthcare - MSCHIP**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
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**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare - MSCHIP**
Name of PM:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2021**
Review Performed:	**10/4/2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
Child Core Set Measure Specifications

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**	

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**	
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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
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**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**N/A**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**N/A**	
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.	**N/A**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			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
R1	**10**	**Met**	10

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	**75**
Measure Weight Score	**75**
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:	**United Healthcare CAN**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS (CLINICAL)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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**	Hinds County had a high rate of readmissions.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in health status.
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 noted.
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**	Methods were documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 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**	Baseline and remeasurement period 1 were reported.
7.4 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**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALLY MET**	The inpatient readmissions PIP showed improvement in the latest rate from 19.2% to 17.7% and the enrollment indicator declined from 46% to 38%. Individual facility rates were reported as well for each of the five facilities. **Recommendation: Focus on interventions that will encourage contact and enrollment with readmitted members; continue interventions to reduce readmissions.**
9.2 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 in readmissions was related to the many interventions in place.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values were presented to determine significance.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	79
Project Possible Score	80
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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:	**United Healthcare CAN**
Name of PIP:	**RESPIRATORY ILLNESS**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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**	Childhood asthma is a major concern in MS. COPD is the fourth leading cause of death.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined. Using HEDIS measures: Pharmacotherapy of COPD Exacerbation and Medication Management for People with Asthma.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in health status.
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 noted.

Component / Standard (Total Points)	Score	Comments
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**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 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**	Baseline and remeasurement rates were reported.
7.4 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**	Report included analysis of rate in comparison to benchmarks.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in thereport.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The AMR rate improved from 70.70% to 74.08%; the corticosteroids improved from 42.24% to 54.02%; the bronchodilators rate improved from 74.96% to 75.13%.
9.2 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 related to the interventions to educate providers and transition to care program.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values were reported
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine.

A.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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 CAN**
Name of PIP:	**SICKLE CELL DISEASE OUTCOMES (CLINICAL)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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**	**In 2018, a low percentage of members were compliant with taking their Hydroxyurea.**
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured processes of care and health status.
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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
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**	Methods are documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using a rate with numerator and denominator.
7.3 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**	Baseline and remeasurement 1 are reported.
7.4 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**	Analysis of results are presented in the report.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate declined from baseline to remeasurement 1 which is improvement. The rate of ER super users for members diagnosed with sickle cell anemia was 36.28% and declined to 26.43% in 2020.
9.2 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 is related to interventions to increase outpatient care.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are presented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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:	**United Healthcare CAN**
Name of PIP:	**IMPROVING PREGNANCY OUTCOMES (CLINICAL)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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 birth was the leading cause of infant death in MS.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure was clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
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 noted.

Component / Standard (Total Points)	Score	Comments
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**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported for baseline and remeasurement 1 In table format.
7.3 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**	Repeated measures were included in the report.
7.4 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**	Report included analysis of baseline in relation to benchmark rates.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate declined from baseline to remeasurement 1. Results are reported for baseline and remeasurement 1. The rate declined from 92.21% to 91.48%. However, the rate is above the DOM goal rate and the NCQA rate. **Recommendation: Continue member focused interventions to enhance trust and case management outreach to provide needed maternity care.**
9.2 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 to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values were presented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	1	1
9.4	NA	NA

Project Score	74
Project Possible Score	75
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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:	**United Healthcare CHIP**
Name of PIP:	**CHILD AND ADOLESCENT WELL CARE VISITS- WCV (CLINICAL)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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**	AWC (retired HEDIS) rate was below the target rate.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 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**	New measure is administrative.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	New measure is administrative.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	New measure is administrative.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and processes of care.
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 noted.
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**	Methods were documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 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**	Baseline and remeasurement periods were reported.
7.4 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**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	New measure for this PIP. Baseline data only. The baseline WCV rates were 36.37% for 12 - 17 year olds and 19.64% for 18-21 year olds.
9.2 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 only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	73
Project Possible Score	73
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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:	**United Healthcare CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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**	FUH rate was below the target rate of 66.6% for 30day follow up and 45.11% for 7 day follow up.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
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 noted.

Component / Standard (Total Points)	Score	Comments
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**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 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**	Baseline and remeasurement periods were reported.
7.4 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**	Report includef analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The follow-up after hospitalization PIP report showed that the 30-day follow up rate improved from 61.39% to 64.55% which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.15% to 37.27% in 2020, then improved to 39.31% for MY 2020/RY2021. The goal rate for United is 30.07% so it is above the United goal rate but below the NCQA rate of 46.22%.
9.2 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 related to continued intervention efforts.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; has not reached benchmark rate yet.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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:	**United Healthcare CHIP**
Name of PIP:	**MEMBER SATISFACTION**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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 was a downward trend from 2016 to 2017 for getting needed care.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
STEP 4: Review Sampling Methods		
4.1 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 survey sampling specifications were used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS survey sampling specifications were used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS survey sampling specifications were used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
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 noted.
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**	Methods were documented as valid and reliable.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods and interim rates are monitored.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 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**	Baseline and remeasurement periods were reported.
7.4 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**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	For the member satisfaction PIP, the goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019 and then it reduced again slightly to 82.3%--this is below the NCQA 50th percentile rate and the United goal of 91.19%. **Recommendation:** Continue working on provider and member interventions to improve the composite score on Getting Needed Care.
9.2 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 to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	1	1
9.4	NA	NA

Project Score	94
Project Possible Score	95
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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:	**United Healthcare CHIP**
Name of PIP:	**REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	**2020**
Review Performed:	**2021**

ACTIVITY 1: ASSESS THE PIP 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 obesity rate was 18.9% for youth and 21.9% for children, making this population at-risk for chronic issues.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 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 sampling specifications were used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS sampling specifications were used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS sampling specifications were used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
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 noted.

Component / Standard (Total Points)	Score	Comments
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**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods and interim rates are monitored.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 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**	Baseline and remeasurement periods were reported.
7.4 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**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Measure 1 declined slightly from 64.96% to 64.23%, but it is above the United goal of 33.17%; below the NCQA rate of 80.5% Measure 2 declined from 55.96% in RY2019 to 52.07% in RY2020. The United goal is 42.34% so that goal has been exceeded; the NCQA goal is 71.55% which was not exceeded. Measure 3 declined slightly from 50.12% in RY2020 to 49.15% in RY2021. The United goal is 34.25%, so it exceeded that goal rate, but it below the NCQA goal of 66.79%. **Recommendation**: Consider implementing additional member focused interventions and provider

Component / Standard (Total Points)	Score	Comments
		education programs to improve rates.
9.2 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 to assess for the most recent remeasurement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; rate has improved but have not achieved benchmark yet.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	1	1
9.4	NA	NA

Project Score	**94**
Project Possible Score	**95**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
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.*

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**UnitedHealthcare MS CAN**
Review Performed:	2021

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					United has established guidelines used for the development, review, revision, and implementation of policies, procedures, and standard operating procedures.
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					Scott Waulters is the interim United Healthcare Chief Executive Officer (CEO).
1.2 *Chief Operating Officer;	X					The Chief Operating Officer is Latrina McClenton.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.3 Chief Financial Officer;	X					Heath Seaman Is the Chief Financial Officer.
1.4 Chief Information Officer;	X					The Chief Information Officer is Mike Rogers.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Jason Bell is the Claims Administrator.
1.6 *Provider Services Manager;	X					The Provider Services Director is Rhona Waldrep.
1.6.1 *Provider credentialing and education;	X					Onsite discussion revealed that 10 staff are dedicated to Provider Relations in support of medical, dental, and behavioral health services. A total of 23 call center agents provide education and provider services support.
1.7 *Member Services Manager;	X					Kenisha Potter is the Member Services Manager.
1.7.1 Member services and education;	X					Onsite discussion revealed that three staff are assigned to the Member Services team with 23 call center agents dedicated to supporting member services.
1.8 Complaint/Grievance Coordinator;	X					Krystal Webb is assigned to Grievance Coordination until the position is filled later this month.
1.9 Utilization Management Coordinator;	X					The Health Services Director is Kim Bollman.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Quality Management Director.
1.11 *Marketing, member communication, and/or public relations staff;	X					The Public Relations Specialist is Angie Richmond.
1.12 *Medical Director;	X					The United Chief Medical Officer and Medical Director is Amit Prasad, MD, MBA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.13 *Compliance Officer.	X					Amanda Rogers is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					United's percent paid average for 30 and 90 days exceeds Mississippi's timeliness requirements. United paid 99% or more clean claims within 30 days and averaged almost 100% of clean claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United's ISCA documentation notes that the organization collects enrollment and member demographics using HIPAA compliant transaction formats and code sets. The data is processed and stored by United's internal encounter data submission and reporting system. The system tests the data for accuracy, completeness, logic, and consistency. Finally, United uses the system to submit encounter data to the State in HIPAA standardized files.
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					HEDIS and HEDIS-like reporting is performed by United using systems running HEDIS-certified software. In addition to verifying data with its systems, staff review performance measure reporting data for accuracy. Finally, United noted that its software was recently audited and received NCQA Certification in May 2021.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Business continuity and disaster recovery plans are in place to mitigate an incident and restore service if there is an incident. The plans include staff roles, emergency access procedures, recovery priorities, and recovery time

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						objectives. United tests its plans annually and documentation indicates recent recovery tests were completed successfully. Finally, United updates its business continuity plans twice yearly.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The 2020-2021 UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program outlines approaches to the prevention, detection, reporting, corrective action, and best practices.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The UnitedHealth Group Code of Conduct emphasizes United's efforts towards representing the highest level of personal and institutional integrity, to never compromise ethics, and their commitment to transparency.
2.2 Identification of the Compliance Officer;						The Compliance Officer is named in the Mississippi addendum to the FWA Plan and the organization chart.
2.3 Information about the Compliance Committee;						The United Compliance Oversight Committee assists in fulfilling responsibilities of developing and implementing the Mississippi Compliance Program. The primary objective is to assess the current state of the compliance program and to ensure that it effectively prevents, detects, and corrects violations of applicable laws, regulations, guidance, government contract

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						requirements, company policies, and ethical guidelines.
2.4 Compliance training and education;						United requires compliance training for all new hires and annually for all employees.
2.5 Lines of communication;						The CAN 2021 Care Provider Manual (Provider Manual) includes the number for reporting to Optum's Anti-Fraud and Recovery Solutions unit.
2.6 Enforcement and accessibility;						The 2020-2021 UnitedHealthcare Community Plan of Mississippi (UHC) Fraud, Waste, and Abuse Program outlines that if an investigation reveals a credible allegation of fraud, United must cease any further investigations and notify the designated contact within the OPI immediately via email. The UnitedHealth Group Code of Conduct informs staff that violations are taken seriously and could result in discipline, up to and including termination of employment and possible legal action, including referral to law enforcement.
2.7 Internal monitoring and auditing;						The 2020-2021 UnitedHealthcare Community Plan of Mississippi (UHC) Fraud, Waste, and Abuse Program describes the process for compliance and performance audits. Allegations are considered credible when they have indicia

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						of reliability. United and DOM review all allegations and facts, and act judiciously on a case-by-case basis.
2.8 Response to offenses and corrective action;						FWA investigations are performed by the special investigative unit (SIU), which is comprised of highly qualified investigators with significant experience in health care and prescription drug fraud and abuse, industry business practices and systems, and infrastructure.
2.9 Exclusion status monitoring.						Policy ID-5881 entitled New Hire and Periodic Employee Sanction Review outlines United's stance on not knowingly hiring, continuing to employ, or contracting with someone if law or contract prohibits the person from providing services for customers.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The 2020- 2021 UnitedHealthcare Community Plan of Mississippi (United) Fraud, Waste, and Abuse Program describes ways to detect, report, and prevent FWA.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I E. Confidentiality *42 CFR § 438.224*						
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					The Code of Conduct states that United is dedicated to taking all reasonable precautions to maintain the confidentiality of those who report an ethics or compliance concern to the extent allowed by Company policy and the law.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
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					Processes and requirements for initial and ongoing credentialing of providers for United's network are documented in the following: •UnitedHealthcare Credentialing Plan 2021 – 2023 •State and Federal Regulatory Addendum, Attachment E to the UnitedHealthcare Credentialing Plan •United Behavioral Health (Optum) Clinician Credentialing Process policy •Additional policies and procedures
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the	X					The UnitedHealthcare Board of Directors delegates responsibility and authority for credentialing and recredentialing to the National Credentialing Committee (NCC). The NCC communicates decisions to the health plan's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
applicant. Such decisions, if delegated, may be overridden by the CCO.						Provider Advisory Committee (PAC), which serves as the local Credentialing Committee. The PAC, chaired by the health plan's Chief Medical Officer and reporting to the Quality Management Committee, reviews and approves all credentialing decisions made by the NCC. Membership of the PAC includes participating MS providers with an appropriate array of specialties to represent the network. The PAC meets at least four times yearly and the quorum is established as the presence of 51% of voting members. Uploaded NCC minutes reflect weekly meetings except for a few weeks during which major holidays fell. PAC meetings were held on August 12, 2020, November 11, 2020, February 10, 2021, and May 12, 2021.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.		X				The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians. Onsite discussion confirmed the complete collaborative agreement is collected at initial credentialing for nurse practitioners. However, one nurse practitioner file included only the signature page of the collaborative agreement. *Corrective Action: Ensure credentialing files contain the complete collaborative agreement for nurse practitioners.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1 Verification of information on the applicant, including:						Any additional issues identified are addressed in standards 3.1.1 through 3.3 below.
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 insurance coverage / 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 Examiners for	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
3.2 Site assessment.	X					
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				The Division of Medicaid requires CCO's contracting with nurse practitioners to collect the complete collaborative agreement between nurse practitioners and collaborating physicians. Onsite discussion confirmed the complete collaborative agreement is collected at recredentialing for nurse practitioners. However, two files did not include the complete collaborative agreement. The information

