2022 External Quality Review

UNITEDHEALTHCARE COMMUNITY PLAN - MISSISSIPPI

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Prepared on behalf of the
Mississippi Division of Medicaid

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 2022 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, including validation of performance improvement projects (PIPs) and performance measures, evaluation of network adequacy, and validation of member and provider satisfaction surveys; and an Information System Capabilities Assessment (ISCA) audit.

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

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)*
- Subcontractual 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)*

To assess United's compliance with the quality, timeliness, and accessibility of services, 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 an established process for developing new policies and for reviewing existing policies for necessary updates at least annually. In general, corporate policies are used when appropriate and riders or addenda are added as needed to address state-specific requirements. Policies are made accessible to all staff and staff are informed of new and revised policies through staff meetings and and/or email.

All key staffing positions are filled. The Compliance Officer position is currently filled on an interim basis, but a permanent Compliance Officer is expected to be in place within 90 days. United has a Chief Medical Officer as well as three additional Medical Directors in Mississippi. Additional Medical Directors from related organizations, such as Optum, are also involved in health plan operations. Overall staffing is sufficient to ensure that all required services are provided to members.

The Compliance Oversight Committee, chaired by the Compliance Officer and Chief Executive Officer, assists the Compliance Officer in developing and implementing the Compliance Program. The committee meets regularly, and review of minutes confirms the presence of a quorum at each meeting and adequate attendance.

Compliance training is mandated for all new employees and provided annually for all employees, applicable delegated vendors, and subcontractors. Appropriate topics are included in the training, which is provided through an online system, web-based tools, live or videotaped presentations, written materials, etc. Training includes the various avenues for reporting suspected or actual fraud, waste, and abuse (FWA), and potential consequences of compliance violations and FWA. The FWA Plan describes routine monitoring and auditing activities, investigations, and resulting actions for credible evidence of FWA.

The High Prescription Utilization Program (Lock-In Program) has been implemented to minimize drug abuse and diversion by identifying and managing members who have a potential for misuse or abuse of certain drugs. Of note, the documentation indicates United has noted an improvement in utilization during member lock-in that continues after the lock-in period has expired.

United has provided appropriate documentation to demonstrate that it has infrastructure capable of meeting DOM contractual requirements, as well as information systems requirements. The infrastructure and related processes are managed in accordance with policies that prioritize data security and system resilience. United performs regular risk assessments to identify potential risks to its infrastructure and to aid the organization in implementing preventative measures. Revision timestamps indicate the organization regularly reviews and updates its documentation.

United's processes for maintaining confidentiality of protected information are documented throughout the materials reviewed. Employees are trained on principles and expectations for maintaining the confidentiality of applicable information. External committee members sign confidentiality agreements.

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

Processes and requirements for provider credentialing and recredentialing are found in the UnitedHealthcare Credentialing Plan 2021–2023 (Credentialing Plan) with state-specific requirements included in an addendum. Neither document addresses querying the Social Security Administration's Death Master File. Overall responsibility for credentialing and recredentialing is delegated to the National Credentialing Committee (NCC), and the local Provider Advisory Committee (PAC) reviews and approves credentialing determinations initially made by the NCC. Initial credentialing and recredentialing files for practitioners and organizational providers comply with initial credentialing and recredentialing requirements and provide evidence that United corrected issues identified during the previous EQR.

United assesses the adequacy of its provider network using geographic access and appointment availability standards that are compliant with contractual requirements. Quarterly geographic access and appointment availability studies are conducted. The most recent geographic access study confirmed that goals are met for access to PCPs; however, a few gaps were identified for specialty providers. The most recent appointment availability study reflected low success rates for contacting providers, and for those successfully contacted, appointment access goals were not met for several categories. The Multicultural Health Care Program has been implemented to reduce health disparity and improve culturally and linguistically appropriate services. Activities

conducted include assessing, measuring, and evaluating the effectiveness of services provided to members, regularly assessing member and practitioner demographics, ethnicity, and languages, routinely assessing for cultural gaps, and monitoring member satisfaction.

Appropriate processes are in place for initial and ongoing provider education. Review of the CAN and CHIP Provider Manuals revealed issues such as incorrect documentation of the hours of operation for the Provider Services Call Center, incorrect or incomplete information about member benefits, and incomplete information about the appointment access standard for post-discharge appointments after an acute psychiatric hospital admission. Ongoing provider education is provided through the website, provider office visits, newsletters, bulletins, and Provider Manual. In addition, educational sessions and meetings are held throughout the state. It was noted that United corrected the previously identified issue related to provider education of medical record retention timeframes and the provider's responsibility to follow-up with members who are not in compliance with the Well-Baby and Well-Child Care (CHIP).

The printed CAN and CHIP Provider Directories and online "Doctor Lookup" tools include all required elements. United's Web-Based Directory Usability Testing policy incorrectly documents the timeframe required for updates to the web-based Provider Directory.

United adopts evidence-based preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) from nationally recognized sources, and makes them available to staff, network providers, and members. The CAN and CHIP Care Provider Manuals include information about the PHGs and CPGs and include links to access the information on the website.

United requires providers to maintain member medical records in compliance with documentation guidelines and appliable regulations, which are included in the CAN and CHIP Care Provider Manuals. Processes are in place to provide additional education to providers who do not meet the performance goal of 85% and to conduct a follow-up review. Continued failure to meet the performance goal results in corrective action. Overall results and opportunities for improvement reported to the Provider Advisory Committee and Quality Management Committee.

United contracts with Escalent, an independent research company, to administer the provider satisfaction survey. The response rate was very low at 1.3%, a decrease from the previous year's rate of 1.9%, and may not reflect the population of providers; therefore, results should be interpreted with great caution. The 2021 results indicate overall satisfaction has decreased since 2020, with more providers rating United unfavorably. High performing areas include Specialty Support, Care Coordination, Medical Records, Communication with Practice, and Credentialing and Contracting. Opportunities for

improvement include the areas of Member Support, Prior Authorization, Appeals, Reimbursement, Customer Service, and First Call Resolution.

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

United provides newly enrolled members with an information packet that includes an introduction letter, member identification card, Member Handbook, and Provider Directory. Members are informed of their benefits and other information needed to understand health plan processes and requirements through the CAN and CHIP Member Handbooks. Incorrect and incomplete information about benefits for well-child care services (CAN) and peer support services (CAN and CHIP) was noted in the Member Handbooks. Both issues were identified and discussed with United during the previous EQR.

United informed members in writing of any changes in benefits in the provider network within appropriate timeframes. Member outreach is conducted to inform them of available wellness and preventive care programs. In addition, member newsletters, mailings, automated calls, and member incentives are used to encourage participation in wellness activities.

United ensures appropriate reading comprehension level for member materials and provides the materials in alternate languages and formats. Oral interpretation and translation services are provided at no cost. The Member Services call center is available during required hours of operation and the NurseLine is available around the clock. In addition, a toll-free Mental Health Crisis Line is available; however, United staff could not verbalize its hours of operation. United conducts routine monitoring and reporting of call center performance. As noted in the 2021 CAN QI Program Evaluation, all performance metrics were met in 2021.

United processes grievances following Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. The policy describes the process used for responding to a member's complaint or grievance. The CAN Member Handbook offers the member the option of filing an expedited grievance. This option is not mentioned in the grievance policy, the CHIP Member Handbook, or on United's website.

The grievance policy includes the steps United follows if an extension or additional time is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension.

CCME reviewed a sample of grievance files for CAN and for CHIP. All the files demonstrated the grievances were process timely and appropriate notifications were provided. The acknowledgement letter for one CAN file was not sent within the five calendar-day requirement.

United contracts with SPH Analytics Research, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, to conduct a formal annual assessment of member satisfaction. For CAN, the Adult CAHPS response rate was low at 14.7%, and the Child CCC survey response rate was also low at 10.8%. Thus, the generalizability of the survey results is difficult to discern. For CHIP, the generalizability of the Child CCC survey results is difficult to discern due to the low response rate of 15.9%.

Quality Improvement

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

Annually, United develops and/or updates their Quality Improvement (QI) program description. For this EQR, United submitted the 2022 Quality Improvement and Population Health Management Program Description and Optum's 2022 Behavioral Health Quality Improvement Program Description for the CAN and CHIP populations. Optum Behavioral Health is a sister company that provides mental health and substance abuse services for members. The QI Program Descriptions are detailed and include the programs' goals, objectives, structure, and scope of work. Details regarding United's Population Health Management Program was added to the 2022 QI Program Descriptions.

United addresses health disparities through their Health Equity Program. Through this program, United addresses health care disparities and culturally and linguistically appropriate services (CLAS). Annually, an evaluation of the effectiveness of the program is conducted. For this EQR, United provided the CAN and CHIP 2021 Health Equity Program Evaluation. The program evaluation included results for areas targeted in 2021. The results listed for the diabetic eye exams in the CAN evaluation were incorrect. Also, the results for Jackson County were missing with no explanation about why this county was excluded.

United develops a work plan annually that includes the planned activities, responsible parties, quarterly updates, and the status of each activity. United submitted the 2021 and 2022 CAN and CHIP work plans for review. The objectives noted in the 2022 CAN Work Plan, under the Objective tab, included improving specific health outcomes in the areas of pre-term births, reduction of hospital admissions, and reduction of COVID-19 spread and hospitalizations. Neither the work plan nor the CAN QI Program Description described any activities related to the reduction of hospital admissions. Onsite discussion revealed this was an error in the work plan. Also, the HEDIS rates had not been updated and were listed as pending in the 2021 CAN and CHIP work plans.

United's Quality Management Committee is the decision-making body ultimately responsible for the QI Program. This committee reports to the Board of Directors and is chaired by the health plan's Chief Medical Officer. The Provider Advisory Committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of medical care rendered within the network. This committee is also chaired by the health plan's Chief Medical Officer and includes network primary care and subspecialty physicians participating as voting members.

United evaluated the effectiveness of the 2021 QI Program and activities. The Quality Improvement & Population Health Management Annual Evaluation for CAN and CHIP was provided for review. The program evaluation included results and interventions underway. Last year, CCME recommended United correct errors identified in the HEDIS rates and include a summary of the interventions planned. The 2021 CAN program evaluation demonstrated the errors were corrected and interventions added.

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, 2021, through December 31, 2021.

Aqurate reviewed the final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by United's NCQA-licensed organization. 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) 2021.

All relevant HEDIS performance measures for the CAN and CHIP populations were compared for the current review year (MY 2021) to the previous year (MY 2020) and the changes from 2020 to 2021 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial increases or decreases in rate from 2020 to 2021. A substantial increase or decrease is a change in rate of greater than 10%.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	29.76%	40.04%	10.28%
Substantial Decrease in Rate (>10% decrease)			
Childhood Immunization Status (cis)			
Rotavirus	82.48%	71.05%	-11.43%
Combination #7	63.75%	53.28%	-10.47%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	55.63%	44.56%	-11.07%
Continuation and Maintenance (C&M) Phase	73.18%	59.32%	-13.86%

The CHIP HEDIS rates were also compared. *Table 2: CHIP HEDIS Measures with Substantial Change in Rates* highlights the HEDIS measures with a substantial increase and a decrease in rate from 2020 to 2021.

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2020	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (12-17)	36.47%	58.64%	22.17%
Blood Glucose Testing (Total)	34.36%	50.21%	15.85%
Annual Dental Visit (adv)			
19-20 Years	44.52%	55.45%	10.93%
Substantial Decrease in Rate (>10% improvement)			
Follow-up care for children prescribed ADHD Medication (add)			
Continuation and Maintenance (C&M) Phase	66.22%	51.79%	-14.43%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2021 and the previous year

(2020). The change from 2020 to 2021 are reported in the tables that follows. The rate changes shown in green indicate substantial (>10%) improvement and those shown in red indicate substantial (>10%) decline.