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						received included only a copy of the information on the Board of Nursing Licensee Gateway listing the collaborating physicians. One contained an additional document listing a collaborative physician with the nurse's signature. *Corrective Action: Ensure recredentialing files contain the complete collaborative agreement for nurse practitioners.*
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						Any additional issues identified are addressed in standards 3.1.1 through 3.3 below.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					For one provider file, CCME was unable to determine the date the query of the Mississippi State Board of Medical Licensure was conducted. *Recommendation: Ensure evidence of verification of active licensure conducted on the State Board of Examiners for the specific discipline includes an indication of the date of the verification.*
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 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.3 Provider office site reassessment, when applicable.	X					
4.4 Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 2021 – 2023 describes the roles of the National Peer Review and Credentialing Policy Committee, Regional Peer Review Committees, and Medical Directors related to suspending, restricting, or terminating a provider's participation in the network for quality of care concerns. It also addresses the role of the Hearing Panel when a provider appeals of determinations to suspend, restrict or terminate a provider for quality of care concerns. Policy PS13, Provider Terminations, addresses processes followed when United makes a determination to terminate a provider from its network. United's process for responding to notification that DOM has terminated a provider is included in United's Fraud, Waste and Abuse Program 2020-2021. Onsite discussion confirmed that if United is notified that DOM has terminated a provider, the health plan immediately terminates the provider also. Written notification is provided to affected members within 48 hours and to the terminated provider within 1 day.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				Regarding verification of CLIA certificates, the following issues were noted: •One file for a rural health clinic and one file for an inpatient hospice included a CLIA number on the provider's application but no verification of the CLIA in the file. •One file for a hospital included a CLIA verification date on the credentialing checklist, but no other evidence of verification of the CLIA in the file.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For these files, verification of the CLIA was submitted after completion of the onsite visit. The verifications were dated 10/6/21. Regarding queries of the MS DOM Sanctioned Provider List, the following issues were noted: •There was no evidence of querying the MS DOM Sanctioned Provider List for three providers. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted. •One file included a screenshot labeled as the query, but there was no way to confirm as there was no identifying information on the screenshot. •Three files contained screenshots labeled as the query, but they appeared to be general searches on DOM's main website and not queries of the MS DOM Sanctioned Provider List. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted. *Corrective Action: Ensure verification of CLIA is conducted prior to issuing the credentialing or recredentialing determination and that evidence is included in the provider file. Ensure queries of the MS DOM Sanctioned Provider List are included in each organizational provider's file and that it is clearly identifiable and includes the date the query was conducted.*
II B. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR §207, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						Policy PS3, Geographic Access Standards, states United ensures members have consistent and convenient access to medical providers, and defines the geographic access standards for the provider network. Access standards defined in the policy include all provider types specified in the *CAN Contract, Section 7 (B)*. The access parameters listed in the policy are compliant with contractual requirements.
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As stated in Policy PS10, PCP Panel Notification, United notifies PCPs of assigned members within five business days of the date United receives the Member Listing Report from DOM. United makes member panel details available to all participating PCPs via its secure provider portal. United also identifies PCPs with changes in member panels and mails a postcard notification about these changes to impacted PCPs within five days of receiving the Member Listing Report from DOM.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					As noted in Policy PS10, PCP Panel Notification, PCPs communicate desired panel restrictions to United during initial credentialing and/or contracting. Providers can request changes to their panel at any time and can update their panels status on the provider portal. Onsite discussion confirmed United runs quarterly reports of providers who are not accepting new patients and meets monthly to review the network and ensure there are sufficient providers in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						network accepting new patients to meet member needs.
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					
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Submitted Geo Access reports indicate quarterly geographic assessments are conducted. The reports provide a breakdown of member access by provider specialty and by rural and urban designation. The 2021 Quality Improvement Program Description indicates United monitors the network to ensure adequate access for members to health care services. Network Management analyzes network gaps, access to care, and availability of care, and implements improvement action plans to address identified issues.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					United's Multicultural Health Care Program includes various activities to ensure its network can serve members with special needs, foreign language, and cultural requirements. These activities include: •Assessments of race, ethnicity and language demographics for both members and providers conducted at least every 3 years to identify any language or cultural gaps in the provider network and to determine if changes are needed in language services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						•Measurement of activities to reduce health care disparities using HEDIS data to identify opportunities and develop action plans. •Measurement of member satisfaction via CAHPS surveys. •Annually identifying and prioritizing opportunities to reduce health care disparities and improve Culturally and Linguistically Appropriate Services. United does not have a formal, written Cultural Competency Plan; however, information is available on the provider portal, in Provider Manuals, newsletters, etc.
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					Appointment access standards are defined in Policy PS2, Access Standards – Appointment Availability Requirements. Standards listed in the policy are compliant with contractual requirements. The policy indicates providers are educated about the appointment access standards and the standards are documented in the Provider Manuals. United conducts quarterly assessments of PCP, OBGYN, and behavioral health provider compliance to the standards. Quarterly and annual assessments are conducted to determine compliance by high-volume specialists. Results are relayed to the Service Quality Improvement Subcommittee (SQIS) for monitoring, tracking, trending, identification of improvement

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						opportunities, and development of corrective action initiatives. Failure to meet access requirements results in direct outreach to providers. Excel spreadsheets documenting results of appointment access and afterhours access call studies conducted by DialAmerica were submitted. Review of these documents indicated: •For appointment access, the percentages of providers requiring corrective action are increasing for Peds (>35%) and OBGYN (>59%). The percentages for BH (>40%) and PCPs (>23%) are trending down from the previous quarter. •For after-hours access, the percentages of providers requiring corrective action is increasing for PCPs (62.42%), OBGYNs (25.93%), and Peds (46.67%). The percentage for BH providers has consistently been at or above 50%, most recently at 61.36%. Onsite discussion of these findings indicated that providers are facing increased challenges related to the COVID-19 pandemic. The discussion confirmed that United continues to address appointment availability and after-hours access requirements with providers during monthly "town hall" meetings, reminds providers of contractual requirements in bulletins, and conducts one-on-one sessions with providers as needed to address findings.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Processes for new provider orientation and education are found in Policy PS14, Provider Orientation Plan, and in SOP-PS14, Standard Operating Procedure – Provider Orientation Plan Summary & Checklist. Monthly Network Notification reports identify newly contracted providers. Once identified, a Provider Advocate is assigned and is responsible for contacting new providers within 30 days of the contract effective date. Welcome calls are placed to answer any immediate questions and to schedule an on-site orientation.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					The CAN Provider Manual includes a listing of covered and excluded benefits. The benefits grid in the CAN Provider Manual, page 11, indicates well child care is not covered; but, the CAN Member Handbook, page 12, states "All well-child visits and immunizations are covered by your plan." Also, onsite discussion indicated Peer Support Services are covered as a behavioral health benefit; however, the benefit grid in the CAN Provider Manual, page 12, does not indicate this as a covered service. A similar finding is noted in the CAN Member Handbook, page 39.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Revise the CAN Provider Manual, pages 11 and 12, to indicate well child care and peer support services are covered benefits. Revise the CAN Member Handbook, page 39, to indicate peer support services is a covered benefit.
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention, and confidentiality;		X				The *CAN Contract, Exhibit C, Section K* indicates medical records must be retained for a period of no less than 10 years. However, the CAN Provider Manual does not include the medical record retention requirement. Review of the following provider contract templates revealed the Mississippi Medicaid Program Regulatory Requirements Appendix document UHN Provider) correctly documented the medical record retention timeframe. However, the following provider contract templates indicated the medical record retention timeframe requirement is at least 6 years: •Ancillary Provider Participation Agreement

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						•Facility Participation Agreement •FQHC/RHC Participation Agreement •Medical Group Participation Agreement *Corrective Action: Update the CAN Provider Manual to include the required medical record retention timeframe. Revise the Ancillary Provider Participation Agreement, the Facility Participation Agreement, the FQHC/RHC Participation Agreement, and the Medical Group Participation Agreement to state the correct medical record retention timeframe.*
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					The CAN Provider Manual includes information about member appeals and grievances, as well as provider claims reconsideration requests and care provider appeals.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 includes all required elements.	X					United's CAN website includes the "Find A Provider" function that allows members or others to search for providers by various parameters, including name, specialty, etc. The PDF versions of the CAN Provider Directories are split into the Central, North, and South regions, are available upon request, and are available for download from the health plan's website. Some provider entries in the printed and online provider directories do not include hours of operation, which is required by the *CAN Contract Section 6 (E) (11)*. Also, Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing, states provider directories must include "Identification of hours of operation including identification of Providers with non-traditional hours…" *Recommendation: Develop and implement processes to gather information about providers' hours of operation and include this information in the CAN provider directories.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
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					United reviews and adopts preventive guidelines (PHGs) that are nationally recognized and include specific criteria for childhood, adult, and geriatric populations. A policy titled "Review of Clinical and Preventive Guidelines" describes the process for review of PHGs. The Medical Technology Assessment Committee (MTAC) is responsible for reviewing the guidelines, and the guidelines are reviewed at least every 12 months.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					The CAN Provider Manual includes information about the PHGs and states United endorses and monitors use of the guidelines. The manual states the guidelines are available at UHCprovider.com. CCME confirmed the link is correct and providers can access the guidelines.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
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					United reviews and adopts clinical practice guidelines (CPGs) that are nationally recognized and include specific criteria for childhood, adult, and geriatric populations. A policy titled "Review of Clinical and Preventive Guidelines" describes the process for review of clinical practice guidelines. The Medical Technology Assessment Committee (MTAC) is responsible for reviewing the guidelines at least every 12 months. The Provider Advisory Committee (PAC) reviewed the MTAC recommendations for the 2021 guidelines during its meeting on 5/12/21. The following notation was found in the minutes: "After reviewing the updated CPG list, Sickle Cell Disease was removed for 2021. However, it will be requested to be put back on the MS CPGs. UHC quality participates in a SCD Performance Improvement Project that is mandated by the State. Also, so many of the UHC members have SCD and the best practice guideline needs to be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						available." United staff confirmed the guideline has been reinstated.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	X					The CAN Provider Manual includes information about the CPGs and indicate that for specific state benefits or services not covered under national guidelines, criteria are developed internally through review of current medical literature, peer reviewed publications, Medical Technology Assessment Reviews, and specialist consultation.
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					Processes and requirements for provider medical record reviews are detailed in Policy NQM-025, Ambulatory Medical Record Review Process, and its associated attachments. The medical record review process is conducted to monitor and assess provider compliance with medical record documentation standards. Although the medical record documentation standards and audit tools are reviewed and approved annually by the National Quality Oversight Committee (NQOC), United may revise the standards and tools to meet state-specific requirements.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					Policy NQM-025 describes medical record audit processes. The policy states: •At completion of the medical record audit, any provider who has a failing score is notified. Education and support is provided and the provider is informed that an additional review will be conducted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						•For providers who fail the additional review, the Medical Director and/or the applicable quality committee will determine appropriate corrective action. •Upon final closure of the medical record review, final results may be presented to the applicable health plan committee. Onsite discussion confirmed the additional review of providers who have failing scores is conducted during the next year's medical record audit. However, Policy NQM-025, as currently written, does not make this clear. For example, the information about the additional review is addressed prior to a statement that indicates final results may be presented to the applicable health plan committee upon final closure of the medical record review. *Recommendation: Revise Policy NQM-025 to clearly indicate the timeframe during which an additional review is conducted for providers who fail the initial medical record review.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					The response rate was 1.9% with 57 providers completing the survey out of the 2,958. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution. *Recommendation: Work on action plan steps as per the report including increasing email quality*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and survey advertisement to improve response rates.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QMC during the March 2021 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MBR4a. Notification of Rights, describes written policies and procedures are present regarding member rights to ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to member rights.
2. Member rights include, but are not limited to, the right:	X					Member rights are detailed in Policy MBR4a, Notification of Rights, the CAN Member Handbook, the CAN Provider Manual, and the CAN member website.
2.1 To be treated with respect and dignity;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;						
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.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. Member responsibilities include the responsibility:	X					Member rights are detailed in Policy MBR4a, Notification of Rights, the CAN Member Handbook, the CAN Provider Manual, and the CAN member website.
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.						
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
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					
1.1 Full disclosure of benefits and services included and excluded in coverage;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						The CAN Member Handbook provides information on coverage limits, specialized services, accessing care from an out-of-network provider, and end-of-coverage explanations.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						No prior approval for family planning services, emergency visits, or BH services is needed. Requirements for prior approval of medical, behavioral health (BH), and pharmaceutical services are described in the CAN Member Handbook. Services that require prior approval are indicated in the benefits grid.
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;						Information on 24-hour access to care and level of care triage is described on the website and the CAN Member Handbook.
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;						The CAN Member Handbook includes information about obtaining prescription medications and durable medical equipment. The Preferred Drug List is available for member reference on the website along with information about

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						participating pharmacies. This information is also available by contacting Member Services.
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;						United notifies members of changes to the CHIP program no later than 30 calendar days prior to implementation and provides 15 days written notice of termination of a provider, as described in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, Policy MBR8b, 15-Day Written Notices of Termed Provider, and noted in the CAN Member Handbook.
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, call center, nurse advice line, and member portal;						Information about the 24-Hour NurseLine and accessing the secure Member Portal is located on the United website. The CAN Member Handbook provides telephone numbers and descriptions for Member Services.
1.13 A description of EPSDT services;						The CAN Member Handbook provides information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Additionally, standard operating procedures indicate United conducts

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						written, telephonic, and in-person outreach to inform members of EPSDT services. Detailed EPSDT information and a current Bright Futures immunization schedule are available on the website.
1.14 Procedures for disenrolling from the CCO;						Information is provided in the CAN Member Handbook about requirements for disenrollment. Members are instructed to make requests directly to DOM either in writing or by phone.
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;						
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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, describe and outline the processes United uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language.
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					Policy MBR1b2, Notification of Oral Interpretation Services, describes that translation services are provided free of charge to non-English speaking members, members who have limited English proficiency, and members who are deaf or hearing impaired. This information is also found in the CAN Member Handbook.
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					A toll-free number is listed for Member Services via the "Have Questions" link on the member website, the Member Handbook, and other public materials.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Training is provided to Call Center staff during orientation and thereafter routinely scheduled via an electronic platform of modules. Training includes scripts for urgent, emergent, and routine call types, and utilizing role-play training per onsite discussion.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call Center trends and performance measures are monitored with monthly and quarterly reporting and analysis. The Call Center metrics are monitored by the Performance Improvement Team and reported to the Quality Improvement Committee and the SQIS.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
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					
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					Information about scheduled preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services is included in the CAN Member Handbook and on the CAN website. Mailers, such as an EPSDT brochure and member newsletters, are sent to members.
2. The CCO identifies pregnant members; provides educational information related to pregnancy,	X					The Healthy First Steps™ (HFS) Program Description outlines United's approach for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.						identifying pregnant members, stratifying them by risk level, and providing care management and health education services for all enrolled pregnant members.
3. The CCO identifies 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 requirements of the CMS Survey Validation Protocol. United contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems Survey vendor, to conduct the Adult and Child Surveys. The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS. For United CAN Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (14.7%) which included 237 completed surveys out of a sample of 1,614. *Recommendation: Work on action plan steps including increasing email quality and survey advertisement to improve Provider Satisfaction Survey response rates.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					United analyzes data obtained from the Member Satisfaction Survey to identify quality problems, as noted in the 2021 MS CAN QI Program Evaluation.
3. The CCO reports results of the member satisfaction survey to providers.	X					The plan reports the results of the Member Satisfaction Survey to providers as seen in the Practice Matters 2021 Newsletter Member Experience Analysis report.
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 as noted in the QMC March 2021 and the MSCAN Adult CAHPS Survey results document.
III G. Grievances *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
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					
1.1 Definition of a grievance and who may file a grievance;	X					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, defines a grievance as "An expression of dissatisfaction about any matter other than an adverse benefit determination." This definition, along with whom may file and how a grievance may be filed, are also provided in the CAN Member Handbook, CAN Provider Manual and in United's website glossary of terms.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 The procedure for filing and handling a grievance;	X					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance captures the process for filing a grievance, which is reflected in the Member Handbook.
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					
2. The CCO applies the grievance policy and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					United tracks and analyzes grievances, and reports results to the SQIS quarterly, as described in the Utilization Management and Quality Improvement Program Description documents. The SQIS monitors trends related to member grievance activities and the quality of other non-clinical services.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
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 2021 Quality Improvement Program Description for the CAN program and the 2021 Behavioral Health Quality Improvement Program Description were submitted. The QI program description is updated annually and presented to the Board of Directors, Quality Management Committee, and the Division of Medicaid for approval. United's Provider Manual includes details regarding their Quality Management program. Providers are advised that United requires their participation and compliance with the program and a copy of the QI program is available upon request. During the onsite, staff explained members and providers are informed in various materials such as newsletter to call United and request additional information about the QI program. Also, United has a link on their website

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						that providers may use to access additional information about the program.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The QI program description describes United's efforts to reduce health disparities through the Multicultural Health Care Program. Three of the goals specific for the CAN population include improving the rates for breast cancer screenings, eye exams for diabetics, and member satisfaction. The 2021 Health Disparities Action Plan was presented to the Quality Management Committee for review and approval.
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					
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					United develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. United presented the 2020 and 2021 QI Work Plans for review. Both are reviewed and updated at least quarterly. The work plans included the QI activities across several tabs, the responsible person(s), quarterly target dates and each activity's status.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Management Committee (QMC) is responsible for oversight of the QI program and is responsible for the implementation, coordination, and integration of all QI activities. Other committees charged with the responsibility of evaluating and monitoring the QI activities include the Provider Advisory Committee,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Healthcare Quality and Utilization Management Committee, and the Service Quality Improvement Subcommittee. Each committee meets at least quarterly and has designated a quorum as 51% of the voting members present. The Utilization Management activities are handled by the Healthcare Quality and Utilization Management Committee. Per the QI Program Description, page 13, the Board of Directors/Executive Committee is the governing body for the organization. The Quality Management Committee reports to the Board at least annually.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Officer chairs the QMC, the Provider Advisory Committee, and the Healthcare Quality and Utilization Management Committee. The Services Quality Improvement Subcommittee is chaired by the Chief Operations Officer. Network primary care and subspecialty physicians are included as voting members for the Provider Advisory Committee. Their specialties include Pediatrics, OB/GYN, Internal Medicine, Psychiatry, Dentistry, and Family Medicine.
3. The QI Committee meets at regular intervals.	X					The Quality Management Committee and the Provider Advisory committee meet at least quarterly as required by the DOM contract. Copies of the committee minutes provided by United demonstrated the committees met at quarterly intervals.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting as evidenced by the committee minutes provided by United. The minutes contained the meeting attendees, the activities, the decisions or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						recommendations, follow-up items, any follow-up needed and responsible party.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The performance measure validation found that United was fully compliant with all information system standards and determined that United submitted valid and reportable rates for all HEDIS measures in scope of this audit. There were no concerns with United's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation. Primary source verification demonstrated concerns in the reporting of the PQI-08 Heart Failure Admission rate and the CDF-AD: Screening for Depression and Follow-up Plan measure for the CAN population. United did not report the Elective Delivery (PC-01) non-HEDIS measures (CAN) as required by DOM. Details of the validation activities and recommendations for the Performance Measures may be found in *Attachment 3, EQR Validation Worksheets.* *Recommendation: Work proactively with DOM for clarification on the non-HEDIS measures that are required to be reported. Improve processes*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						around calculation, reporting, and verification of the rates reported for the DOM required Adult and Child Core set measures.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
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					DOM requires the CCOs to conduct performance improvement projects that address these topics: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). United submitted four Performance Improvement Projects (PIPs) that addressed the DOM required topics.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					For the previous EQR (2020), United submitted four PIPs for validation that addressed the DOM required topics. All four PIPS scored in the High Confidence in Reported Results range and met the validation requirements. CCME provided recommendations regarding the presentation of the results in the PIP documents. For the current EQR, United provided the same four PIP documents for validation. It was noted that the recommendations from the previous EQR were implemented and included in the PIP documents uploaded. All the CAN PIPs scored in the "High Confidence in Reported Results." The Pregnancy Outcomes and Behavioral Health Readmission PIPs demonstrated no quantitative improvement in process or care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Details of the validation activities and recommendations for the PIPs may be found in *Attachment 3, CCME EQR Validation Worksheets.* *Recommendation: Continue to work on provider and member interventions to enhance trust and case management outreach to improve the Pregnancy Outcomes and Behavioral Health Readmission PIPs.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					United's Provider Manual includes details regarding their Quality Management program. Providers are advised that United requires their participation and compliance with the program. A copy of the QI program is available upon request.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, on an annual basis, United measures Provider Performance against at least two of the clinical guidelines. United selected the Comprehensive Diabetes Care and Weight Assessment and Counseling for Nutrition and Physical Activity measures to assess compliance. The results are provided to DOM with a summary of any corrective actions taken to ensure compliance with the guidelines. This policy was not specific regarding how providers receive the results of this monitoring.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Include how results of the provider monitoring of Clinical and Preventive Health Guidelines are shared with network providers in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						United provided the Standard Operating Procedure for the EPSDT Screening rates and the tracking process. The SOP provides details for how the health plan handles provider compliance with EPSDT services.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					The Standard Operating Procedure titled "EPSDT Services – Tracking Process" indicates members identified with significant conditions receive additional outreach for case management and referrals, if needed. United provided a copy of the EPSDT tracking reports used to identify members who received EPSDT services and the identified, if any, abnormal findings.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					United evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors , the Quality Management Committee, and to the Division of Medicaid. The 2020 Mississippi Coordinated Access Network (MSCAN) Quality Improvement Program Evaluation was provided. The program evaluation included the results of all completed activities conducted in 2020. Pages eight through nine included a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						description, a three-year trend of HEDIS rates, and if the 2020 rate met the goal established by United (Quality Compass ® 50th percentile). There were three measures noted as not meeting the 50th percentile goal; however, the reported rates exceeded the 50th percentile goal. Those measures included Follow-up for Children Prescribed ADHD Medications (Continuation), Follow-up for Children Prescribed ADHD Medications (Maintenance Phase), and the Use of Opioids from Multiple Providers – Multiple Prescribers and Multiple Pharmacies. The program evaluation, page 105, listed the area United planned to target for improvements in 2021. However, this section lacked the interventions United planned to use to improve those areas targeted. *Recommendation: Correct the errors in the HEDIS results table and include a summary of the interventions planned for 2021.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. 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 CAN Utilization Management Program Description Addendum and the Behavioral Health Utilization Management Program Description and Work Plan, outline the objectives, scope, staff roles for physical health, 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					External and internal guidelines and criteria used to make clinical coverage decisions are noted in the CAN UM Program Description Addendum and described in policies UCSMM.06.10, Clinical Review Criteria, and UCSMM.06.13, Non-Clinical Intake and Initial Screening.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness of UM decisions are correctly documented in the UM Program Description Addendum and in Policy UCSMM.06.16, Initial Review Timeframes. United addressed corrective actions from the 2020 EQR by updating Policy UCSMM.06.16, Initial Review Timeframes, to include all UM timeframe requirements The 2021