Table 3: CAN Non-HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS 2020 (MY 2020)	HEDIS MY 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Heart Failure Admission Rate (PQI-08)			
Ages 65+	115.61	381.68	266.07
Substantial Decrease in Rate (>10% decrease)			
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)			
Ages 65+	115.61	0.00	-115.61
Use of Pharmacotherapy for Opioid Use Disorder			
Overall	54.63%	39.98%	-14.65%
Prescription for Buprenorphine	53.24%	38.63%	-14.61%

For the CHIP non-HEDIS measures, there were several measures not reported by United or not enough data was available for reporting. None of the measures that could be compared showed a substantial increase or decrease.

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.

For this review, the same four PIPs that were submitted for the 2021 EQR were also submitted and validated for this EQR. Topics for PIPs include Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each CAN PIP's status and the interventions is also included.

Table 4: CAN Behavioral Health Readmissions PIP

Behavioral Health Readmissions	
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 no improvement in the latest readmission rate from 17.7% in 2020 to 21.4% in 2021 with a goal of 14.2%. The case management enrollment indicator had a decline from 38% in 2020 to 28% in 2021. Individual facility rates were reported as well for each of the five facilities.	
Previous Validation Score	**Current Validation Score**
79/80=99% High Confidence in Reported Results	74/75=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. • Direct referrals to Genoa Pharmacy • Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from Inpatient level of care.	

Table 5: CAN 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 and received a prenatal care visit in the first trimester or within 42 days of enrollment. For this validation, this PIP showed some improvement. The baseline rate was 92.21% and the remeasurement one rate was 91.48%. The most recent remeasurement improved to 93.67% which is above the DOM goal rate of 93.62%. This rate reflects an improvement in the visit rate.	
Previous Validation Score	**Current Validation Score**
79/80=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Improved Pregnancy Outcomes
• 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. • Provider education with OB Toolkits. • Weekly data analysis with risk stratification. • Healthy Starts Program to address social needs.

Table 6: CAN 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. For this validation, the PIP showed no improvement. The rate was 26.43% in 2020 and increased to 28.50% in 2021. The goal is to reduce it to 25.64%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% 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. • Weekly interdisciplinary rounds for Case Management. • Provider education with the After Hour Care newsletter.	

Table 7: CAN Respiratory Illness: COPD/Asthma PIP

Respiratory Illness: COPD/Asthma	
The Respiratory Illness PIP examines the COPD exacerbations and pharmacotherapy management HEDIS rate. The bronchodilators baseline rate was 75.13%% which improved to 76.36%% although it is still below the DOM goal rate of 77.38%. The corticosteroids baseline rate was 54.02% at remeasurement one and declined to 49.89% for 2021. It is below the goal rate of 55.62% for DOM. The AMR rate for 2021 was 73.36% which is a decline from the remeasurement one rate of 74.08%.	
Previous Validation Score	**Current Validation Score**

Respiratory Illness: COPD/Asthma	
80/80=100% High Confidence in Reported Results	74/75=99% 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.	

United submitted the same four CHIP PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction, Follow Up After Hospitalization, and Obesity. All 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.

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

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
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. The rate for the 12-17-year-olds improved from 36.37% to 40.16%. This is above the goal rate of 37.46%. The rate for 18-21-year-olds also improved from 19.64% to 25.34% which is above the goal rate of 24.63%.	
Previous Validation Score	**Current Validation Score**
73/73/=100% Hight Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Phone calls to noncompliant members and after-hours 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.	

Table 9: CHIP 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 remained about the same over the last 2 measurement periods, with a rate of 65.9% in 2020 and 65.8% in 2021. The 7-day follow up rate declined from 39.31% to 35.11% in 2021. The goal rate for United is 38.95%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% 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: CHIP 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. BMI percentile documentation improved from 64.23% in 2020 to 70.07% in 2021. The goal rate is 76.64%. Counseling on nutrition improved slightly from 52.07% to 53.04% with a goal of 70.11%. Counseling for physical activity improved slightly from 49.15% to 49.88% with a goal of 66.18%.	
Previous Validation Score	**Current Validation Score**
99/100 = 99% High Confidence in Reported Results	100/100=100% 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.	

Reducing Adolescent and Childhood Obesity
• Community outreach activities such as the Farm to Fork program and health fairs.

Table 11: CHIP 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 regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. For this review the rate improved from 82.3% to 90.3% which is above the goal of 79.8%.	
Previous Validation Score	**Current Validation Score**
99/100=99% High Confidence in Reported Results	100/100=100% 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)

The CAN and CHIP 2022 Utilization Management Program Descriptions include the program's objectives, scope, and the structure. Optum manages behavioral health services, and the Optum Behavioral Health Utilization Management Program Description was provided for review.

United's Chief Medical Officer (CMO) is responsible for providing clinical consultation and oversight for all clinical activities. The CMO chairs and serves on various committees, such as the Provider Advisor Committee, Service Quality Improvement Committee, and Utilization Management Program Committee. The Behavioral Health Regional Medical Director provides clinical oversight of the Behavioral Health Utilization Management Program. The Pharmacy Director works directly with the CMO, other medical directors, and clinical staff to promote appropriate and cost-effective drug utilization.

External and internal clinical review criteria such as InterQual and Milliman Care Guidelines are used to determine medical necessity. During the previous EQR (2021), United mentioned the health plan was transitioning from Milliman to InterQual criteria.

Policy UCSMM.06.10, Clinical Review Criteria (UCSMM 06.10 Rider 1), was not updated to reflect the review criteria currently being used and still references Milliman as the review criteria.

Timeframes for completing authorization requests and information about extension of those timeframes are included in the CAN and CHIP UM Program Descriptions. However, notices sent to members when United requests an extension are missing information about the member's right to file a grievance regarding the extension, as required by *42 CFR § 438.408 (c)*. This requirement is also not specifically mentioned in the CAN and CHIP UM Program Descriptions, the policy, the CAN and CHIP Provider Manual, or in the CAN and CHIP Member Handbooks.

OptumRx is the pharmacy benefit manager and is responsible for implementing pharmaceutical services. United uses the most current version of the MS Medicaid Program Preferred Drug List (PDL), which is accessible from the CAN and CHIP websites. However, links provided in the CAN Member Handbook to access the PDL and a listing of over the counter (OTC) medicines result in an error message indicating "page not found." During the previous EQR, CCME alerted United to the failed links and recommended this issue be resolved.

The sample of CAN and CHIP UM decisions reviewed reflect that physical and behavioral health utilization decisions are made within required timeframes and are consistent with Policy UCSMM.06.16, Initial Review Timeframes, and UM Program Descriptions. Denial decisions were communicated timely to the member and provider, and the adverse benefit determination notices included the rationale for the denial and instructions for filing an appeal. However, most of the adverse benefit notices (2022 decisions) and the adverse benefit determination notice letter templates incorrectly stated the member is required to follow an oral appeal request with a written appeal request. Updated adverse benefit determination notices were provided by United and included the correct information regarding the submission of an appeal.

Annually, United evaluates the UM Program and makes updates as needed. This includes evaluating the program structure, scope, processes, clinical criteria, and the level of involvement of senior-level physicians and behavioral health practitioners. Member and practitioner experience data are also considered.

United addresses the process for filing and handling member appeals in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. Information is also provided on United's website, the CAN and CHIP Member Handbooks and in the CAN and CHIP Provider Manuals. However, the website, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals incorrectly require members to follow a verbal appeal with a written appeal. The written notice used to inform members of a plan-

initiated extension, as well as the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals and United's website, do not inform the member of their right to file a grievance if they disagree with the extension, as required by the *CAN Contract, Section 6, CHIP Contract, Section 6,* and *42 CFR § 438.408 (c)*. During the previous EQR CCME noted the "Your Additional Rights" document, provided to members when an appeal is upheld, did not include the requirement that members have the right to request and receive benefits while the Independent External Review is pending. This document was not corrected.

A sample of CAN and CHIP appeal files were reviewed. Noted issues were related to language in resolution notices that was not clear and understandable to members. Information about the physician who made the appeal decision was confusing. Also, CHIP resolution letters sent when the denial was upheld did not include the member right to request and receive benefits while the Independent External Review is pending.

United's 2022 Care Management Model Program Description and Addenda for CAN and CHIP, and Optum's Behavioral Health Complex Case Management Program Description, give program overviews, including scope, purpose, and goals. Population Health Management is also addressed in the QI Program Descriptions. Policies and procedures provide additional detailed information to guide staff in conducting Care Management (CM) activities. The policies address methods of identifying members for care management, conducting health risk assessments and reassessments, and developing and modifying member-centered care plans. The sample of CAN and CHIP care management files reviewed reflected United staff conduct care management activities appropriately.

Delegation

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

Processes for delegation activities and oversight requirements are found in the UnitedHealthcare Credentialing Plan 2021–2023, Policy ID-5714, Pharmacy Delegated Entity Oversight, Optum's Delegated Credentialing policy, and the United Behavioral Health Credentialing Plan 2022 – 2023.

United reported 19 current delegation agreements. 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.

Oversight documentation submitted for review confirmed each delegate submits routine reports and United holds routine meetings with the delegates to discuss performance and any needs. The documentation confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated are subjected to an annual evaluation process. United did not provide evidence of a formal annual evaluation

of all activities delegated to Optum Behavioral Health, Medical Transportation Management (CAN only), eviCore National, MARCH Vision Care, and Optum RX.

Quality Improvement Plans and Recommendations from Previous EQR

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

- The review of credentialing and recredentialing files revealed issues related to collecting complete collaborative agreements for nurse practitioners (CAN), verifying CLIA certificates for applicable providers (CAN and CHIP), and verifying the MS DOM Sanctioned Provider List (CAN and CHIP).
- The process for collecting fingerprints for CHIP providers designated as high-risk by DOM was not identified in any of the credentialing documentation reviewed.
- The CHIP Provider Manual did not include all appointment access standards for behavioral health providers.
- The CAN and CHIP Provider Manuals did not include the medical record retention requirement. CAN and CHIP Provider Contract templates contained incorrect medical record retention timeframes.
- The CHIP document titled, "Your Additional Rights" that is sent to members provided information and instructions for requesting an Independent External Review but did not include full information about requesting continuation of benefits while an Independent External Review is pending.
- For CAN and CHIP, 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.

After the 2021 EQR, United submitted its response to the Corrective Action Plan on January 13, 2021. Additional documentation was submitted on February 8, 2022, February 15, 2022, March 4, 2022, March 25, 2022, April 1, 2022, and April 8, 2022. The CAP was accepted on April 18, 2022. 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 regarding correcting the "Your Additional Rights" to include the member's right to request continuation of benefits while an Independent External Review is pending was not implemented.

Conclusions

Overall, United met most of 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*. *Table 12: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of United's compliance scores relative to each of the 11 Subpart D and QAPI standards above.

Table 12: Compliance Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	United CAN and CHIP	
			Number of Standards Scored as "Met"	2022 Overall Score
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services (§ 438.207, § 457.1230)	Provider Services, Section II. B	18	18	100%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D and Section V. E	36	36	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	26	25	96%
Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	77	77	100%
Confidentiality *(§ 438.224)*	Administration, Section I. E	2	2	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	40	29	73%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	4	2	50%
Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	20	20	100%
Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	8	8	100%

Category	Report Section	Total Number of Standards	United CAN and CHIP	
			Number of Standards Scored as "Met"	2022 Overall Score
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	38	38	100%

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

As noted in the table above, issues were noted with the following:

- For Coverage and Authorization of Services, links provided in the Member Handbook to access the listing of over-the-counter medicines and for the Preferred Drug List result in error messages indicating "Page Not Found." This issue was identified during a previous EQR and CCME recommended the link be corrected.
- For Grievance and Appeal Systems, there were issues with documentation of grievance and appeal filing processes and requirements in the CAN and CHIP grievance extension notices, Member Handbooks, CAN and CHIP Provider Manuals, and United's website; resolution notices were not written in clear, understandable language to ensure member understanding; the CHIP "Your Additional Rights" document does not include complete information regarding continuation of benefits while an Independent External Review is pending, including that the member can be held liable for the cost (identified during the 2021 EQR and not corrected); and CHIP appeal resolution letters for upheld denials did not include complete information about continuation of benefits while an Independent External Review is pending.
- For Sub-contractual Relationships and Delegation, oversight documentation reflected that not all delegated activities are subjected to an annual evaluation process.