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						UM Program Description no longer includes UM timeframe requirements.
1.5 Consideration of new technology;	X					United's UM Program Description indicates functions of the Medical Technology Assessment Committee (MTAC) include, but are not limited to, reviewing supporting evidence used for new and emerging technologies. Additionally, the Medical Policies Team conducts medical technology assessment reviews for current, new and emerging technologies to support medical policies.
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description Addendum clearly describes the role and responsibilities of the Chief Medical Officer/Medical Director, Amit Prasad, MD. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting reviews, and chairing the Healthcare Quality Utilization Management Committee (HQUM) and the Physician Advisory Committee (PAC). Operating authority is delegated to the UnitedHealthcare Health Services Director. The BH Regional Medical Director and the Pharmacy Director collaborate with the CMO and have clinical oversight of the respective programs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 and related policies and procedures are evaluated at least annually to assess 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. The CAN 2020 UM Program Evaluation was approved by the HQUM Committee on July 15, 2021. Onsite discussion confirmed United ensures practitioner input in UM activities, such as appeals and grievances, and UM guidelines and criteria. during quarterly Physician Advisory Meetings. Grievance and appeal reports, and Medical Technology Assessment Committee (MTAC) minutes are provided prior to the quarterly Physician Advisory Committee meeting and confirmed in the minutes.
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.*						
1. Services that require prior authorization by the CCO include only the services specified by the Mississippi Division of Medicaid.	X					During the onsite United explained that administrative codes are researched and verified to ensure services requiring prior authorization are specified by the Division of Medicaid.
2. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					United uses external clinical review criteria such as Milliman Care Guideline (MCG) and InterQual, and internal clinical review criteria such as medical policies and utilization review guidelines to determine medical necessity and service authorizations as indicated in Policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						UCSMM.06.10, Clinical Review Criteria, and the UM Program Description Addendum. United's BH Level of Care Guidelines and Optum's Clinical Criteria are used to conduct BH determinations. Onsite discussion revealed United transitioned from MCG to InterQual guidelines in May 2021.
3. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of CAN UM approval files reflect consistent decision-making utilizing evidenced base criteria such as MCG, InterQual, United's clinical guidelines, the PDL and other pharmacy guidelines, and the member's relevant clinical information.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Approval files reflect that UM nurses review pertinent medical records and consider the local delivery system and the member's individual circumstances while making UM decisions. UM clinicians consult with Medical Directors on appropriate service requests.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					United conducts an online inter-rater reliability (IRR) assessment for all clinical staff including medical directors where the minimum passing score is 90%. As reported in the 2020 UM Evaluation, staff achieved the established goal in each MCG IRR product: Inpatient & Surgical Care, Ambulatory Care, and Recovery Facility Care. Onsite discussions confirmed that BH and Pharmacy reviewers achieved passing scores in their respective IRR testing.
6. Pharmacy Requirements						
6.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The Pharmacy Program Description explains that OptumRx is the pharmacy benefit manager (PBM)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and is responsible for implementing all pharmaceutical services for United, including but not limited to prior authorizations and pharmacy network management. The Universal Preferred Drug List (PDL) for the CAN program is specified by DOM and indicates over-the-counter availability, age or quantity limitations, and if step therapy is required. A link to access the most current version of PDL is available on United's CAN website The user is automatically directed to DOM's website, where the PDL is available in a searchable, electronic format. Links provided in the Member Handbook to access the listing of OTC medicines and for the PDL results in an error message indicating "page not found". This issue was discussed during a previous EQR. *Recommendation: Ensure the embedded links for the PDL and OTC medications on page 33 in the CAN Member Handbook are in working order.*
6.2 The CCO has established policies and procedures for prior authorization of medications.	X					The Pharmacy Program Description and UM Program Description Addendum, and policies such as Policy RX-036, Emergency Medication Supply / Temporary Coverage Override, describe United's process for conducting prior authorization of medications. Optum Rx conducts the PA process according to state, federal and regulatory requirements. Prior authorization requests are determined, and notification is provided to the requesting provider within 24 hours. United ensures a 3-day supply of medication will be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						approved while a prior authorization request is pending.
7. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The UM Program Description Addendum and the Behavioral Health Benefits Addendum explain that United does not require prior authorization for physical health or BH emergency hospital services. Policy UCSMM.04.11, Consumer Safety, correctly describes emergency and post-stabilization service requirements and the member's ability to access them.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Policies such as Policy UCSMM.06.14, Initial Clinical Review, Policy UCSMM.06.13, Non-Clinical Intake and Initial Screening, and Policy UCSMM.02.10, Staff Qualifications and Credentials, describe United's approach for ensuring UM decisions are conducted by qualified staff. Initial clinical reviews are performed by a Mississippi-licensed nurse or Referral Specialist, and Level II clinical reviews are performed by a Mississippi-licensed physician or other appropriate healthcare practitioner. Non-licensed staff perform intake and initial screenings that do not require clinical interpretation and use scripted interview material to obtain further information. Additionally, BH Care Advocates are licensed and hold advanced degrees in the BH field or are registered psychiatric nurses, and pharmacy reviewers are trained technicians or licensed pharmacists.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of approval files reflect physical and BH utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within 3 calendar days/2 business days.
11. Denials						
11.1 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					UM denial files reflect clinical reviewers request additional information from providers prior to making a decision to deny services. Providers are given a specified timeframe to submit this information.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files indicate United ensures denial decisions are reviewed and determined by an appropriate physician. Clinical reviewers forward requests to a medical director, or appropriate physician, when requests do not meet medical necessity criteria and cannot be approved. Additionally, denials for pharmacy requests are determined by a licensed pharmacist and signed off by a health plan medical director.
11.3 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 confirmed denial decisions are made according to the processes described in Policy UCSMM.06.18, Initial Adverse Determination Notices. Determinations were communicated verbally to the requesting provider. An adverse benefit determination letter, mailed to the provider and member, explains the basis for the denial and includes appeal procedures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V C. Appeals *42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260*						
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 UM Program Description and policies such as POL2015-01 Member Appeal, State Fair Hearing, External Appeal and Grievance Policy describes United's approach for handling and processing member and provider appeals. Additionally, information is provided in the Provider Manual, Member Handbook, and the member section of the website.
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," and information about who may file an appeal, are correctly defined and described in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy.
1.2 The procedure for filing an appeal;	X					Procedures for filing an appeal are described and outlined in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy. United ensures members and their representative have access to appeals information, processes, and procedures by making it available on the member facing website, which addresses the CAP identified during the previous EQR. CCME identified appeals instructions posted on the member website are available in English only, unlike other materials such as the Member Handbook and member rights and responsibilities which are available in both English and Spanish. During the onsite, United staff explained members can access appeals information in Spanish from the Spanish version of the Member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Handbook on the website and by calling Member Services where a Spanish speaking interpreter can be provided. Onsite discussions confirmed United is aware of changes to the appeals process, according to *42 CFR 438.402 (c) (3)*, which no longer requires a member's verbal appeal to be followed by a signed written appeal. United will ensure appeals documents are updated upon approval from the Division of Medicaid. *Recommendation: Post appeals instructions in Spanish on the member website to be consistent with other member materials such as the Member Handbook and Member Rights & Responsibilities and to ensure information is readily accessible to Spanish-speaking members.*
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					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN Member Handbook, and the CAN Provider Manual correctly document the resolution timeframe for standard and expedited appeals. Standard appeal requests are resolved within 30 calendar days,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						expedited appeals are resolved within 72 hours and either timeframe can be extended up to 14 calendar days by the member or by the plan. The appeal timeframe starts the day United receives the verbal request or the written request, as noted in Policy CSMM.07.11, Appeal Review Timeframes.
1.6 Written notice of the appeal resolution as required by the contract;	X					The CAN Uphold and Overturned letter templates contain the required information. Additionally, the "Your Additional Rights" enclosure provides correct information and instructions for requesting a State Fair Hearing. United updated the MS Member Admin or Clinical Uphold letter template and it no longer includes references for an independent external review, which addresses the CAP identified in the previous EQR.
1.7 Other requirements as specified in the contract.	X					Other appeal requirements are described in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and the CAN Member Handbook.
2. The CCO applies the appeal policies and procedures as formulated.		X				During the onsite, CCME discussed that the review of appeal files reflected United did not consistently follow guidelines in Policy UCSMM.07.11, Appeal Review Timeframes, which indicated the appeal timeframe starts the day United receives the verbal or the written request. CCME identified the following issues in five out of 24 CAN files: •"Received dates" in the Resolution Letter and/or the Standard Acknowledgement Letter reflected the appeal start time began when the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						member's consent form was received instead of when the verbal request was received by the Call Center. •Discrepancies were noted in documentation of "received dates" between the Resolution Letter, the Standard Acknowledgement Letter, and the Verbal Acknowledgment Letter. Additionally appeal resolution letters in five out of 24 CAN files incorrectly use the term "previously upheld" instead of "previously denied" when referencing the adverse benefit determination for the original service authorization request. *Corrective Action Plan:* *•Ensure staff are following the guidelines for appeals start times outlined in Policy UCSMM.07.11, Appeal Review Timeframes, to reflect when the verbal request was made with Call Center and ensure staff are consistently documenting the same "received date" on the Verbal Acknowledgement Letter, Standard Acknowledgement letter and Resolution Letter.* *•Ensure appeal Resolution Letters correctly reference the adverse benefit determination in the original service authorization as "previously denied" instead of "previously upheld."*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United tracks, trends, and analyzes appeals for medical and BH services. Results and analysis are documented in the UM Program Evaluation, QI Program Evaluation, and the Behavioral Quality Management and Improvement Program Evaluation. Results are reported to the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Healthcare Quality and Utilization Management (HQUM) Committee. The 2020 CAN UM Program Evaluation categorized appeal results in a comparative table from calendar 2019 to 2020. The report indicates the appeals uphold rate decreased -11.54 percentage points from 72.86% to 61.31%. The BH Quality Management and Improvement Program Evaluation reports no CAN member appeals were noted in 2020 and no barriers or opportunities were identified.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR §438.208, 42 CFR § 457.1230 (c)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Onsite discussion confirmed United's Care Management program has been updated and revised. The United Healthcare C&S Care Model Program Description defines and outlines United's approach to providing medical and BH CM services for members who meet program criteria and who require coordination of complex care. The Care Management Program is an integrated complex clinical management model that is member focused. Policies such as Policy MS 002 Rider 1, Case Management Process, and Policy NCM 002, Case Management Process, provide direction and guidance to CM staff. The CAN Quality Improvement (QI) Program Description explains that the Population Health Management (PHM) Program is coordinated in conjunction with the QI Program which serves as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						the framework to provide PHM programs and activities such as, but not limited to: •Supporting members with emerging risks and chronic conditions. •Addressing social determinants of health through targeted care management efforts. •Improving coordination of care through interdisciplinary care management staff and teams.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Policy NCM 001, Identification of High Risk Members for Case Management and the United Healthcare C&S Care Model Program Description describe methods for how eligible members are identified and referred into case management. United conducts a Health Risk Assessment (HRA) for new and existing members to identify medical, behavioral and Social Determinants of Health needs that are eligible for case management or special programs. Additionally, sources such as, referrals, claims, medical records and utilization management data can identify members who can benefit from case management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					A health risk assessment will be completed within 30 calendar days for members newly assigned to medium and high-risk categories and treatment plan will be completed within 30 calendar days after the HRA as described in Policy MS 002 Rider, Case Management Process.
4. The detailed health risk assessment includes all required elements:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The Adult Core 3.0 assessment requires documentation of demographic information such as verifying and updating the member's race, ethnicity, and preferred language, where the member lives and who they live with, and their employment status.
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					Policy NCM 002, Case Management Process states, "A person centered POC is developed by the CM in collaboration with the member, caregiver/family (with member's consent), and the interdisciplinary care team, including the member's PCP, other medical and behavioral health providers as appropriate and external case managers involved in the members care". Care Managers and Behavioral Health Advocates are licensed in Mississippi.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Policy NCM 012, Risk Stratification Process, explains that CM use their clinical judgement to revise and adjusts a member's risk level. During the onsite United explained Standard Operating Procedures are built in the CM documentation systems that give alerts when risks should be reassessed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					United uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process, such as face-to-face, telephonic, or mailings. Review of CM files reflect CM activities including, but not limited to, documentation of referral services, health education and support, and appropriate referrals and scheduling assistance.
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 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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The C&S Care Model Program Description explains that members with moderate risks will be assigned to the Chronic Illness Program and receive care coordination, telephonic outreach, and or field visits, evaluation for peer support services, and other non-clinical care management services.
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 including high risk perinatal and infant services.	X					The C&S Care Model Program Description indicates that members identified as high-risk or emerging risk will be assigned to the Intensive Opportunity Program: Complex Care Management Program. Onsite discussion confirmed that members in high risk categories receive all the services that members in lower risk categories receive. Identified pregnant members will be stratified as healthy or high risk. High risk pregnant members are engaged with Maternity Case Management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy NCM 002, Case Management Process, indicates cases are evaluated for closure when a member disenrolls from care management or changes health plans. Upon request, the CM will forward care plan information and utilization data to the new health plan.
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					During the onsite United explained the Disease Management Program is incorporated within Complex Care Management. Additionally, the CAN Member Handbook and Provider Manual describes United's Disease Management Program and provides instructions for members to obtain more information.
V E. Transitional Care Management *42 CFR § 438.208, § 457.1230*						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Policy MS021, Transitional Care Management and the CAN Care Management Program Description describe United's approach for ensuring transitional care management is accessible to eligible members and outline processes and requirements for managing transitions of care across healthcare settings. United tracks and monitors transition of care data including, but not limited to, hospital admission logs and admission/discharge diagnoses, which are used by the interdisciplinary care team and other staff to ensure timely continuity of care activities. Additionally, the Pharmacy Program Description and Policy RX-046, Pharmacy – Automated Transition of Care (TOC), indicate United provides new members with continuation of their