Table 13, Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2021 review. For 2022, 2012 of 223 standards received a score of "Met." Eleven standards were scored as "Partially Met."

Table 13: Scoring Overview—CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	31	0	0	0	0	31	100%
2022	31	0	0	0	0	31	100%
Provider Services							
2021	80	4	0	0	0	84	95.2%
2022	82	2	0	0	0	84	97.6%
Member Services							
2021	33	0	0	0	0	33	100%
2022	30	3	0	0	0	33	90.9
Quality Improvement							
2021	19	0	0	0	0	19	100%
2022	19	0	0	0	0	19	100%
Utilization Management							
2021	54	1	0	0	0	54	98.2%
2022	49	5	0	0	0	54	90.7%
Delegation							
2021	2	0	0	0	0	2	100%
2022	1	1	0	0	0	2	50%
Totals							
2021	**219**	**5**	**0**	**0**	**0**	**224**	**97.8%**
2022	**212**	**11**	**0**	**0**	**0**	**223**	**95.1%**

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

Table 14, Scoring Overview—CHIP, provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2021 review. For 2022, 209 out of 221 standards received a score of "Met." Twelve standards were scored as "Partially Met."

Table 14: Scoring Overview—CHIP

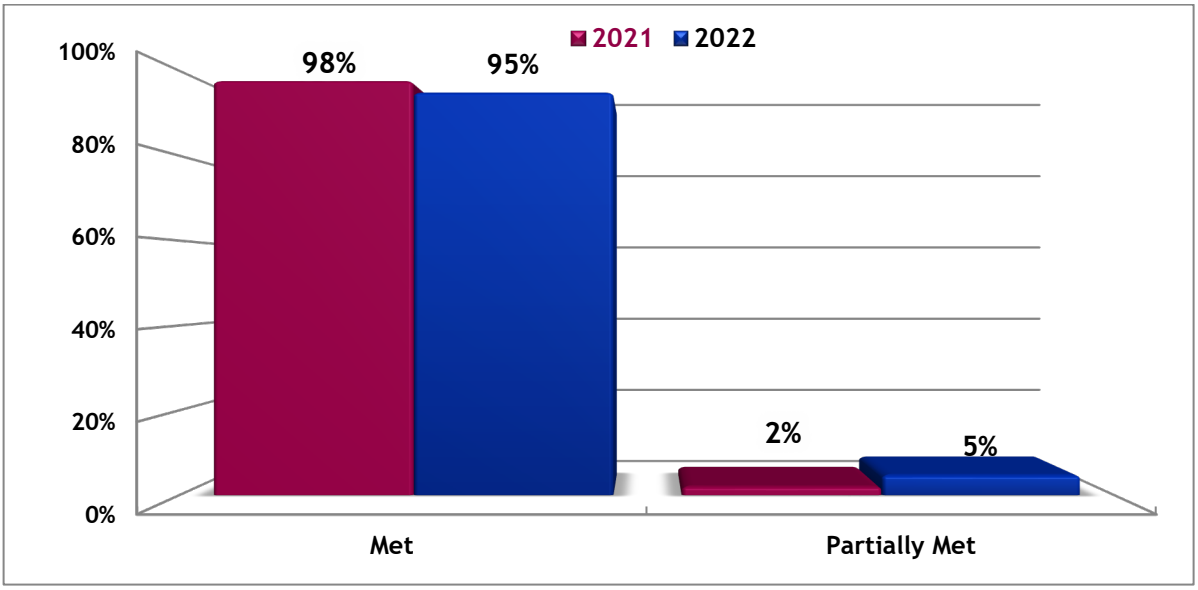
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	31	0	0	0	0	31	100%
2022	31	0	0	0	0	31	100%
Provider Services							
2021	78	4	0	0	1	83	95.1%
2022	80	3	0	0	0	83	96.4%
Member Services							
2021	33	0	0	0	0	33	100%
2022	29	3	0	0	0	32	90.6%
Quality Improvement							
2021	19	0	0	0	0	19	100%
2022	19	0	0	0	0	19	100%
Utilization Management							
2021	53	2	0	0	0	55	96.4%
2022	49	5	0	0	0	54	90.7%
Delegation							
2021	2	0	0	0	0	2	100%
2022	1	1	0	0	0	2	50%
Totals							
2021	**216**	**6**	**0**	**0**	**0**	**222**	**96.9%**
2022	**209**	**12**	**0**	**0**	**0**	**221**	**94.6%**

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

The 2022 Annual EQR for CAN shows that United achieved "Met" scores for 96% of the standards reviewed, and 5% of the standards were scored as "Partially Met." For CHIP, 95% of the standards were scored as "Met" and 5% were scored as "Partially Met."

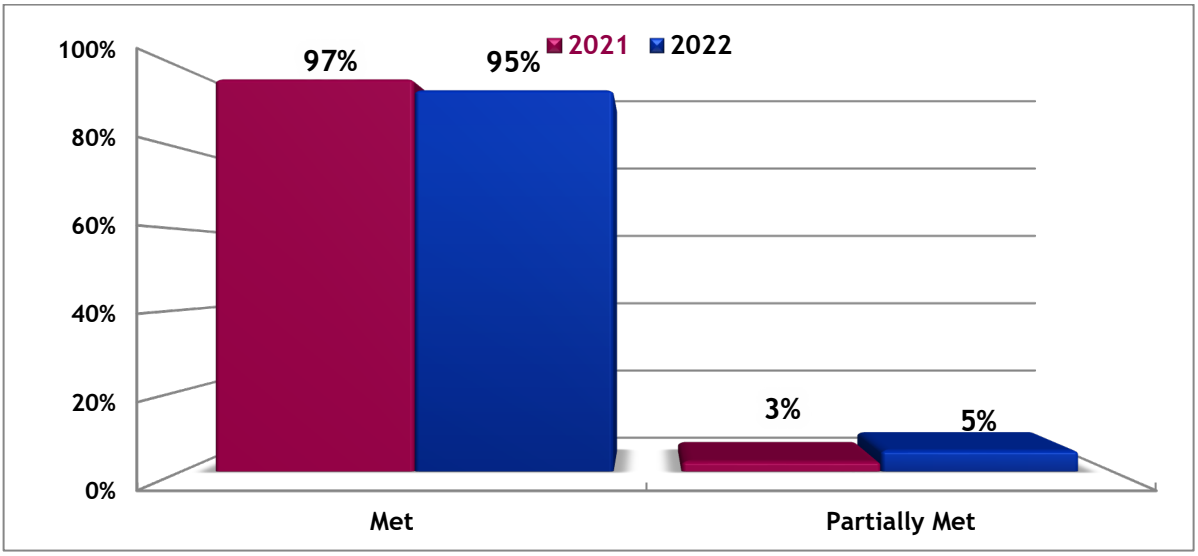
The charts that follow provide a comparison of the current review results to the 2021 review results for CAN and CHIP.

Figure 1: 2021 and 2022 Annual EQR Review Results for CAN



Scores were rounded to the nearest whole number

Figure 2: 2021 and 2022 Annual EQR Review Results for CHIP



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvement

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

Table 15: Evaluation of Quality

Strengths Related to Quality

• United processes provider claims at a rate that exceeds DOM requirements.
• Disaster recovery and business continuity plans are thorough and are tested regularly.
• United has noted an improvement in drug utilization during member lock-in that continues after the lock-in period has expired.
• Credentialing and recredentialing files were compliant with all required elements.
• Provider education includes information about preventive health and clinical practice guidelines, and the guidelines are available to providers.
• Member and Provider Satisfaction survey results are presented and addressed in QIC meetings.
• Member rights and responsibilities are well documented in plan materials.
• Call center performance metrics/goals were met for 2021
• United was fully compliant with all information system standards and submitted valid and reportable rates for all HEDIS measures in the scope of the 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. United followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.
• The following CAN HEDIS MY 2021 measure rates and CAN non-HEDIS Adult Core Set measure rates were strengths for United since their rates had a greater than 10% improvement:
  ○ Initiation and Engagement of AOD Dependence Treatment (IET), the Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years indicator improved by 10.28 percentage points.
  ○ Heart Failure Admission Rate (PQI-08), the Ages 65+ indicator improved by 266.07 member months per 100,000 member months.
• The following CHIP HEDIS MY 2021 measure rates were strengths for United since their rates had a greater than 10% improvement:
  ○ Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), the Blood Glucose Testing (12-17) indicator and the Blood Glucose Testing (Total) improved by 22.17 and 15.85 percentage points respectively.
  ○ Annual Dental Visit (ADV), the 19-20 Years indicator improved by over 10 percentage points.
• PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented.
• All PIPs were validated in the High Confidence range.
• The overall InterQual Interrater Reliability scores were 99.85%, exceeding the goal of 90%.
• Clinical reviews are conducted by actively licensed health care professionals that hold a current licensure.
• Care management staff conduct appropriate care management activities for members in all risk levels.
• Oversight documentation submitted for review confirmed each delegate submits routine reports and United holds routine meetings with the delegates to discuss performance and any needs.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
• The corporate FWA Plan includes information about the corporate UHC Compliance Program	• Recommendation: Revise the Mississippi FWA Plan Addendum to include information about the health

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
Integrity Oversight Committee. However, the FWA Plan Addendum (for Mississippi) does not include information about the local health plan Compliance Oversight Committee (Compliance Oversight Committee). Information about the local committee was noted in the QI Program Description.	plan's C&S Mississippi Compliance Oversight Committee.
• The Credentialing Plan did not address querying the Social Security Administration's Death Master File (SSDMF). Onsite discussion confirmed the SSDMF is checked by another department within the organization prior to completing initial credentialing.	• Recommendation: Update the Credentialing Plan to include information about querying the SSDMF at initial credentialing.
• Page 53 of the CHIP Care Provider Manual states it is a provider's responsibility to contact members who are non-compliant with EPSDT screenings and services. It does not reference Well-Baby and Well-Child screenings and services, which is the term used for the CHIP population.	• Recommendation: Revise the CHIP Care Provider Manual, page 53, to reference Well-Baby and Well-Child screenings and services instead of EPSDT screenings and services.
• For the provider satisfaction survey administered by Escalent, an independent research company, on behalf of United, the response rate was 1.3%. The response rate may not reflect the population of providers and may affect generalizability of the results; therefore, results should be interpreted with great caution.	• Recommendation: Continued efforts should be made to gather a better representation of the providers. Additional reminders may be appropriate, as well as other interventions that incentivize providers to respond to the survey.
• For the CAN 2022 Adult CAHPS survey, the survey response rate was 14.4%. For the CAN Child CCC CAHPS survey, the response rate was 10.3%. Thus, generalizability of the survey results is difficult to discern.	• Recommendation: Additional reminders for awareness and member Incentives may need to be considered to increase Member Satisfaction Survey response rates.
• The CAN 2021 Health Equity Program Evaluation included errors for the results reported for the diabetic eye exams. Also, the results for Jackson County were missing with no explanation regarding why this county was excluded.	• Recommendation: Correct the errors identified in the CAN 2021 Health Equity Program Evaluation.
• It was noted in the 2022 CAN work plan, under the Objectives tab, incorrectly included an objective to reduce hospital admissions. Also, the HEDIS rates had not been updated and were listed as pending in the 2021 CAN and CHIP work plans.	• Recommendation: Correct the objectives regarding hospital admissions in the 2022 CAN Work Plan and update the HEDIS rates in the 2021 CAN and CHIP Work Plans.

Weaknesses Related to Quality	Corrective Actions / Recommendations Related to Quality
• The following CAN HEDIS MY 2021 measure rates and CAN non-HEDIS Adult Core Set measure rates were determined to be areas of opportunities for United since their rates had a greater than 10% decline: ○ Childhood Immunization Status (CIS), the Rotavirus indicator and the Combination #7 indicator had a greater than 10 percentage point decline. ○ Follow-Up Care for Children Prescribed ADHD Medication (ADD), both the Initiation Phase indicator and the Continuation and Maintenance (C&M) Phase indicator both had more than an 11 percentage point decline. ○ Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission rate (PQI-05), the Ages 65+ indicator declined by 115.61 member months per 100,000 member months. ○ Use of Pharmacotherapy for Opioids Use Disorder (OUD-AD), the Overall indicator and the Prescription for Buprenorphine indicators declined by over 14 percentage points. • The following CHIP HEDIS MY 2021 measure rates were determined to be areas of opportunities for United since their rates had a greater than 10% decline: ○ Follow-up care for children prescribed ADHD Medication (ADD), the Continuation and Maintenance (C&M) Phase indicator had a decline of 14.43 percentage points.	• Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement and verification of the rates reported.
• The Behavioral health Readmission, Respiratory Illness, and Sickle Cell Disease CAN PIPs demonstrated no quantitative improvement in process or care. • The Follow Up After Hospitalization CHIP PIP 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. Determine if there are ways to identify the most impactful interventions and focus efforts on those methods and processes.
• The rational in the resolution notices in five CAN files and four CHIP files was not written in language clear and understandable to members. The rational was confusing regarding the Physician who made the appeal decision.	• Corrective Action: Continue working on a solution to improve the appeal resolution notifications for CAN and CHIP. Develop a plan to monitor and edit the notifications before sending the notices to members.
• Although formal annual evaluations are conducted for some delegated activities, the submitted oversight documentation reflected that not all delegated activities are subjected to an annual evaluation process. Issues noted with documentation of delegation oversight include evidence of a formal, annual evaluation for all delegated entities.	• Corrective Action: Ensure that each entity that is delegated to conduct any service or activity that is ultimately a health plan responsibility is subjected to a formal evaluation at least once a year and that the formal annual evaluation includes all activities delegated to the entity. Refer to the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B).*

Table 16: Evaluation of Timeliness

Strengths Related to Timeliness
• Grievances are processed in a timely manner. • UM decisions are completed timely.

Weaknesses Related to Timeliness	Corrective Actions / Recommendations Related to Timeliness
• The CAN Member Handbook, page 62, offers the member the option of filing an Expedited Grievance. This option is not mentioned in the grievance policy, the CHIP Member Handbook or on United's website.	• Corrective Action: Update policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, United's website, and the CHIP Member Handbook to include the process followed for an expedited grievance.
• The grievance policy includes the steps United follows if an extension or additional time is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension.	• Corrective Action: Update the notice sent to members regarding the need for an extension and include the member's right to file a grievance if they disagree with the extension.
• The acknowledgement letter for one CAN file was not sent within the 5-calendar day requirement.	• Recommendation: Ensure the acknowledgement letters are sent within five calendar days of receipt of the Grievances as required by the *CAN Contract, Section 6, K.*
• United's CAN and CHIP UM Program Descriptions do not include an explanation regarding what is considered a suspended review.	• Recommendation: Update the CAN and CHIP UM Program Descriptions and include an explanation of what is considered a suspended review.
• The notice sent to members when United requests an extension for completing a UM decision is missing the information regarding the member's right to file a grievance regarding the extension as required by 42 CFR § 438.408 (c). This requirement is also not specifically mentioned in the CAN and CHIP UM Program Descriptions, the policy, the CAN and CHIP Provider Manuals, or in the CAN and CHIP Member Handbooks.	• Corrective Action: Update the notice sent to members when United requests an extension for completing a UM decision to include the member's right to file a grievance as required by 42 CFR § 438.408 (c). Also, update the CAN and CHIP UM Program Descriptions, the policy, the CAN and CHIP Provider Manuals, and the CAN and CHIP Member Handbooks regarding the member's right to file a grievance.
• During the previous EQR (2021) United mentioned the health plan was transitioning from Milliman to InterQual review criteria. Policy UCSMM.06.10 Clinical Review Criteria (UCSMM 06.10 Rider 1), received for this review was not updated to reflect the review criteria currently being used by United. This policy still references Milliman as the review criteria being used.	• Recommendation: Update policy UCSMM.06.10 Clinical Review Criteria (UCSMM 06.10 Rider 1) to address the current criteria used by United for making utilization management decisions.

Table 17: Evaluation of Access to Care

Strengths Related to Access to Care
• United monitors network adequacy and makes efforts to address and close any identified gaps.

Strengths Related to Access to Care
• Appropriate processes are in place to inform members of changes in benefits and the provider network. • Adverse decisions were reviewed by an appropriate physician when requests did not meet medical necessity in the review of Optum's Behavioral Health and United denial files.

Weaknesses Related to Access to Care	Corrective Actions / Recommendations Related to Access to Care

• Issues noted with the listing of covered and excluded benefits in the CAN Provider Manual included:
  ○ The benefits grid on page 11 indicates well child care is not covered. However, information about well child care is found elsewhere in CAN Provider Manual.
  ○ The behavioral health benefits grid on page 12 lists peer support services but does not indicate whether these are covered.
• The behavioral health benefits grid on page 10 of the CHIP Provider Manual lists peer support services but does not indicate whether these are covered.
	• Corrective Action: Revise the CAN Care Provider Manual to correct the issues identified with documentation of benefits for well child care and peer support services. Revise the CHIP Care Provider Manual to correct the issues identified with documentation of benefits for peer support services.

• The CHIP Care Provider Manual correctly documents most appointment access standards; however, page 56 does not include the 7 day timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge.	• Corrective Action: Revise the CHIP Care Provider Manual to include complete information about the timeframe for appointments post-discharge from an acute psychiatric hospital.
• The *CAN Contract, Section 6 (E)* and the *CHIP Contract, Section 6 (E)* state, "The Contractor must also utilize a web-based provider directory, which must be updated within 5 business days upon changes to the provider network." However, Policy NQM-052, Web-Based Directory Usability Testing, page 2, item D, states, "The Web-based practitioner and hospital directory information is updated within 30 calendar days of when new information is received." Onsite discussion confirmed updates are made to the online Provider Directory within 24 hours.	• Corrective Action: Revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.
• Issues were noted with documentation of benefits for well child care in the CAN Member Handbook. Issues with documentation of benefits for peer support services were noted in the CAN and CHIP Member Handbooks. Both issues were identified during the previous EQR.	• Corrective Action: Revise the CAN Member Handbook to correct the issues identified with documentation of benefits for well child care and peer support services. Revise the CHIP Member Handbook to correct the issues identified with documentation of benefits for peer support services.
• The CAN and CHIP Member Handbooks incorrectly reference the name of the agency to which members may submit complaints about advance directives. They refer to the "State Survey and Mississippi State Department of Health." The *CAN Contract, Section 5 (J)* and *CHIP Contract, Section 5 (I)* refer to the agency as the "State Survey and Certification Division of the State Department of Health."	• Recommendation: Revise the CAN Member Handbook, page 54, and the CHIP Member Handbook, page 44, to reference the correct state agency name in the information for members with complaints about advance directives.

Weaknesses Related to Access to Care	Corrective Actions / Recommendations Related to Access to Care
• The CAN and CHIP Member Handbooks indicate a Mental Health Crisis Line is available by toll-free telephone and TTY 711 but do not include the hours of operation for the Mental Health Crisis Line.	• Recommendation: Revise the CAN and CHIP Member Handbooks to list the hours of operation for the Mental Health Crisis Line.
• Links provided in the CAN Member Handbook to access the listing of OTC medicines and for the PDL results in an error message indicating "Page Not Found.	• Corrective Action: Ensure the embedded links for the Preferred Drug List and the Over-the-Counter medications list in the CAN Member Handbook are in working order.
• Most of the adverse benefit notices (2022 decisions) found in the sample of CAN and CHIP denial decisions reviewed by CCME and the adverse benefit determination letter templates titled "CAN UHCCP NABD DENIAL, "CAN UHCCP NABD REDUCTION IN SERVICE," "CHP UHCCP INITIAL REVIEW", and "CHP UHCCP TERM RED" incorrectly stated the member is required to submit their oral appeal in writing.	• Recommendation: Remove the information in the Adverse Benefit Determination Notices requiring a member to submit their oral appeal request in writing.
• The appeal process and timeframe are also found in the CAN and CHIP Member Handbooks, Provider Manual, and on United's website. However, the website, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals incorrectly requires the member to follow a verbal appeal with a written appeal.	• Corrective Action: Correct the appeal information found on United's website, in the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals and remove the requirement that a verbal appeal must be followed with a written appeal.
• United provided a copy of the notice sent to members if an extension is needed for resolving appeals. This notice, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals and United's website does not inform the member of their right to file a grievance if they disagree with this extension as required by the *CAN Contract, Section 6, CHIP Contract, Section 6,* and *42 CFR § CRF 438.408 (c).*	• Corrective Action: Include in the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal in the member notice, the CAN Member Handbook, the CAN and CHIP Provider Manuals and United's website.
• The "Your Additional Rights" document 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. This was an issue identified during the 2021 EQR and not corrected. • None of the CHIP appeal resolution letters sent when the denial was upheld, contained the requirement that members have a right to request and receive benefits while the Independent External Review is pending.	• Corrective Action: Edit the "Your Additional Rights" enclosure for CHIP appeal resolution notifications to include the requirement that members have the right to request and receive benefits and can be held liable for the cost, according to *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 June 23, 2022, 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 July 25, 2022, for review at the CCME offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on September 21 and September 22, 2022. 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 are 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

The Administration section of the review encompasses policy development and management processes, staffing, information systems, compliance, program integrity, and confidentiality.

United has an established process for developing new policies and for reviewing existing policies at least annually for necessary updates. In general, corporate policies are used when appropriate, and riders or addenda are added as needed to address state-specific requirements. Standard Operating Procedures are created, when possible, to outline processes and provide detailed instructions. All new and revised policies are reviewed by the Policy and Review Steering Committee before being presented to other committees, including the Health Quality Utilization Management (HQUM) and Service Quality Improvement Subcommittee (SQIS). All policies are ultimately presented to the Quality Management Committee (QMC) for final review and approval. Policies are available to staff via SharePoint and in a shared file folder. Staff are informed of new and revised policies during routine team meetings and as needed during ad hoc meetings and/or email.

Review of United's Organizational Chart and onsite discussion indicated all key positions are filled. Due to the recent departure of the Compliance Officer, this position is currently filled on an interim basis; however, at the time of the onsite, the position is being posted and is expected to be filled within 90 days. United has a Chief Medical Officer, as well as three additional Medical Directors in Mississippi. Additional Medical Directors from related organizations, such as Optum, work with the CCO Medical Directors. Overall, United's staffing appears to be sufficient to ensure that all required services are provided to members.

The Compliance Oversight Committee assists United's Compliance Officer in developing and implementing the Compliance Program. The committee is chaired by the Compliance Officer and Chief Executive Officer (CEO) and meets quarterly and as needed. Committee membership includes the Compliance Officer, CEO, and senior executive leaders. A minimum of 51% of the committee membership constitutes a quorum. Members may designate surrogate attendees with voting privileges.