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						current medications, up to 31 days without prior authorization, until the provider can transition the member to formulary medications.
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					The CAN UM Program Description Addendum and Policy MS021, Transitional Care Management, describe United's approach for ensuring transitional care management is accessible to eligible members and outlines processes and requirements for managing transitions of care across healthcare and community settings. During the onsite CCME discussed CM files reflect documentation of outreach to providers within seven days to confirm applicable members receive post-discharge follow up, as required by the *CAN Contract, Section (9) (B) (1) (d)*. However, Policy MS021, Transitional Care Management, indicates providers will be notified within 14 days of a member's discharge, instead of seven days. *Recommendation: Correct Policy MS021, Transitional Care Management to indicate United will notify providers within 7days of a member's discharge, instead of 14 days.*
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					
4. The CCO meets other Transition of Care requirements.	X					Documentation in Policy MS021, Transitional Care Management, the UM Program Description Addendum, and Policy HFS 003, Covered Services and Continuity of Benefit Coverage for Pregnant

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Members, indicate United meets other transition of care contract requirements as noted in the *CAN Contract, Section 8 (B) (5)*. The transition of care process is available to members in the Member Handbook.
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					United performs an evaluation of the UM Program annually. The 2020 CAN UM Program Evaluation provides a summary of UM program activities, reports and analyzes measurement outcomes, determines the overall effectiveness of the UM Program, and offers recommendation for improvement for 2021. The COVID-19 pandemic caused United to leverage resources and to suspend and/or revamp certain services to achieve goals and provide care to members. The UM Program Evaluation informs that United will transition from MCG to InterQual decision-making criteria and a Utilization Management Program Committee (UMPC) will be added to the committee roster. Overall, the evaluation report indicates the UM Program was effective in meeting its objectives. Additionally, a focused evaluation was conducted for the CM Program.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2020 CAN Utilization Management Program Evaluation was reviewed and approved by the Healthcare Quality and Utilization Management (HQUM) and by the Quality Management Committee.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
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					Delegation agreements are in place specifying activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.
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 function.	X					Processes for vendor oversight and assessment are detailed in Policy DOV-01, Delegated Vendor Oversight Strategy. The UnitedHealthcare Credentialing Plan 2021–2023 includes processes for delegation of credentialing and recredentialing functions and oversight of delegated entities. It addresses delegation agreements, sub-delegation, preassessments, annual evaluation, oversight and monitoring, and required follow-up. Delegated entities are expected to provide routine reporting to facilitate performance monitoring. The reporting assists in identifying operational trends or issues so that performance improvement initiatives may be implemented as needed. Routine joint operating committee meetings are held with subcontractors to review performance and discuss any needed remediation. Evidence of the oversight conducted for non-credentialing delegates was submitted prior to the onsite visit. Oversight documentation for the credentialing delegates was requested from the health plan three times and was submitted after

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						completion of the onsite. Therefore, findings for the credentialing delegates were not discussed with the plan during the onsite visit. No issues were identified from review of oversight documentation of United's delegates.

CCME CHIP Data Collection Tool

Plan Name:	**UnitedHealthcare CHIP**
Review Performed:	2021

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					United has established guidelines used for the development, review, revision, and implementation of policies, procedures, and standard operating procedures.
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					Scott Waulters is the interim United Healthcare Chief Executive Officer (CEO).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.2 *Chief Operating Officer;	X					The Chief Operating Officer is Latrina McClenton.
1.3 Chief Financial Officer;	X					Heath Seaman Is the Chief Financial Officer.
1.4 Chief Information Officer;	X					The Chief Information Officer is Mike Rogers.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Jason Bell is the Claims Administrator.
1.6 *Provider Services Manager;	X					The Provider Services Director is Rhona Waldrep.
1.6.1 *Provider credentialing and education;	X					Onsite discussion revealed that 10 staff are dedicated to Provider Relations in support of medical, dental, and behavioral health services. A total of 23 call center agents provide education and provider services support.
1.7 *Member Services Manager;	X					Kenisha Potter is the Member Services Manager.
1.7.1 Member services and education;	X					Onsite discussion revealed that three staff are assigned to the Member Services team with 23 call center agents dedicated to supporting member services.
1.8 Grievance and Appeals Coordinator;	X					Krystal Webb is assigned to Grievance Coordination until the position is filled later this month.
1.9 Utilization Management Coordinator;	X					The Health Services Director is Kim Bollman.
1.9.1 *Medical/Care Management Staff;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.10 Quality Management Director;	X					Cara Roberson is the Quality Management Director.
1.11 *Marketing and/or Public Relations;	X					The Public Relations Specialist is Angie Richmond.
1.12 *Medical Director;	X					The United Chief Medical Officer and Medical Director is Amit Prasad, MD, MBA.
1.13 *Compliance Officer.	X					Amanda Rogers is the Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					United's percent paid average for 30 and 90 days exceeds Mississippi's timeliness requirements. United paid 99% or more clean claims within 30 days and averaged almost 100% of clean claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United's ISCA documentation notes that the organization collects enrollment and member demographics using HIPAA compliant transaction formats and code sets. The data is processed and stored by United's internal encounter data submission and reporting system. The system tests the data for accuracy, completeness, logic, and consistency. Finally, United uses the system to submit encounter data to the State in HIPAA standardized files.
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					HEDIS and HEDIS-like reporting is performed by United using systems running HEDIS-certified software. In addition to verifying data with its systems, staff review performance measure

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						reporting data for accuracy. Finally, United noted that its software was recently audited and received NCQA Certification in May 2021.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Business continuity and disaster recovery plans are in place to mitigate an incident and restore service if there is an incident. The plans include staff roles, emergency access procedures, recovery priorities, and recovery time objectives. United tests its plans annually and documentation indicates recent recovery tests were completed successfully. Finally, United updates its business continuity plans twice yearly.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The 2020-2021 UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program outlines approaches to the prevention, detection, reporting, corrective action, and best practices.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The UnitedHealth Group Code of Conduct emphasizes United's efforts towards representing the highest level of personal and institutional integrity, to never compromise ethics, and their commitment to transparency.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The Compliance Officer is named in the Mississippi addendum to the FWA Plan and the organization chart.
2.3 Information about the Compliance Committee;						The United Compliance Oversight Committee assists in fulfilling responsibilities of developing and implementing the Mississippi Compliance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Program. The primary objective is to assess the current state of the compliance program and to ensure that it effectively prevents, detects, and corrects violations of applicable laws, regulations, guidance, government contract requirements, company policies, and ethical guidelines.
2.4 Compliance training and education;						United requires compliance training for all new hires and annually for all employees.
2.5 Lines of communication;						The CAN 2021 Care Provider Manual (Provider Manual) includes the number for reporting to Optum's Anti-Fraud and Recovery Solutions unit.
2.6 Enforcement and accessibility;						The 2020-2021 UnitedHealthcare Community Plan of Mississippi (UHC) Fraud, Waste, and Abuse Program outlines that if an investigation reveals a credible allegation of fraud, United must cease any further investigations and notify the designated contact within the OPI immediately via email. The UnitedHealth Group Code of Conduct informs staff that violations are taken seriously and could result in discipline, up to and including termination of employment and possible legal action, including referral to law enforcement.
2.7 Internal monitoring and auditing;						The 2020-2021 UnitedHealthcare Community Plan of Mississippi (UHC) Fraud, Waste, and Abuse Program describes the process for compliance and performance audits. Allegations are considered credible when they have indicia of reliability. United and DOM review all allegations and facts, and act judiciously on a case-by-case basis.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.8 Response to offenses and corrective action;						FWA investigations are performed by the special investigative unit (SIU), which is comprised of highly qualified investigators with significant experience in health care and prescription drug fraud and abuse, industry business practices and systems, and infrastructure.
2.9 Exclusion status monitoring.						Policy ID-5881 entitled New Hire and Periodic Employee Sanction Review outlines United's stance on not knowingly hiring, continuing to employ, or contracting with someone if law or contract prohibits the person from providing services for customers.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The 2020- 2021 UnitedHealthcare Community Plan of Mississippi (United) Fraud, Waste, and Abuse Program describes ways to detect, report, and prevent FWA.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					
I E. Confidentiality *42 CFR § 438.224*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The Code of Conduct states that United is dedicated to taking all reasonable precautions to maintain the confidentiality of those who report an ethics or compliance concern to the extent allowed by Company policy and the law.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
II. A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
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				Processes and requirements for initial and ongoing credentialing of providers for United's network are documented in the following: •UnitedHealthcare Credentialing Plan 2021 – 2023 •State and Federal Regulatory Addendum, Attachment E to the UnitedHealthcare Credentialing Plan •United Behavioral Health (Optum) Clinician Credentialing Process policy •Additional policies and procedures The process for collecting fingerprints for CHIP providers designated as high-risk by DOM was not identified in any of the credentialing documentation reviewed. During onsite discussion, United staff could not verbalize the process for collecting fingerprints or which staff are responsible for this activity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						After the onsite visit was completed, United submitted a document stating the following: "The health plan has evaluated the high risk providers as defined by the Division of Medicaid and have determined all of the contracted providers are CMS enrolled therefore the health plan is in compliance with the requirement of *42 CFR § 455.450*. The health plan will develop a policy to ensure UnitedHealthcare remains in compliance with regulatory and internal business requirements as it relates to "high" risk providers following the requirement of 42 CFR § 455.450.The plan is trying to determine if this is being conducted by another department within the organization. Further information to be provided by the health plan." *Corrective Action: Develop and implement a process for collecting fingerprints for all CHIP providers designated as high risk by DOM at initial credentialing. The process must be detailed in a policy and evidence of fingerprint collection must be included in applicable provider credentialing files. Refer to the CHIP Contract, Section 7 (E) 6.*
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 UnitedHealthcare Board of Directors delegates responsibility and authority for credentialing and recredentialing to the National Credentialing Committee (NCC). The NCC communicates decisions to the health plan's Provider Advisory Committee (PAC), which serves as the local Credentialing Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The PAC, chaired by the health plan's Chief Medical Officer and reporting to the Quality Management Committee, reviews and approves all credentialing decisions made by the NCC. Membership of the PAC includes participating MS providers with an appropriate array of specialties to represent the network. The PAC meets at least four times yearly and the quorum is established as the presence of 51% of voting members. Uploaded NCC minutes reflect weekly meetings except for a few weeks during which major holidays fell. PAC meetings were held on 8/12/20, 11/11/20, 2/10/21, and 5/12/21.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						Any issues identified are addressed in standards 3.1.1 through 3.3 below.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) 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					
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number or providers billing laboratory services;	X					
3.1.15 Fingerprints, when applicable.				X		None of the CHIP providers reviewed were designated is high-risk by DOM.
3.2 Site assessment.	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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.3 Provider office site reassessment, when applicable.	X					
4.4 Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 2021 – 2023 describes the roles of the National Peer Review and Credentialing Policy Committee, Regional Peer Review Committees, and Medical Directors related to suspending, restricting, or terminating a provider's participation in the network for quality of care concerns. It also addresses the role of the Hearing Panel when a provider appeals of determinations to suspend, restrict or terminate a provider for quality of care concerns. Policy PS13, Provider Terminations, addresses processes followed when United makes a determination to terminate a provider from its network. United's process for responding to notification that DOM has terminated a provider is included in United's Fraud, Waste and Abuse Program 2020-2021. Onsite discussion confirmed that if United is notified that DOM has terminated a provider, the health plan immediately terminates the provider also. Written notification is provided to affected members within 48 hours and to the terminated provider within 1 day.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				Regarding verification of CLIA certificates, the following issues were noted: •One file for a rural health clinic and one file for an inpatient hospice included a CLIA number on the provider's application but no verification of the CLIA in the file. •One file for a hospital included a CLIA verification date on the credentialing checklist, but no other evidence of verification of the CLIA in the file.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						For all of these files, verification of the CLIA was submitted after completion of the onsite visit. All of the verifications were dated 10/6/21. Regarding queries of the MS DOM Sanctioned Provider List, the following issues were noted: •There was no evidence of querying the MS DOM Sanctioned Provider List for three providers. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted. •One file included a screenshot labeled as the query, but there was no way to confirm as there was no identifying information on the screenshot. •Three files contained screenshots labeled as the query, but they appeared to be general searches on DOM's main website and not queries of the MS DOM Sanctioned Provider List. Evidence was provided after the onsite but did not include a date stamp for when the verification was conducted. *Corrective Action: Ensure verification of CLIA is conducted prior to issuing the credentialing or recredentialing determination and that evidence is included in the provider file. Ensure queries of the MS DOM Sanctioned Provider List are included in each organizational provider's file and that it is clearly identifiable and includes the date the query was conducted.*
II B. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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.						Policy PS3, Geographic Access Standards, states United ensures members have consistent and convenient access to medical providers, and defines the geographic access standards for the provider networks. Access standards defined in the policy include all provider types specified in the *CHIP Contract Section 7 (B)*. The access parameters listed in the policy are compliant with contractual requirements.
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As stated in Policy PS10, PCP Panel Notification, United notifies PCPs of assigned members within five business days of the date United receives the Member Listing Report from DOM. United makes member panel details available to all participating PCPs via its secure provider portal. United also identifies PCPs with changes in member panels and mails a postcard notification about these changes to impacted PCPs within five days of receiving the Member Listing Report from DOM.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					As noted in Policy PS10, PCP Panel Notification, PCPs communicate desired panel restrictions to United during initial credentialing and/or contracting. Providers can request changes to their panel at any time and can update their panels status on the provider portal. Onsite discussion confirmed United runs quarterly reports of providers who are not accepting new patients and meets monthly to review the network and ensure there are sufficient providers

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						in the network accepting new patients to meet member needs.
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					
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Submitted Geo Access reports indicate quarterly geographic assessments are conducted. The reports provide a breakdown of member access by provider specialty and by rural and urban designation. The 2021 Quality Improvement Program Description indicates United monitors the network to ensure adequate access for members to health care services. Network Management analyzes network gaps, access to/availability of care, and implements improvement action plans to address identified issues.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					United's Multicultural Health Care Program includes various activities to ensure its network can serve members with special needs, foreign language, and cultural requirements. These activities include: •Assessments of race, ethnicity and language demographics for both members and providers conducted at least every 3 years to identify any language or cultural gaps in the provider network

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and to determine if changes are needed in language services. •Measurement of activities to reduce health care disparities using HEDIS data to identify opportunities and develop action plans. •Measurement of member satisfaction via CAHPS surveys. •Annually identifying and prioritizing opportunities to reduce health care disparities and improve Culturally and Linguistically Appropriate Services. United does not have a formal, written Cultural Competency Plan; however, information is available on the provider portal, in Provider Manuals, newsletters, etc.
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 written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Appointment access standards are defined in Policy PS2, Access Standards – Appointment Availability Requirements. Standards listed in the policy are compliant with contractual requirements. The policy indicates providers are educated about the appointment access standards and the standards are documented in the Provider Manuals. United conducts quarterly assessments of PCP, OBGYN, and behavioral health provider compliance to the standards. Quarterly and annual assessments are conducted to determine compliance by high-volume specialists. Results are relayed to the SQIS for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						monitoring, tracking, trending, identification of improvement opportunities, and development of corrective action initiatives. Failure to meet access requirements results in direct outreach to providers. Excel spreadsheets documenting results of appointment access and afterhours access call studies conducted by DialAmerica were submitted. Review of these documents indicated: •For appointment access, the percentages of providers requiring corrective action are increasing for Peds (>35%) and OBGYN (>59%). The percentages for BH (>40%))and PCPs (>23%) are trending down from the previous quarter. •For after-hours access, the percentages of providers requiring corrective action is increasing for PCPs (62.42%), OBGYNs (25.93%), and Peds (46.67%). The percentage for BH providers has consistently been at or above 50%, most recently at 61.36%. Onsite discussion of these findings indicated that providers are facing increased challenges related to the COVID-19 pandemic. The discussion confirmed that United continues to address appointment availability and after-hours access requirements with providers during monthly "town hall" meetings, reminds providers of contractual requirements in bulletins, and conducts one-on-one sessions with providers as needed to address findings.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Processes for new provider orientation and education are found in Policy PS14, Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Orientation Plan, and in SOP-PS14, Standard Operating Procedure – Provider Orientation Plan Summary & Checklist. Monthly Network Notification reports identify newly contracted providers. Once identified, a Provider Advocate is assigned and is responsible for contacting new providers within 30 days of the contract effective date. Welcome calls are placed to answer any immediate questions and to schedule an on-site orientation.
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	X					The CHIP Provider Manual includes a listing of covered and excluded benefits. Onsite discussion indicated Peer Support Services are covered as a behavioral health benefit; however, the benefit grid in the CHIP Provider Manual, page 10, does not indicate this as a covered service. A similar finding is noted in the CHIP Member Handbook, page 32. *Recommendation: Revise the CHIP Provider Manual, page 10, and the CHIP Member Handbook, page 32, to indicate peer support services is a covered benefit.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;		X				The CHIP Provider Manual, page 56, defines appointment access standards for BH provides, but does not include the requirement that appointments after discharge from an acute psychiatric hospital are required within 7 days. *Corrective Action: Revise the CHIP Provider Manual, page 56, to include the 7-day timeframe for appointments after discharge from an acute psychiatric hospital.*
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				The *CHIP Contract, Exhibit D, Section J* indicates medical records must be retained for a period of no less than 10 years. However, the CHIP Provider Manual does not include the medical record retention requirement. Review of the provider contract templates revealed the Mississippi Medicaid Program Regulatory Requirements Appendix document UHN Provider) correctly documented the medical record retention timeframe. However, the following provider contract templates indicated the medical record retention timeframe requirement is at least 6 years: •Ancillary Provider Participation Agreement •Facility Participation Agreement •FQHC/RHC Participation Agreement

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						•Medical Group Participation Agreement The MississippiCHIP Regulatory Requirements Appendix Downstream Provider template indicated the medical record retention timeframe is not less than 5 years. The following indicated the medical record retention timeframe is 3 years: •Facility Contract •Group Contract •Individual Contract *Corrective Action: Update the CHIP Provider Manual to include the required medical record retention timeframe. Revise the following documents to state the correct medical record retention timeframe of 10 years:* *•Ancillary Provider Participation Agreement* *•Facility Participation Agreement* *•FQHC/RHC Participation Agreement* *•Medical Group Participation Agreement* *•MississippiCHIP Regulatory Requirements Appendix Downstream Provider* *•Facility Contract* *•Group Contract* *•Individual Contract*
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					The CHIP Provider Manual includes information about member appeals and grievances, as well as provider complaints, grievances, and appeals.
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
emergency supply of medication until authorization is complete;						
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
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 includes all required elements.	X					United's CHIP website includes the "Find A Provider" function that allows members or others to search for providers by various parameters, including name, specialty, etc. The .pdf versions of the CHIP Provider Directories are split into the Central, North, and South regions, are available upon request, and are available for download from the health plan's website. Some provider entries in the printed and online provider directories do not include hours of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						operation, which is required by the *CHIP Contract Section 6 (E) (5)*. Also, Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing, states provider directories must include "Identification of hours of operation including identification of Providers with non-traditional hours…" *Recommendation: Develop and implement processes to gather information about providers' hours of operation and include this information in the CHIP provider directories.*
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
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					United reviews and adopts preventive guidelines (PHGs) that are nationally recognized and include specific criteria for childhood, adult, and geriatric populations. A policy titled "Review of Clinical and Preventive Guidelines" describes the process for review of PHGs. The Medical Technology Assessment Committee (MTAC) is responsible for reviewing the guidelines, and the guidelines are reviewed at least every 12 months.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					The CHIP Provider Manual includes information about the PHGs and states United endorses and monitors use of the guidelines. The manual states the guidelines are available at UHCprovider.com. CCME confirmed the link is correct and providers can access the guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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 *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
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					United reviews and adopts clinical practice guidelines (CPGs) that are nationally recognized, and include specific criteria for childhood, adult, and geriatric populations. A policy titled "Review of Clinical and Preventive Guidelines" describes the process for review of clinical practice guidelines. The Medical Technology Assessment Committee (MTAC) is responsible for reviewing the guidelines at least every 12 months. The Provider Advisory Committee (PAC) reviewed the MTAC recommendations for the 2021 guidelines during its meeting on 5/12/21. The following notation was found in the minutes: "After reviewing the updated CPG list, Sickle Cell Disease was removed for 2021. However, it will be requested to be put back on the MS CPGs. UHC

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						quality participates in a SCD Performance Improvement Project that is mandated by the State. Also, so many of the UHC members have SCD and the best practice guideline needs to be available." United staff confirmed the guideline has been reinstated.
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO members.	X					The CHIP Provider Manual includes information about the CPGs and indicate that for specific state benefits or services not covered under national guidelines, criteria are developed internally through review of current medical literature, peer reviewed publications, Medical Technology Assessment Reviews, and specialist consultation.
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					Processes and requirements for provider medical record reviews are detailed in Policy NQM-025, Ambulatory Medical Record Review Process, and its associated attachments. The medical record review process is conducted to monitor and assess provider compliance with medical record documentation standards. Although the medical record documentation standards and audit tools are reviewed and approved annually by the National Quality Oversight Committee (NQOC), United may revise the standards and tools to meet state-specific requirements.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	X					Policy NQM-025 describes medical record audit processes. The policy states: •At completion of the medical record audit, any provider who has a failing score is notified. Education and support is provided and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						provider is informed that an additional review will be conducted. •For providers who fail the additional review, the Medical Director and/or the applicable quality committee will determine appropriate corrective action. •Upon final closure of the medical record review, final results may be presented to the applicable health plan committee. Onsite discussion confirmed the additional review of providers who have failing scores is conducted during the next year's medical record audit. However, Policy NQM-025, as currently written, does not make this clear. For example, the information about the additional review is addressed prior to a statement that indicates final results may be presented to the applicable health plan committee upon final closure of the medical record review. *Recommendation: Revise Policy NQM-025 to clearly indicate the timeframe during which an additional review is conducted for providers who fail the initial medical record review.*
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					The response rate was 1.9% with 57 providers completing the survey out of the 2,958. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Work on action plan steps as per the report including increasing email quality and survey advertisement to improve response rates.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					Results were presented to the QMC during the March 2021 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Policy MBR4a, Notification of Rights, describes written policies and procedures are present regarding member rights to ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to member rights.
2. Member rights include, but are not limited to, the right:	X					Member rights are detailed in Policy MBR4a, Notification of Rights, the CHIP Member Handbook, the CHIP Provider Manual, and the CHIP member website.
2.1 To be treated with respect and dignity;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To 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 detailed in Policy MBR4a, Notification of Rights, the CHIP Member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Handbook, the CHIP Provider Manual, and the CHIP member website.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
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					
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	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; information regarding co-payments and out-of-pocket maximums;						The CHIP Member Handbook provides information on coverage limits, specialized services, accessing care from an out-of-network provider, and end-of-coverage explanations.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						No prior approval for family planning services, emergency visits, or BH is needed. Requirements for prior approval of medical, BH, and pharmaceutical services is described in the CHIP Member Handbook. Services that require prior approval are indicated in the benefits grid.
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;						Information on 24-hour access to care and level of care triage is described on the website and in the CHIP Member Handbook.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The CHIP Member Handbook includes information about obtaining prescription medications and durable medical equipment. The Preferred Drug List is available for member reference on the website along with information about participating pharmacies. This information is also available by contacting Member Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	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;						United notifies members of changes to the CHIP program no later than 30 calendar days prior to implementation and provides 15 days written notice of termination of a provider, as described in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, Policy MBR8b, 15-Day Written Notices of Termed Provider, and noted in the CHIP Member Handbook.
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;						Information about the 24-Hour NurseLine and accessing the secure Member Portal is located on the United website. The CHIP Member Handbook provides telephone numbers and descriptions for Member Services.
1.13 A description of the Well-Baby and Well-Child services which include:						
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/education and referral for identified problems.						
1.14 Procedures for disenrolling from the CCO;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;	X					
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					
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, describe and outline the processes United uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	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					Policy MBR1b2, Notification of Oral Interpretation Services, describes that translation services are provided free of charge to non-English speaking members, members who have limited English proficiency, and members who are deaf or hearing impaired. This information is also found in the CHIP Member Handbook.
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					A toll-free number is listed for Member Services via the "Have Questions" link on the member website, the Member Handbook, and other public materials.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Training is provided to Call Center staff during orientation and thereafter routinely scheduled via an electronic platform of modules. Training includes scripts for urgent, emergent, and routine call types, and utilizing role-play training per onsite discussion.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call Center trends and performance measures are monitored with monthly and quarterly reporting and analysis. The Call Center metrics are monitored by the Performance Improvement Team and reported to the Quality Improvement Committee and the SQIS.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
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					Information about scheduled preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services is included in the CHIP Member Handbook and on the CHIP website. Mailers, such as an EPSDT brochure and member newsletters, are sent to members.
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 Healthy First Steps™ (HFS) Program Description outlines United's approach for identifying pregnant members, stratifying them by risk level, and providing care management and health education services for all enrolled pregnant members.
3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits 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					Onsite discussion provided information about Each year, an annual preventive care goals, how to achieve new initiatives (or conditions), community resources are also included. During the initial call, members are told about the information for each annual initiative. 2021 was modified to include