Compliance training is mandated for all new employees and provided annually for all employees, applicable delegated vendors, and subcontractors. Training topics include the Code of Conduct, Privacy and Security Awareness, Conflicts of Interest, Anti-Corruption, Harassment Prevention, and Prevention of Fraud, Waste, and Abuse (FWA). Additional role-focused or specialized compliance training may also be required for certain business/job functions and operations. A variety of forums are used for training, including an online system, web-based tools, live/videotaped presentations, written materials, etc.

Staff, vendors, subcontractors, and any other applicable parties are trained on avenues for reporting suspected or actual FWA. Available reporting methods include designated web portals, call centers, databases, and anonymous hotlines. Through the Code of Conduct and compliance training activities, staff and other stakeholders are informed of

the potential consequences of compliance violations and FWA, up to and including termination of employment and referral to law enforcement.

United conducts routine monitoring and auditing to mitigate and/or identify areas of risk and FWA. The FWA Plan and FWA Addendum address how the health plan investigates and responds to detected offenses. When investigations indicate there is credible evidence of FWA, recovery actions are taken against paid claims, as well as other appropriate actions, in accordance with contractual, regulatory, and legal requirements. Routine monthly monitoring is conducted to identify staff, vendors, etc. that are debarred, suspended, or otherwise excluded from participating in Federal procurement activities so that appropriate responsive action may be taken.

United's High Prescription Utilization Program (Lock-In Program) has been implemented to minimize drug abuse and diversion by identifying and managing members who have a potential for misuse or abuse of certain drugs. Of note, the documentation indicates United has noted an improvement in utilization during member lock-in that continues after the lock-in period has expired.

Health Information Systems

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

United provided appropriate documentation to demonstrate that it has infrastructure capable of meeting DOM contractual as well as information systems requirements. The infrastructure and related processes are managed in accordance with policies that prioritize data security and system resilience. United performs regular risk assessments to identify potential risks to its infrastructure and to aid the organization in implementing preventative measures. Revision timestamps indicate the organization regularly reviews and updates its documentation.

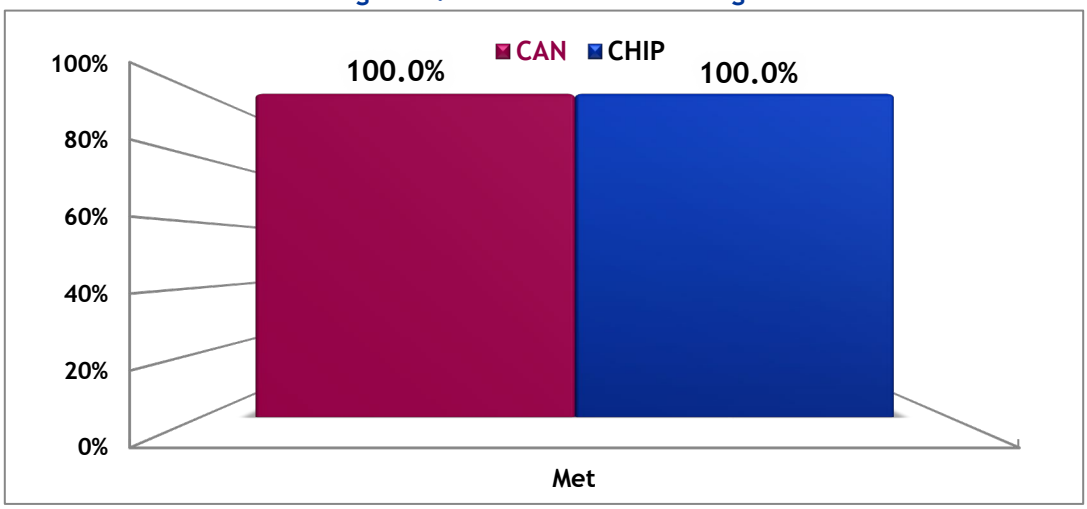
Confidentiality

§ 438.224

United's processes for maintaining confidentiality of protected information are documented throughout the materials reviewed. Employees are trained on principles and expectations for maintaining the confidentiality of applicable information. External committee members sign confidentiality agreements.

For 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

- United processes provider claims at a rate that exceeds DOM requirements.
- Disaster recovery and business continuity plans are thorough and are tested regularly.
- United has noted an improvement in drug utilization during member lock-in that continues after the lock-in period has expired.

Weaknesses

- The corporate FWA Plan includes information about the corporate UHC Compliance Program Integrity Oversight Committee. However, the FWA Plan Addendum for Mississippi does not include information about the local health plan Compliance Oversight Committee. Information about the local committee was noted in the QI Program Description.

Recommendations

- Revise the Mississippi FWA Plan Addendum to include information about the health plan's C&S Mississippi Compliance Oversight Committee.

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 Provider Services section of the EQR focuses on provider credentialing and recredentialing, network adequacy, processes for provider education, preventive health and clinical practice guidelines, provider medical record documentation and maintenance, and the provider satisfaction survey.

Provider Credentialing and Selection

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

Processes and requirements for provider credentialing and recredentialing are found in the UnitedHealthcare Credentialing Plan 2021–2023 (Credentialing Plan) with state-specific requirements included in an addendum. The Credentialing Plan addresses conducting queries for sanctions and exclusions and lists the queries conducted. However, it did not address querying the Social Security Administration's Death Master File (SSDMF). Onsite discussion confirmed the SSDMF is checked by another department within the organization prior to completing initial credentialing.

The Board of Directors delegates overall responsibility for credentialing and recredentialing to the National Credentialing Committee (NCC). The health plan's Medical Director administers the Credentialing Plan and credentialing activities at the local level. The local Provider Advisory Committee (PAC), which is chaired by the Chief Medical Officer and includes practicing network providers, conducts reviews and approves credentialing determinations initially made by the NCC. The PAC meets at least four times each year and reports to the QMC. Review of PAC meeting minutes confirmed the quorum was established for each meeting and attendance was satisfactory.

A sample of initial credentialing and recredentialing files for practitioners and organizational providers was reviewed for both CAN and CHIP. All files were compliant with initial credentialing and recredentialing requirements. The files provided evidence that United corrected issues identified during the previous EQR, which are noted in *Table 18* and *Table 19* below.

Table 18: Previous Provider Credentialing and Selection CAP Items - CAN

Standard	EQR Comments
II. A. Credentialing and Recredentialing - CAN	
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	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.*
United's Response: The Regulatory Quality Manager will oversee the training and education of the National Credentialing Center processors to make sure all collaborative agreements are attached and validated. This will ensure credentialing files contain the complete agreement for nurse practitioners. Training was completed 12/21/2021.	

Standard	EQR Comments
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	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 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.*
United's Response: The Regulatory Quality Manager will oversee the training and education of the National Credentialing Center processors to make sure all collaborative agreements are attached and validated. This will ensure credentialing files contain the complete agreement for nurse practitioners. Training was completed 12/21/2021.	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	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. 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.*

Standard	EQR Comments
United's Response: The Regulatory Quality Manager will oversee the training and education of the National Credentialing Center processors to make sure all Primary Source Verifications are attached and validated. Re-education of the NCC State and Federal Requirement Grid will also be completed. This will ensure verification of CLIA is conducted prior to issuing the credentialing or recredentialing determination and that evidence is included in the provider file. Also ensures 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. Training was completed 12/21/2021.	

Table 19: Previous Provider Credentialing and Selection CAP Items - CHIP

Standard	EQR Comments
II. A. Credentialing and Recredentialing - CHIP	
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.	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 state the process for collecting fingerprints or which staff are responsible for this activity. 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 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.*
United's Response: Under current CMS requirements it has been established to reduce unnecessary costs and burden to providers. If they meet the provisions under 455.101 and are already enrolled with Medicare, the State can rely on the provider's enrollment to satisfy the fingerprinting requirement.	

Standard	EQR Comments
United has already established a requirement for all providers to be enrolled with Medicare prior to participation into the network. Given the opportunity for the State to rely on Medicare it is only natural to allow the CCO the same. **United's Follow-up Response 03/25/22:** United developed a Policy and Procedure to address the process for collecting fingerprints for the remaining provider types designated by DOM to be high-risk: • Hospice providers Optum Behavioral Health has a policy in development, and it is to follow the UHC policy and procedure to address the following provider types: • Private Mental Health Centers • Community Mental Health Centers • IDD Community Support Programs • Mental Health Clinics/Groups. See attachment PS15-CHIP Finger Printing	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	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. For all these files, verification of the CLIA was submitted after completion of the onsite visit. All 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.*
United's Response: The Regulatory Quality Manager will oversee the training and education of the National Credentialing Center processors to make sure all Primary Source Verifications are attached and validated.	

Standard	EQR Comments
	Re-education of the NCC State and Federal Requirement Grid will also be completed. This will ensure verification of CLIA is conducted prior to issuing the credentialing or recredentialing determination and that evidence is included in the provider file. Also ensures 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. Training was completed 12/21/2021.

Processes are in place for Regional Peer Review Committees (RPRCs) to conduct peer review and investigate Quality of Care (QOC) complaints and referrals. Recommendations for action plans and/or disciplinary action are made to the National Peer Review and Credentialing Policy Committee (NPRCPC). The NPRCPC has the final decision-making authority for all actions that affect restriction, suspension, or termination of network participation. Appropriate processes are in place for notifying affected providers of termination or suspension, and for resulting appeals of these decisions.

Availability of Services

42 CFR § 438.206(c)(1), 42 CFR § 438.207, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Geographic access standards for CAN and CHIP providers are documented in United's Geographic Access Standards policy and are compliant with contractual requirements. United conducts quarterly geographic access studies to evaluate network adequacy. The most recent Quarterly Report on Accessibility of MississippiCAN Members, and the corresponding report for CHIP, both dated 7/11/22, indicate goals are met for member access to PCPs. For specialty providers, a few gaps were identified, including pediatric specialists and other specialties. Onsite discussion included United's ongoing efforts to mitigate the identified gaps.

Appointment availability requirements for network providers are defined in United's Access Standards – Appointment Availability Requirements policy and are compliant with contractual requirements. United contracted with DialAmerica to conduct quarterly assessments of provider compliance with appointment access standards. Failure to meet access requirements results in direct provider outreach and education. Review of the MSCAN_2022 2nd Quarter Appointment Availability Analysis document and the corresponding CHIP document reflected low success rates for contacting providers. Onsite discussion revealed United continues efforts to determine barriers to successful contacts and implement interventions to improve the success rates.

United's Multicultural Health Care Program has been implemented to reduce health disparity and improve culturally and linguistically appropriate services. Activities conducted include assessing, measuring, and evaluating the effectiveness of services provided to members, regularly assessing member and practitioner demographics,

ethnicity, and languages, routinely assessing for cultural gaps, and monitoring member satisfaction.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Policy PS14, Provider Orientation Plan, describes United's processes for new provider orientation to the health plan and the CAN and CHIP programs. Provider Relations staff use the monthly Network Notification report to ensure all new providers are contacted for orientation. New providers are contacted within 30 days of the contract effective date to answer any immediate questions and schedule an orientation meeting at the provider's earliest convenience.

Review of the CAN and CHIP Provider Manuals revealed the following issues:

- The CAN and CHIP Provider Manuals list incorrect hours of operation for the Provider Services Call Center. However, United staff confirmed the Provider Services Call Center hours of operation comply with requirements in the *CAN and CHIP Contract, Section 7 (H) (1)*.
- The benefits grid in the CAN Provider Manual, page 11, incorrectly indicates well child care is not covered.
- Page 53 of the CHIP Care Provider Manual states it is the provider's responsibility to contact members who are non-compliant with EPSDT screenings and services. It does not reference Well-Baby and Well-Child screenings and services, which is the term used for the CHIP population.
- The behavioral health benefits grid in the CAN Provider Manual, page 12, lists peer support services but does not indicate whether these are covered.
- The behavioral health benefits grid in the CHIP Provider Manual, page 10, lists peer support services but does not indicate whether these are covered.
- The CHIP Provider Manual correctly documents most appointment access standards; however, page 56 does not include the seven-day timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge.