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						virtually to enhance availability. Preventive care topics are used in different platforms to include online magazines and newsletters to provide information to members along with applicable interventions. United is working with DOM to address asthma and respiratory conditions.
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 requirements of the CMS Survey Validation Protocol. United contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems Survey vendor, to conduct the Adult and Child Surveys. For United CHIP, the generalizability of the Child CCC survey results is difficult to discern due to low response rate of 15.9% (315 completed surveys out of 1,979 sampled). This is a decrease from last year's response rates although it was higher than the average United CHIP general population response rate of 12.6%. *Recommendation: Work on action plan steps including increasing email quality and survey advertisement to improve Provider Satisfaction Survey response rates.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					United analyzes data obtained from the Member Satisfaction Survey to identify quality problems, as noted in the 2021 MS CHIP QI Program Evaluation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
3. The CCO reports the results of the member satisfaction survey to providers.	X					The plan reports the results of the Member Satisfaction Survey to providers as seen in the Practice Matters 2021 Newsletter Member Experience Analysis report.
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 identified, to the correct committee as noted in the QMC March 2021 and the MSCAN Adult CAHPS Survey results document.
III G. Grievances *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457.1260*						
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					
1.1 Definition of a grievance and who may file a grievance;	X					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, defines a grievance as "An expression of dissatisfaction about any matter other than an adverse benefit determination." This definition, along with who may file and how a grievance may be filed, are also provided in the CHIP Member Handbook, CHIP Provider Manual and in United's website glossary of terms.
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
2. The CCO applies the grievance policy and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United tracks, analyzes grievances, and reports results to the SQIS quarterly, as described in the Utilization Management and Quality Improvement Program Description documents. The SQIS monitors trends related to member grievance activities and the quality of other non-clinical services.
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					
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
IV A. Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
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 2021 Quality Improvement Program Description for the CHIP program and the 2021 Behavioral Health Quality Improvement Program Description were provided for review. The QI program description is updated annually and presented to the Board of Directors, Quality Management Committee and the Division of Medicaid for approval. United's Provider Manual includes details regarding their Quality Management program. Providers are advised that United requires their participation and compliance with the program and a copy of the QI program is available upon request. During the onsite, staff explained members and providers are informed in various materials such as newsletter to call United and request additional information about the QI program. Also, United has a link on their website that providers may use to access additional information about the program.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The QI program description describes United's efforts to reduce health disparities through the Multicultural Health Care program. Two goals specific for the CHIP population includes improving the rates for adolescent well child exams and member satisfaction.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
analysis that demonstrate potential health care delivery problems.						
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 presented the 2020 and 2021 QI Work Plans for review. Both are reviewed and updated at least quarterly. The work plans included the QI activities across several tabs, the responsible person(s), quarterly target dates and each activity's status.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Management Committee (QMC) is responsible for oversight of the QI program for the CHIP population. Other committees charged with the responsibility of evaluating and monitoring the QI activities include the Provider Advisory Committee, Healthcare Quality and Utilization Management Committee, and the Service Quality Improvement Subcommittee. Each committee meets at least quarterly and has designated a quorum as 51% of the voting members present. The Utilization Management activities are handled by the Healthcare Quality and Utilization Management Committee. Per the QI Program Description, page 13, the Board of Directors/Executive Committee is the governing body for the organization. The Quality Management Committee reports to the Board at least annually.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Officer chairs the QMC, the Provider Advisory Committee, and the Healthcare Quality and Utilization Management Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						The Services Quality Improvement Subcommittee is chaired by the Chief Operations Officer. Voting members for the QMC include United's senior leaders representing all departments of the organization. Network primary care and subspecialty physicians are included as voting members for the Provider Advisory Committee. Their specialties include Pediatrics, OB/GYN, Internal Medicine, Psychiatry, Dentistry, and Family Medicine.
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The performance measure validation found that United was fully compliant with all information system standards and determined that United submitted valid and reportable rates for all HEDIS measures in scope of this audit. There were no concerns with United's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation. Primary source verification demonstrated concerns in the reporting of the CDF-AD/CH:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Screening for Depression and Follow-up Plan measure. *Recommendation: Improve processes around calculation, reporting, and verification of the rates reported for the DOM required Adult and Child Core set measures.*
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
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					United submitted the same four PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction, Follow Up After Hospitalization, and Obesity.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					Last year there were some recommendations regarding the documentation of statistical analysis, causal analysis, and the reporting of results. All of those recommendations were implemented and reflected in the PIP documentation submitted with the desk materials. All the CHIP PIPs scored in the "High Confidence in Reported Results" range The Getting Needed Care and the Reducing Adolescent and Childhood Obesity PIPs demonstrated no quantitative improvement in process or care. Details of the validation activities for the PIPs, along with specific outcomes related to each activity, may be found in *Attachment 3, CCME EQR Validation Worksheets*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Recommendation: Continue working on provider and member interventions to improve the composite score on Getting Needed Care PIP and improve the measure rates for the Reducing Adolescent and Childhood Obesity PIP.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					United's Provider Manual includes details regarding their Quality Management program. Providers are advised that United requires their participation and compliance with the program. A copy of the QI program is available upon request.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Per Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, on an annual basis, United measures Provider Performance against at least two (2) of the clinical guidelines. For CHIP, United selected the Antidepressant Medication Management and the Weight Assessment Counseling for Nutrition and Physical Activity measures for monitoring provider compliance with the guidelines. The policy indicates the results of the monitoring is provided to DOM with a summary of any corrective actions taken to ensure compliance with the guidelines. This policy was not specific regarding how providers receive the results of this monitoring. *Recommendation: Include how results of the provider monitoring of Clinical and Preventive Health Guidelines are shared with network*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						providers in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines.
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 Well-Baby and Well-Child screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					The Standard Operating Procedure titled "Well-Child Services – Tracking Process" indicates members identified with significant conditions receive additional outreach for case management and referrals, if needed. United tracks the Well Child Services, the abnormal findings and referrals. During the previous EQR CCME recommended that United update the Well-Baby or Well-Child exam tracking report and include the date the Well-Baby or Well-Care exam was provided, ICD 10 or CPT codes, treatment/referral, if provided, and members who received additional outreach for case management referrals. United provided a copy of the EPSDT tracking reports used to identify members who received EPSDT services and the identified, if any, abnormal findings. The tracking reports were updated, and the recommendations implemented.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Annually United completes an evaluation of the QI program to assess the overall effectiveness of the organization's QI processes for its CHIP

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						members. The 2020 Quality Improvement Program Evaluation was provided as evidence of this evaluation. The evaluation included an assessment of how the 2020 goals and objectives were met, a summary of activities, the impact the results had on improving the quality and safety of clinical care and services, and the overview of potential barriers to achieving goals. Pages seven through nine included a description, a three-year trend of HEDIS rates, and if the 2020 rate met the goal established by United (Quality Compass ® 50th percentile). There were two measures noted as not meeting the 50th percentile goal; however, the reported 2020 rates exceeded the 50th percentile goal. Those measures included Annual Dental Visits (Total Rare) and Asthma Medication Ratio (Total Rate). The program evaluation, pages 84 and 85, listed the area United planned to target for improvements in 2021. However, this section lacked the interventions United planned to use to improve those areas targeted. *Recommendation: Correct the errors in the HEDIS results table and include a summary of the interventions planned for 2021.*
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V A. 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 CHIP Utilization Management Program Description Addendum and the Behavioral Health Utilization Management Program Description and Work Plan outline the objectives, scope, staff roles for physical health, 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					The UM Program Description indicates that the functions of the Medical Technology Assessment Committee (MTAC) include, but are not limited to, reviewing supporting evidence used for new and emerging technologies. Additionally, the Medical Policies Team conducts medical technology assessment reviews for current, new and emerging technologies to support medical policies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The CHIP UM Program Description Addendum clearly describes the role and responsibilities of the Chief Medical Officer/Medical Director, Amit Prasad, MD. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting reviews, and chairing the Healthcare Quality Utilization Management Committee (HQUM) and the Physician Advisory Committee (PAC). Operating authority is delegated to the UnitedHealthcare Health Services Director. The BH Regional Medical Director and the Pharmacy Director collaborate with the CMO and have clinical oversight of the respective programs.
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 CHIP UM Program Description and related policies and procedures are evaluated at least annually to assess 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. Onsite discussion confirmed United ensures practitioner input in UM activities, such as appeals and grievances, and guidelines and criteria. during quarterly Physician Advisory Meetings. Grievance and appeal reports, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Medical Technology Assessment Committee (MTAC) minutes are provided prior to the quarterly Physician Advisory Committee meeting and confirmed in the minutes. The CHIP 2020 UM Program Evaluation was approved by the HQUM Committee on May 20, 2021.
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457.*						
1. Services that require prior authorization by the CCO include only the services specified by the Mississippi Division of Medicaid.	X					During the onsite United explained that administrative codes are researched and verified to ensure services requiring prior authorization are specified by the Division of Medicaid.
2. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					The member's eligibility status, Division of Medicaid's contract requirements, Milliman Care Guideline (MCG) and InterQual, and internal clinical review criteria such as medical policies and utilization review guidelines are used to determine medical necessity and service authorizations as indicated in Policy UCSMM.06.10, Clinical Review Criteria, and the UM Program Description Addendum. United's BH Level of Care Guidelines and Optum's Clinical Criteria are used to conduct BH determinations. Policy UCSMM 06.10 Rider 1, Clinical Review Criteria, lists the hierarchy for evaluating service authorization requests.
3. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of CHIP UM approval files reflect consistent decision-making utilizing evidenced base criteria such as MCG, InterQual, United's clinical guidelines, the PDL and other pharmacy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						guidelines, and the member's relevant clinical information.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Approval files reflect that UM nurses review pertinent medical records and consider the local delivery system and the member's individual circumstances while making UM decisions. UM clinicians consult with Medical Directors on appropriate service requests.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					United conducts an online inter-rater reliability (IRR) assessment for all clinical staff including medical directors where the minimum passing score is 90%. As reported in the 2020 CHIP UM Evaluation, staff achieved the established goal in each MCG IRR product: Inpatient & Surgical Care, Ambulatory Care, and Recovery Facility Care. Onsite discussions confirmed that BH and Pharmacy reviewers achieved passing scores in their respective IRR testing.
6. Pharmacy Requirements						
6.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The Pharmacy Program Description explains that OptumRx is the pharmacy benefit manager (PBM) and is responsible for implementing all pharmaceutical services for United, including but not limited to prior authorizations and pharmacy network management. It describes that the Universal Preferred Drug List (PDL) for the CHIP program is aligned with DOM. A link to access the most current version of PDL is available on United's CHIP website directs the user to DOM's website, where the PDL is available in a searchable, electronic format. The PDL indicates over-the-counter (OTC) availability, age