The Provider website (www.uhcprovider.com) includes news and updates for providers, including policy updates, trainings, etc. In addition, various educational sessions and meetings are held throughout the state and ongoing provider education is provided through the website, provider office visits, newsletters, bulletins, and Provider Manual updates.

It was noted that United corrected the previously identified issue related to provider education of medical record retention timeframes for CAN and CHIP and the provider's

responsibility to follow-up with members who are not in compliance with the Well-Baby and Well-Child Care (CHIP). See *Table 20* for the specific issues, the required corrective actions, and United's responses.

Table 20: Previous Provider Education CAP Items – CAN and CHIP

Standard	EQR Comments
II C. Provider Education – CAN	
2. Initial provider education includes: 2.8 Medical record handling, availability, retention, and confidentiality;	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 •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.*
United's Response: The following language is in each of the provider participation agreements mentioned below supporting the medical records retention requirement found in the regulatory appendix. Therefore, the information is not incorporated into the provider manual. In addition, there is no need to update the Provider Participation Agreement. Language from Base Agreement referenced in each section below: One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable. ▫Sec. 9.11 of the Ancillary Provider Participation Agreement ▫Sec. 9.11 of the Facility Participation Agreement ▫Sec. 9.11 of the FQHC/RHC Participation Agreement ▫ Sec. 10.11 of the Medical Group Participation Agreement The accurate timeframe for medical record retention can be found in the MSCAN Regulatory Appendix; Section 3.9. Please see below:	

Standard	EQR Comments
Language from the MSCAN Regulatory Appendix: 3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates, and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness, and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records, including, as applicable, grievance and appeal records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by United if the Agreement is continuous. SUPPORTING DOCUMENTATION: 4_MSCAN_MS Medicaid CAN Reg App	
II C. Provider Education – CHIP	
2. Initial provider education includes: 2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	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.*
United's Response: Page 56 of the CHIP provider Manual was updated to include the 7-day timeframe. SUPPORTING DOCUMENTATION: •8_MS-Care-Provider-Manual-CHIP_12_15_21 •8_MS-Screenshot-Pg56	
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 Care 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 Care 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 Care Provider Manual_CHIP_DRAFT	
2.8 Medical record handling, availability, retention, and confidentiality;	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.

Standard	EQR Comments
	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 •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*
United's Response: The following language is in each of the provider participation agreements mentioned below supporting the medical records retention requirement which is found in the regulatory appendix. Therefore, the information is not incorporated into the provider manual. In addition, there is no need to update the provider participation agreements. Language from Base Agreement referenced in each section below: One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable. •Sec. 9.11 of the Ancillary Provider Participation Agreement •Sec. 9.11 of the Facility Participation Agreement •Sec. 9.11 of the FQHC/RHC Participation Agreement • Sec. 10.11 of the Medical Group Participation Agreement The accurate timeframe for medical record retention can be found in the MSCHIP Regulatory Appendix; Section 3.6. Please see below:	

Standard	EQR Comments
Language from the MSCHIP Regulatory Appendix: 3.6 Records Retention. As required under State or federal law or the MississippiCHIP Program Contract, Provider shall maintain a record keeping system of current, detailed, and organized records for recording services, charges, dates, and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness, and timeliness of services rendered to Members. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Member. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the MississippiCHIP Program Contract. Such records, including, as applicable, grievance and appeals records shall be maintained for a period of not less than ten (10) years from the close of the Agreement, or such other period as required by law. If records are under review or audit or are the subject of litigation, they must be retained for a minimum of ten (10) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by CCO if the Agreement is continuous. Provider shall have written records retention policies and procedures and will make such policies and procedures available to CCO or DOM upon request. DOM requires ready access to any and all documents and records of transactions pertaining to the provisions of services provided by Provider and those copies of requested documents/records will be provided to DOM or its designee free of charge. SUPPORTING DOCUMENTATION: •9_CHIP_MS CS CHIP Reg App	

The printed CAN and CHIP Provider Directories and online "Doctor Lookup" tools include all required elements. United's Web-Based Directory Usability Testing policy references a 30 calendar day timeframe to update information in the web-based Provider Directory; however, the *CAN Contract, Section 6 (E)* and the *CHIP Contract, Section 6 (E)* require these updates to be done within five business days.

Practice Guidelines

§ 438.236, § 457.1233

United adopts evidence-based preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) from nationally recognized sources. The Medical Technology Assessment Committee (MTAC) reviews the guidelines and reports the guidelines to the National Medical Care Management Committee (NMCMC) for oversight. These guidelines are available to staff, network providers, and members via United's website, and providers are notified annually by mail, fax, or e-mail of the availability. The CAN and CHIP Care Provider Manuals include information about the PHGs and CPGs and include links to access the information on the website.

United requires providers to maintain member medical records in compliance with documentation guidelines and appliable regulations. Medical record documentation requirements are included in the CAN and CHIP Care Provider Manuals. As noted in the 2021 Quality Improvement Program Description, United conducts Medical Record Review (MRR) of high volume providers for compliance with documentation standards. The performance goal is 85%. Providers who do not pass are notified of the score and

identified deficiencies. Education and support are provided, and a follow-up review is conducted. If the follow-up review is not successfully passed, the Medical Director and/or quality committee reviews the documentation and determines an appropriate corrective action. Re-audits are conducted the in the next year after HEDIS season has ended and during the new annual medical record review audit. Overall results and opportunities for improvement reported to the Provider Advisory Committee and Quality Management Committee. Detailed results of the 2021 MRR were included in the Quality Improvement & Population Health Management Annual Evaluation Report for 2021.

Provider Satisfaction Survey Validation

The provider satisfaction survey was administered by Escalent, an independent research company, on behalf of United. The response rate was 1.3%, a decrease from the previous year's rate of 1.9%. A total of 33 providers completed the survey out of 2,730. The very low response rate may not reflect the population of providers; thus, results should be interpreted with great caution.

The 2021 results indicate that overall satisfaction has decreased directionally since 2020, with more providers rating United unfavorably. High performing areas include Specialty Support, Care Coordination, Medical Records, Communication with Practice, and Credentialing and Contracting. Opportunities for improvement include the areas of: Member Support, Prior Authorization, Appeal, Reimbursement, Customer Service, and First Call Resolution. Results were presented to the QMC in June 2022 and to the Provider Advisory Committee in May 2022.

Table 21 below offers the section of the worksheet that needs improvement, the reason, and the recommendation.

Table 21: Provider Satisfaction Survey Validation Results—CAN and CHIP

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Of the 2730 sample providers, only 33 responded, creating a response rate of 1.3%. This is a decrease from last year's rate of 1.9%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution.	Although this is in line with the national response rate range, continued efforts should be made to gather a better representation of the providers. Additional reminders may be appropriate, as well as other interventions that incentivize providers to respond to the survey.

As noted in *Figure 4, Provider Services Findings*, United received "Met" scores for 98% of the Provider Services standards for CAN and 96% of the standards for CHIP.

Figure 4: Provider Services Findings

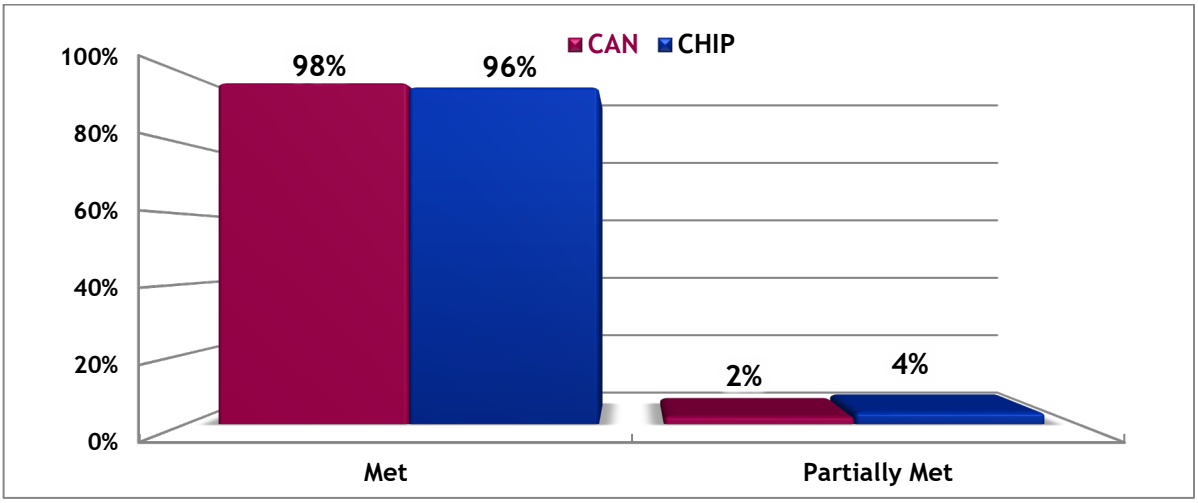


Table 22: Provider Services

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Provider Education	Initial provider education includes: CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: 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	Partially Met	Partially Met
	Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Partially Met
	The CCO regularly maintains and makes available a Provider Directory that includes all required elements	Met	Partially Met

Strengths

- Credentialing and recredentialing files were compliant with all required elements.
- United monitors network adequacy and makes efforts to address and close any identified gaps.
- Provider education includes information about preventive health and clinical practice guidelines, and the guidelines are available to providers.

- Member and Provider Satisfaction survey results are presented and addressed in QIC meetings.

Weaknesses

- The Credentialing Plan did not address querying the Social Security Administration's Death Master File (SSDMF). Onsite discussion confirmed the SSDMF is checked by another department within the organization prior to completing initial credentialing.
- Issues noted with the listing of covered and excluded benefits in the CAN Provider Manual included:
    - The benefits grid on page 11 indicates well child care is not covered. However, information about well child care is found elsewhere in CAN Provider Manual.
    - The behavioral health benefits grid on page 12 lists peer support services but does not indicate whether these are covered. Onsite discussion confirmed these services are covered.
- Issues noted with the listing of covered and excluded benefits in the CHIP Provider Manual included:
    - The behavioral health benefits grid on page 10 lists peer support services but does not indicate whether these are covered. Onsite discussion confirmed these services are covered.
- The CHIP Care Provider Manual correctly documents most appointment access standards; however, page 56 does not include the seven day timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge. This is a repeated finding from the 2021 EQR.
- Page 53 of the CHIP Care Provider Manual states it is a provider's responsibility to contact members who are non-compliant with EPSDT screenings and services. It does not reference Well-Baby and Well-Child screenings and services, which is the term used for the CHIP population.
- The *CAN Contract, Section 6 (E)* and the *CHIP Contract, Section 6 (E)* state, "The Contractor must also utilize a web-based provider directory, which must be updated within 5 business days upon changes to the provider network." However, Policy NQM-052, Web-Based Directory Usability Testing, page two, item D, states, "The Web-based practitioner and hospital directory information is updated within 30 calendar days of when new information is received." Onsite discussion confirmed updates are made to the online Provider Directory within 24 hours.
- For the provider satisfaction survey administered by Escalent, an independent research company, on behalf of United, the response rate was 1.3%. The response rate may not reflect the population of providers and may affect generalizability of the results; therefore, results should be interpreted with great caution.

Corrective Actions

- Revise the CAN Care Provider Manual to correct the issues identified with documentation of benefits for well child care and peer support services.
- Revise the CHIP Care Provider Manual to correct the issues identified with documentation of benefits for peer support services.
- Revise the CHIP Care Provider Manual to include complete information about the timeframe for appointments post-discharge from an acute psychiatric hospital.
- Revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.

Recommendations

- Update the Credentialing Plan to include information about querying the SSDMF at initial credentialing.
- Revise the CHIP Care Provider Manual, page 53, to reference Well-Baby and Well-Child screenings and services instead of EPSDT screenings and services.
- Continued efforts should be made to gather a better representation of the providers. Additional reminders may be appropriate, as well as other interventions that incentivize providers to respond to the survey.

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 policies. Members are educated about their rights and responsibilities through information included in the CAN and CHIP Member Handbook.

United provides newly enrolled members with an information packet within 14 days of receiving notification of the member's enrollment. The packet includes an introduction letter, member identification card, Member Handbook, and Provider Directory. Members are informed of their benefits and other information needed to understand health plan processes and requirements through the CAN and CHIP Member Handbooks. For CAN, the Member Handbook included incorrect information about coverage of well child care services. For both CAN and CHIP, the Member Handbooks included incomplete information about coverage of peer support services. Both issues were identified and discussed with United during the previous EQR.

Appropriate processes have been implemented to inform members in writing of any changes in benefits and to inform affected members of changes in the provider network. United conducts outreach to members and practitioners regarding the wellness and

preventive care programs and monitors/evaluates quality indicators for preventive care services. Member incentives (gift cards) are offered to motivate members to schedule appointments and close gaps in care. In addition, member newsletters, mailings, automated calls, etc. are used to inform members of risk factors and encourage participation in wellness activities. The health plan partners with community organizations for educational events.

United ensures member materials are written at an appropriate reading comprehension level and provides member materials in alternate languages and formats, including Braille, audio, large print, etc. to meet member needs. United provides oral interpretation and translation services at no cost. Hearing impaired services are available by dialing 711.

The Member Services Call Center is available by toll free telephone, with the hours of operation listed in the Member Handbooks. The NurseLine is available 24 hours/day, 7 days/week via toll free telephone and TTY 711. In addition, a Mental Health Crisis Line is available by toll-free telephone and TTY 711; however, the CAN and CHIP Member Handbooks do not specify its hours of operation. During onsite discussion, United staff were unable to state the hours of operation for the Mental Health Crisis Line. United conducts routine monitoring of call center performance. Untied reports the call center performance data to the Service Quality Improvement Subcommittee (SQIS) quarterly. As noted in the 2021 CAN QI Program Evaluation, all performance metrics were met in 2021 and no opportunities for improvement were identified.

Grievances

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

United processes grievances following Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, which describes processes for responding to a member's complaint or a grievance. The term "grievance" is appropriately defined in United's policy, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and on United's 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. However, the CAN Member Handbook, page 62, offers the member the option of filing an expedited grievance. This option is not mentioned in the grievance policy, the CHIP Member Handbook, or on United's website.

The grievance policy includes the steps United follows if an extension or additional time is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension.

United tracks all complaints and grievances received. Copies of the complaint and grievance logs were provided with the desk materials. These logs lacked detail regarding how the complaint or grievance was received. This was discussed during the onsite and United indicated the logs submitted with the desk review materials did not include how the grievance was received. Another grievance log was provided after the onsite and contained all the requirements.

CCME reviewed a sample of grievance files for CAN and CHIP. All files demonstrated that grievances were process timely and appropriate notifications were provided. The acknowledgement letter for one CAN file was not sent within the five calendar-day requirement.

Member Satisfaction Survey Validation

Member Satisfaction Survey validation for United CAN and CHIP was performed based on the CMS Survey Validation Protocol. United contracts with SPH Analytics Research, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, to conduct a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.

For CAN, the Adult CAHPS response rate was low at 14.7%. the Child CCC survey response rate was also low at 10.8%. Thus, the generalizability of the survey results is difficult to discern.

For CHIP, the generalizability of the Child CCC survey results is also difficult to discern due to the low response rate of 15.9%. This is a decrease from the previous year's response rate although it was higher than the average United CHIP general population response.

As noted in *Figure 5: Member Services Findings*, United achieved "Met" scores for 91% of the Member Services Standards for both CAN and CHIP.

Figure 5: Member Services Findings

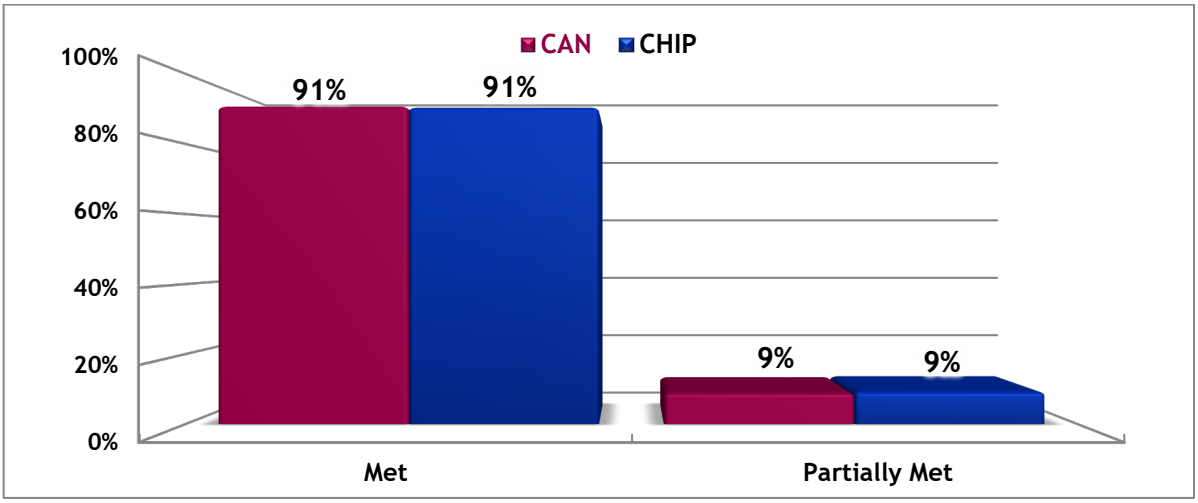


Table 23: Provider Services

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Member CCO Program Education	Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: Full disclosure of benefits and services included and excluded in coverage	Partially Met	Partially Met
Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: The procedure for filing and handling a grievance	Partially Met	Partially Met
	Timeliness guidelines for resolution of grievances as specified in the contract	Partially Met	Partially Met

Strengths

- Member rights and responsibilities are well-documented in plan materials.
- Appropriate processes are in place to inform members of changes in benefits and the provider network.
- Call center performance metrics/goals were met for 2021.
- Grievances are processed in a timely manner.

Weaknesses

- Issues noted with documentation of benefits in the CAN Member Handbook include:
  - Page 38 indicates well child care is not covered. This issue was identified during the previous EQR.
  - The behavioral health benefits grid on page 39 lists peer support services but does not indicate whether these are covered. This issue was identified during the previous EQR.
- For the CHIP Member Handbook, page 32 lists peer support services but does not indicate whether these are covered. This issue was identified during the previous EQR.
- Page 54 of the CAN Member Handbook and page 44 of the CHIP Member Handbook provide information about advance directives. The last sentence states, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." The *CAN Contract, Section 5 (J)* and *CHIP Contract, Section 5 (I)* refer to the agency as the "State Survey and Certification Division of the State Department of Health."
- The CAN and CHIP Member Handbooks indicate a Mental Health Crisis Line is available by toll-free telephone and TTY 711 but do not include the hours of operation for the Mental Health Crisis Line. United staff were unable to state the hours of operation.
- For the CAN 2022 Adult CAHPS survey, the survey response rate was 14.4%. For the CAN Child CCC CAHPS survey, the response rate was 10.3%. Thus, generalizability of the survey results is difficult to discern.
- The CAN Member Handbook, page 62, offers the member the option of filing an expedited grievance. This option is not mentioned in the grievance policy, the CHIP Member Handbook, or on United's website.
- The grievance policy includes the steps United follows if an extension or additional time is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension.
- The acknowledgement letter for one CAN file was not sent within the five calendar-day requirement.

Corrective Actions

- Revise the CAN Member Handbook to correct the issues identified with documentation of benefits for well child care and peer support services.
- Revise the CHIP Member Handbook to correct the issues identified with documentation of benefits for peer support services.

- Update Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, United's website, and the CHIP Member Handbook to include the process followed for an expedited grievance.
- Update the notice sent to members regarding the need for an extension and include the member's right to file a grievance if they disagree with the extension.

Recommendations

- Revise the CAN Member Handbook, page 54, and the CHIP Member Handbook, page 44, to reference the correct state agency name in the information for members with complaints about advance directives.
- Revise the CAN and CHIP Member Handbooks to list the hours of operation for the Mental Health Crisis Line.
- Additional reminders for awareness and member incentives may need to be considered to increase Member Satisfaction Survey response rates.
- Ensure the acknowledgement letters are sent within five calendar days of receipt of a grievance, as required by the *CAN Contract, Section 6 (K)*.

IV. Quality Improvement

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

Annually, United develops and/or updates their Quality Improvement (QI) Program Description. For this EQR, United submitted the 2022 Quality Improvement and Population Health Management Program Description and the Optum 2022 Behavioral Health Quality Improvement Program Description for the CAN and CHIP populations. Optum Behavioral Health is a sister company that provides mental health and substance abuse services for members. The QI Program Descriptions are detailed and include the programs' goals, objectives, structure, and scope of work. Details regarding United's Population Health Management Program were added to the 2022 QI Program Descriptions.

United addresses health care disparities and culturally and linguistically appropriate services (CLAS) through their Health Equity Program. United conducts an annual analysis to identify language, race and ethnicity disparities needing improvement. In 2021, areas targeted for CAN included eye exams for diabetics, breast cancer screenings and the health care rating. For CHIP, United targeted improving the rates for adolescent well-child exams and member satisfaction in 2021.Annually, an evaluation of the effectiveness of the program is conducted. For this EQR, United provided the CAN and CHIP 2021 Health Equity Program Evaluation. The program evaluation included results for areas targeted in 2021. The results listed for the diabetic eye exams in the CAN evaluation

were incorrect. Also, the results for Jackson County were missing with no explanation regarding why this county was excluded.

United develops a work plan annually that includes planned activities responsible party, quarterly updates, and status of each activity. United submitted the 2021 and 2022 CAN and CHIP Work Plans for review. United tracks HEDIS measure results on a quarterly basis and the final rates are included when available. The objectives noted in the 2022 CAN Work Plan, under the Objectives tab, included improving specific health outcomes in the areas of pre-term births, reduction of hospital admissions, and reduction of COVID-19 spread and hospitalizations. Neither the work plan nor the CAN QI Program Description described any activities related to the reduction of hospital admissions. Onsite discussion revealed this was an error in the work plan. Also, the HEDIS rates had not been updated and were listed as pending in the 2021 CAN and CHIP work plans.

United's Quality Management Committee is the decision-making body ultimately responsible for the QI Program. This committee reports to the Board of Directors and is chaired by the health plan's Chief Medical Officer. The Provider Advisory Committee is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of medical care rendered within the network. This committee is also chaired by the health plan's Chief Medical Officer and includes network primary care and subspecialty physicians participating as voting members.

United's CAN and CHIP Provider Manuals inform network providers about their expected participation in the QI Program. The Provider Manuals indicate additional information regarding United's QI Program is available upon request. United's network providers receive feedback regarding their performance data through the Primary Care Provider Profile report and the Patient Care Opportunities report.

Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, provides the process used for monitoring provider compliance with the clinical practice and preventive health guidelines adopted by United. During the previous EQR, CCME recommended United include details regarding how the results are shared with providers. The policy received for this EQR found the policy had been updated and included specific details regarding how results are shared with providers.

United evaluated the effectiveness of their 2021 QI Program and activities. The Quality Improvement & Population Health Management Annual Evaluation for CAN and CHIP was provided for review. The program evaluation included results and interventions underway. Last year, CCME recommended United correct errors identified in the HEDIS rates and include a summary of the interventions planned. The 2021 CAN program evaluation demonstrated the errors were corrected and interventions added.