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						or quantity limitations, and if step therapy is required.
6.2 The CCO has established policies and procedures for the prior authorization of medications.	X					The Pharmacy Program Description and UM Program Description Addendum, and policies such as Policy RX-036, Emergency Medication Supply / Temporary Coverage Override, describe United's process for conducting prior authorization of medications. Optum Rx conducts the PA process according to state, federal and regulatory requirements. Within 24 hours PA requests are determined and notification is provided to the requesting provider. United ensures a 3-day supply of medication will be approved while a prior authorization request is pending.
7. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The UM Program Description Addendum and the Behavioral Health Benefits Addendum explains that United does not require prior authorization for physical health or BH emergency hospital services. Policy UCSMM.04.11, Consumer Safety, describes emergency and post-stabilization service requirements and the member's ability to access them.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Policies such as Policy UCSMM.06.14, Initial Clinical Review, Policy UCSMM.06.13, Non-Clinical Intake and Initial Screening, and Policy UCSMM.02.10, Staff Qualifications and Credentials, describe United's approach for ensuring UM decisions are conducted by qualified staff. Initial clinical reviews are performed by a Mississippi-licensed nurse or Referral Specialist,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						and Level II clinical reviews are performed by a Mississippi-licensed physician or other appropriate healthcare practitioner. Non-licensed staff perform intake and initial screenings that do not require clinical interpretation and use scripted interview material to obtain further information. Additionally, BH Care Advocates are licensed and hold advanced degrees in the BH field or are registered psychiatric nurses, and pharmacy reviewers are trained technicians or licensed pharmacists.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of CHIP approval files reflect physical and BH utilization decisions are determined within required timeframes. Urgent service authorization requests are determined and communicated to providers within 24 hours and standard requests are communicated within 3 calendar days/2 business days.
11. Denials						
11.1 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					CHIP UM denial files reflect clinical reviewers request additional information from providers prior to making a decision to deny services. Providers are given a specified timeframe to submit this information.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files indicate United ensures denial decisions are reviewed and determined by an appropriate physician. Clinical reviewers forward requests to a medical director, or appropriate physician, when requests do not meet medical necessity criteria and cannot be approved. Additionally, denials for pharmacy requests are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						determined by a licensed pharmacist and reviewed by a health plan medical director.
11.3 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 confirmed denial decisions are made according to processes described in Policy UCSMM.06.18 Initial Adverse Determination Notices. Determinations were communicated verbally to the requesting provider. An adverse benefit determination letter, mailed to the provider and member, includes the basis for the denial along with appeal procedures.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
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 UM Program Description and policies such as POL2015-01 Member Appeal, State Fair Hearing, External Appeal and Grievance Policy describes United's approach for handling and processing member and provider appeals. Additionally, information is provided in the Provider Manual, Member Handbook, and the member section of the website.
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," and information about who may file an appeal, are correctly defined and described in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal.
1.2 The procedure for filing an appeal;	X					Procedures for filing an appeal are described and outlined in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy. United ensures members and their representative have access to appeals information, processes, and procedures by

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						making it available on the member facing website, which addresses the CAP identified during the previous EQR. CCME identified appeals instructions posted on the member website are available in English only, unlike other materials such as the Member Handbook and member rights and responsibilities which are available in both English and Spanish. During the onsite, United staff explained members can access appeals information in Spanish from the Spanish version of the Member Handbook on the website and by calling Member Services where a Spanish speaking interpreter can be provided. Onsite discussions confirmed United is aware of changes to the appeals process, according to *42 CFR 438.402 (c) (3)*, which no longer requires a member's verbal appeal to be followed by a signed written appeal. United will ensure appeals documents are updated upon approval from the Division of Medicaid. *Recommendation: Post appeals instructions in Spanish on the member website to be consistent with other member materials such as the Member Handbook and Member Rights & Responsibilities and to ensure information is readily accessible to Spanish-speaking members.*
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
medical expertise who has not previously reviewed the case;						
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					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, and the CHIP Provider Manual correctly document the resolution timeframe for standard and expedited appeals. Standard appeal requests are resolved within 30 calendar days, expedited appeals are resolved within 72 hours, and either timeframe can be extended up to 14 calendar days by the member or by the plan. The appeal's timeframe starts the day United receives the verbal request or the written request, as noted in Policy CSMM.07.11, Appeal Review Timeframes.
1.6 Written notice of the appeal resolution;		X				The CHIP Uphold and Overturned letter templates contain the required information. Additionally, the "Your Additional Rights" enclosure provides information and instructions for requesting an Independent External Review. However, it does not include the requirement that members have right to request and receive benefits while the Independent External Review is pending and that the member can be held liable for the cost. *Corrective Action Plan: Edit the "Your Additional Rights" enclosure for CHIP appeal letters to include the requirement that members have the right to request and receive benefits and can be*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						held liable for the cost, according to CHIP Contract Section E (14)(d).
1.7 Other requirements as specified in the contract.	X					Other appeal requirements are described in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and the CAN Member Handbook.
2. The CCO applies the appeal policies and procedures as formulated.		X				During the onsite, CCME discussed that the review of appeal files reflected United did not consistently follow guidelines in Policy UCSMM.07.11, Appeal Review Timeframes, which indicates that the appeal timeframe starts the day United receives the verbal request or the written request. CCME identified the following issues in 10 out of 20 CHIP files: •"Received dates" in the Resolution Letter and/or the Standard Acknowledgement Letter reflect the appeals start time began when the member's consent form was received instead of when the verbal request was made with Call Center. •Discrepancies were noted in documentation of "received dates" between the Resolution Letter, the Standard Acknowledgement Letter, and the Verbal Acknowledgment Letter. Additionally appeal resolution letters in eight out of 20 CHIP files incorrectly use the term "previously upheld" instead of "previously denied" when referencing the adverse benefit determination for the original service authorization request.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						Corrective Action Plan: Ensure staff are following the guidelines for appeals start times outlined in Policy UCSMM.07.11, Appeal Review Timeframes, to reflect when the verbal request was received by the Call Center and ensure staff are consistently documenting the same "received date" on the Verbal Acknowledgement Letter, Standard Acknowledgement letter and Resolution Letter. Ensure appeal Resolution Letters correctly reference the adverse benefit determination in original service authorization as "previously denied" instead of "previously upheld".
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The 2020 CHIP Quality Improvement Program Evaluation reports appeal results categorized in a comparison table from calendar year 2019 to 2020. The report states, "CHIP members submitted a total of 7 grievances for 2020, a decrease of 36 percentage from the previous year 2019 (11). Even though the Access to Services/Providers (0.19) category made up approximately 85 percent of the total grievances received, it did not reach the threshold 0.25/1000 by 0.06 percentage points". The BH Quality Management and Improvement Program Evaluation reports two CHIP member appeals related to lack of medical necessity were noted in 2020 and no barriers or opportunities were identified.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
V D. Care Management *42 CFR § 436.208, 42 CFR § 457.1230 (c)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					Documentation of United's Care Management program has been updated and revised. The United Healthcare C&S Care Model Program Description defines and outlines United's approach to providing medical and BH CM services for members who meet program criteria and who require coordination of complex care. It is an integrated complex clinical management model that is member focused. Policies such as, Policy MS 002 Rider 1, Case Management Process, and Policy NCM 002, Case Management Process, provide direction and guidance to CM staff. The CHIP Quality Improvement (QI) Program Description explains that United has a Population Health Management (PHM) Program that is coordinated in conjunction with the QI Program which serves as the framework to provide PHM programs and activities such as, but not limited to: •Supporting members with emerging risks and chronic conditions. •Addressing social determinants of health through targeted care management efforts. •Improving coordination of care through interdisciplinary care management staff and teams.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Policy NCM 001, Identification of High Risk Members for Case Management and the United Healthcare C&S Care Model Program Description describe methods for identifying and referring

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						eligible members into case management. United conducts a Health Risk Assessment (HRA) for new and existing members to identify physical health, behavioral health and Social Determinants of Health needs that are eligible for case management or special programs. Additionally, sources such as, referrals, claims, medical records and utilization management data can identify members who can benefit from case management.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					A health risk assessment will be completed within 30 calendar days for members newly assigned to medium and high-risk categories. The treatment plan will be completed within 30 calendar days after the HRA as described in Policy MS 002 Rider, Case Management Process.
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					Policy NCM 002, Case Management Process states, “A person centered POC is developed by the CM in collaboration with the member, caregiver/family (with member’s consent), and the interdisciplinary care team, including the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						member's PCP, other medical and behavioral health providers as appropriate and external case managers involved in the members care". Care Managers and Behavioral Health Advocates are licensed in Mississippi. Policy MS 002 Rider 1, Case Management Process, explains that a treatment plan is established within 30 days after the detailed HRA in completed.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Policy NCM 012, Risk Stratification Process, explains that CM use their clinical judgement to revise and adjusts a member's risk level. During the onsite United explained Standard Operating Procedures are built in the CM documentation systems that give alerts when risks should be reassessed.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					United uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process, such as face-to-face, telephonic, or mailings. Review of CHIP CM files reflect CM activities including, but not limited to, documentation of referral services, health education and support, and appropriate referrals and scheduling assistance.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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;						
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.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					The C&S Care Model Program Description explains that members with moderate risks will be assigned to the Chronic Illness Program and receive care coordination, telephonic outreach, and or field visits, evaluation for peer support services, and other non-clinical care management services.
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 C&S Care Model Program Description indicates that members identified as high-risk or emerging risk will be assigned to the Intensive Opportunity Program: Complex Care Management Program. Onsite discussion confirmed that members in high-risk categories receive all the services that members in lower risk categories receive.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy NCM 002, Case Management Process, indicates cases are evaluated for closure when a member disenrolls from care management or changes health plans. Upon request, the CM will forward care plan information and utilization data to the new health plan.
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					During the onsite, United explained the Disease Management Program is incorporated within the Complex Care Management. Additionally, the CHIP Member Handbook and Provider Manual describes United's Disease Management Program and provides instructions for members to obtain more information.
V E. Transitional Care Management *42 CFR § 438.208, § 457.1230*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Policy MS021, Transitional Care Management explains that the Quality Improvement department assists with monitoring and evaluating provider performance with continuity and coordination of care activities by performing medical record audits, conducting member and provider satisfaction surveys, and conducting utilization reviews. Additionally, United tracks and monitors transition of care data such as hospital admission logs and admission/discharge diagnoses to ensure members receive services that are appropriate and timely.
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					The CHIP UM Program Description Addendum and Policy MS021, Transitional Care Management, describe United's approach for ensuring transitional care management is accessible to eligible members and outline processes and requirements for managing transitions of care across healthcare and community settings. Review of CM files reflect assessment of members' follow-up appointments post-discharge, according to requirements in the *CHIP Contract, Section (8) (B) (1) (d)*. Additionally, the Pharmacy program Description and Policy RX-046, Pharmacy – Automated Transition of Care (TOC), indicate United provides new members with continuation of their current medications, up to 31 days without prior authorization, until the provider can transition the member to formulary medications.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
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					
4. The CCO meets other Transition of Care Requirements.	X					Documentation in Policy MS021, Transitional Care Management and the UM Program Description Addendum indicate United meets the other transition of care contract requirements as noted in the *CHIP Contract, Section 8 (B) (5)*.
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					United performs an evaluation of the UM Program annually. The 2020 CHIP UM Program Evaluation provides a summary of UM program activities, reports and analyzes measurement outcomes, determines the overall effectiveness of the UM Program, and offers recommendation for improvement for 2021. The COVID-19 pandemic caused United to leverage resources and to suspend and/or revamp certain services to achieve goals and provide care to members. The UM Program Evaluation informs that United will transition from MCG to InterQual decision-making criteria and a Utilization Management Program Committee (UMPC) will be added to the committee roster. Overall, the evaluation report indicates the UM Program was effective in meeting its objectives. Additionally, United conducted a specific evaluation of the CM Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2020 CHIP Utilization Management Program Evaluation was reviewed and approved by the Healthcare Quality and Utilization Management (HQUM) on July,17 2021 and by the Quality Management Committee (QMC) June 9, 2021.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
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					Delegation agreements are in place that specify activities being delegated, reporting responsibilities, and performance expectations and consequences that may result from noncompliance with the performance expectations.
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					Processes for vendor oversight and assessment are detailed in Policy DOV-01, Delegated Vendor Oversight Strategy. The UnitedHealthcare Credentialing Plan 2021–2023 includes processes for delegation of credentialing and recredentialing functions and oversight of delegated entities. It addresses delegation agreements, sub-delegation, preassessments, annual evaluation, oversight and monitoring, and required follow-up. Delegated entities are expected to provider routine reporting to facilitate performance monitoring. The reporting assists in identifying operational trends or issues so that performance improvement initiatives may be implemented as needed. Routine joint operating committee meetings are held with subcontractors to review performance and discuss any needed remediation. Evidence of the oversight conducted for non-credentialing delegates was submitted prior to the onsite visit. Oversight documentation for the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	N/A	Not Evaluated	
						credentialing delegates was requested from the health plan three times and was submitted after completion of the onsite. Therefore, findings for the credentialing delegates were not discussed with the plan during the onsite visit. No issues were identified from review of oversight documentation of United's delegates.