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, 2021, through December 31, 2021.

Per the contract between the CCOs and DOM, the CCOs were required to submit HEDIS data to NCQA. To ensure the 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 (FARs), information systems compliance tools, and Interactive Data Submission System (IDSS) files approved by United's NCQA-licensed organization. Aqurate found that the CCO's information systems and processes were compliant with the applicable standards and HEDIS reporting requirements for HEDIS MY 2021.

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 reviewed several aspects crucial to the calculation of PM data: data integration, data control, and documentation of PM calculations. The following are some of the main steps 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 the CCO, 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 was acceptable.

Data Control — The CCO'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 CCO'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 the CCO was acceptable.

All relevant CAN HEDIS performance measures were compared for the current review year (MY 2021) to the previous year (MY 2020), and the changes from 2020 to 2021 are reported in *Table 24: CAN HEDIS Performance Measure Results*. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

Table 24: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	47.10%	53.13%	6.03%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	68.61%	68.37%	-0.24%
Counseling for Nutrition	55.96%	53.28%	-2.68%
Counseling for Physical Activity	51.82%	48.42%	-3.4%
Childhood Immunization Status (cis)			
DTaP	81.27%	72.51%	-8.76%
IPV	95.38%	90.51%	-4.87%
MMR	93.92%	88.32%	-5.6%
HiB	90.02%	85.4%	-4.62%
Hepatitis B	96.11%	91.24%	-4.87%
VZV	93.19%	86.86%	-6.33%
Pneumococcal Conjugate	82.24%	75.43%	-6.81%
Hepatitis A	81.75%	76.4%	-5.35%
Rotavirus	82.48%	71.05%	-11.43%
Influenza	34.06%	32.12%	-1.94%
Combination #3	76.4%	68.86%	-7.54%
Combination #7	63.75%	53.28%	-10.47%
Combination #10	26.28%	23.6%	-2.68%
Immunizations for Adolescents (ima)			

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Meningococcal	61.56%	52.07%	-9.49%
Tdap/Td	80.05%	74.45%	-5.6%
HPV	25.79%	19.22%	-6.57%
Combination #1	61.56%	51.82%	-9.74%
Combination #2	24.82%	18.98%	-5.84%
Lead Screening in Children (lsc)	74.21%	68.13%	-6.08%
Breast Cancer Screening (bcs)	45.54%	44.72%	-0.82%
Cervical Cancer Screening (ccs)	50.85%	48.91%	-1.94%
Chlamydia Screening in Women (chl)			
16-20 Years	45.72%	45.73%	0.01%
21-24 Years	58.9%	61.34%	2.44%
Total	47.78%	48.25%	0.47%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Appropriate Testing for Pharyngitis (3-17)	75.62%	74.71%	-0.91%
Appropriate Testing for Pharyngitis (18-64)	61.47%	61.47	0.00%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	73.89%	72.75%	-1.14%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	25.68%	22.65%	-3.03%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	54.02%	49.89%	-4.13%
Bronchodilator	75.13%	76.36%	1.23%
Asthma Medication Ratio (amr)			
5-11 Years	82.00%	81.97%	-0.03%
12-18 Years	74.79%	73.43%	-1.36%
19-50 Years	52.36%	57.05%	4.69%
51-64 Years	51.16%	58.42%	7.26%
Total	74.08%	73.36%	-0.72%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	50.61%	57.42%	6.81%
Persistence of Beta-Blocker Treatment After a Heart Attack	76.92%	76.67%	-0.25%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	73.25%	75.73%	2.48%
Statin Adherence 80% - 21-75 years (Male)	61.43%	57.49%	-3.94%
Received Statin Therapy - 40-75 years (Female)	73.73%	71.7%	-2.03%
Statin Adherence 80% - 40-75 years (Female)	52.73%	48.66%	-4.07%
Received Statin Therapy - Total	73.48%	73.76%	0.28%
Statin Adherence 80% - Total	57.22%	53.28%	-3.94%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	81.27%	90.51%	9.24%
HbA1c Poor Control (>9.0%)	51.82%	45.26%	-6.56%
HbA1c Control (<8.0%)	37.47%	46.47%	9.00%
Eye Exam (Retinal) Performed	57.91%	56.69%	-1.22%
Blood Pressure Control (<140/90 mm Hg)	53.77%	59.12%	5.35%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	15.43%	17.64%	2.21%
Kidney Health Evaluation for Patients With Diabetes (65-74)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	15.41%	17.62%	2.21%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	57.83%	57.70%	-0.13%
Statin Adherence 80%	51.43%	50.77%	-0.66%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	46.77%	48.82%	2.05%
Effective Continuation Phase Treatment	30.43%	31.22%	0.79%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	55.63%	44.56%	-11.07%
Continuation and Maintenance (C&M) Phase	73.18%	59.32%	-13.86%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	60.2%	61.7%	1.5%
6-17 years - 7-Day Follow-Up	35.88%	37.26%	1.38%
18-64 years - 30-Day Follow-Up	56.72%	51.85%	-4.87%
18-64 years - 7-Day Follow-Up	33.73%	29.52%	-4.21%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	58.61%	57.33%	-1.28%
7-Day Follow-Up	34.9%	33.83%	-1.07%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	47.30%	52.51%	5.21%
6-17 years - 7-Day Follow-Up	32.43%	32.96%	0.53%
18-64 years - 30-Day Follow-Up	37.41%	43.68%	6.27%
18-64 years - 7-Day Follow-Up	22.73%	26.71%	3.98%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	40.69%	47.05%	6.36%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Total- 7-Day Follow-Up	25.98%	29.10%	3.12%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	28.72%	37.35%	8.63%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	15.6%	19.28%	3.68%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	27.84%	35.91%	8.07%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	2.94%	0.0%	-2.94%
7-Day Follow-Up: 13-17 Years	2.94%	0.0%	-2.94%
30-Day Follow-Up: 18+ Years	5.96%	6.17%	0.21%
7-Day Follow-Up: 18+ Years	3.64%	3.29%	-0.35%
30-Day Follow-Up: Total	5.65%	5.43%	-0.22%
7-Day Follow-Up: Total	3.57%	2.90%	-0.67%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	33.14%	33.79%	0.65%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	33.33%	33.64%	0.31%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	66.52%	69.47%	2.95%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	63.61%	71.62%	8.01%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	77.78%	85.37%	7.59%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	59.45%	57.86%	-1.59%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	28.51%	33.63%	5.12%
Cholesterol Testing (1-11)	21.27%	24.65%	3.38%
Blood Glucose and Cholesterol Testing (1-11)	18.21%	21.24%	3.03%
Blood Glucose Testing (12-17)	39.27%	47.33%	8.06%
Cholesterol Testing (12-17)	23.73%	29.56%	5.83%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Blood Glucose and Cholesterol Testing (12-17)	21.62%	27.36%	5.74%
Blood Glucose Testing (Total)	34.87%	42.07%	7.2%
Cholesterol Testing (Total)	22.73%	27.68%	4.95%
Blood Glucose and Cholesterol Testing (Total)	20.23%	25.01%	4.78%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.47%	1.51%	0.04%
Appropriate Treatment for Upper Respiratory Infection (uri)			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	71.17%	72.99%	1.82%
Appropriate Treatment for Upper Respiratory Infection (18-	55.84%	57.41%	1.57%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection	69.35%	71.22%	1.87%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	44.14%	45.13%	0.99%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	36.48%	41.65%	5.17%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	42.73%	44.43%	1.70%
Use of Imaging Studies for Low Back Pain (lbp)	71.78%	69.51%	-2.27%
Use of Opioids at High Dosage (hdo)	0.98%	0.84%	-0.14%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	15.58%	15.26%	-0.32%
Multiple Pharmacies	2.41%	1.87%	-0.54%
Multiple Prescribers and Multiple Pharmacies	1.44%	1.21%	-0.23%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	4.69%	4.99%	0.3%
18-64 years - >=31 Days covered	3.47%	3.27%	-0.2%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	4.68%	5.00%	0.32%
Total - >=31 Days covered	3.46%	3.28%	-0.18%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	83.74%	84.01%	0.27%
45-64 Years	88.95%	89.06%	0.11%
65+ Years	79.17%	78.57%	-0.6%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Total	85.79%	85.99%	0.2%
Annual Dental Visit (adv)			
2-3 Years	41.78%	48.43%	6.65%
4-6 Years	60.11%	66.21%	6.1%
7-10 Years	62.81%	68.38%	5.57%
11-14 Years	61.8%	65.2%	3.4%
15-18 Years	54.72%	58.18%	3.46%
19-20 Years	39.58%	41.9%	2.32%
Total	57.52%	62.41%	4.89%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	62.5%	70.73%	8.23%
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	65.97%	67.27%	1.3%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.71%	4.55%	-0.16%
Total: Initiation of AOD Treatment: 13-17 Years	62.56%	65.98%	3.42%
Total: Engagement of AOD Treatment: 13-17 Years	4.27%	4.1%	-0.17%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	40.08%	46.06%	5.98%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	5.16%	5.84%	0.68%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	29.76%	40.04%	10.28%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	11.9%	16.67%	4.77%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	41.65%	40.03%	-1.62%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.91%	5.52%	0.61%
Total: Initiation of AOD Treatment: 18+ Years	37.56%	40.11%	2.55%
Total: Engagement of AOD Treatment: 18+ Years	6.95%	7.85%	0.9%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.24%	47.36%	6.12%

Measure/Data Element	HEDIS MY 2020 CAN Rates	HEDIS MY 2021 CAN Rates	Change
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.9%	5.53%	0.63%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	30.32%	40.21%	9.89%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	11.73%	16.6%	4.87%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	44.84%	43.7%	-1.14%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	4.88%	5.39%	0.51%
Total: Initiation of AOD Treatment: Total	39.65%	42.56%	2.91%
Total: Engagement of AOD Treatment: Total	6.73%	7.50%	0.77%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	91.48%	93.67%	2.19%
Postpartum Care	72.51%	74.70%	2.19%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	58.44%	60.97%	2.53%
12-17 years	64.71%	62.31%	-2.4%
Total	62.2%	61.81%	-0.39%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	51.3%	57.07%	5.77%
15 Months-30 Months	65.25%	60.51%	-4.74%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	38.6%	43.57%	4.97%
12-17 Years	32.61%	36.72%	4.11%
18-21 Years	17.24%	19.15%	1.91%
Total	34.83%	39.16%	4.33%

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR: Biased Rate
NR indicates that the rate was not reported.

As shown, the Initiation and Engagement of AOD Dependence Treatment (IET), Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years indicator improved by 10.28 percentage points.

The following HEDIS MY 2021 CAN measure rates had a substantial decline (greater than 10%) from the previous HEDIS rate (2020):

- Childhood Immunization Status (CIS), Rotavirus indicator and Combination #7 indicator had a greater than 10 percentage point decline.

- Follow-Up Care for Children Prescribed ADHD Medication (ADD), both the Initiation Phase indicator and the Continuation and Maintenance (C&M) Phase indicator, had more than an 11 percent decline.

All relevant CHIP HEDIS performance measures were compared for MY 2021 and the previous year (2020), and the change from 2020 to 2021 is reported in the table that follows. Rate changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 25: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	64.23%	70.07%	5.84%
Counseling for Nutrition	52.07%	53.04%	0.97%
Counseling for Physical Activity	49.15%	49.88%	0.73%
Childhood Immunization Status (cis)			
DTaP	85.89%	82.97%	-2.92%
IPV	96.11%	92.46%	-3.65%
MMR	94.40%	91.73%	-2.67%
HiB	92.94%	88.56%	-4.38%
Hepatitis B	97.08%	91.73%	-5.35%
VZV	93.67%	91.73%	-1.94%
Pneumococcal Conjugate	90.51%	85.4%	-5.11%
Hepatitis A	82.24%	82.97%	0.73%
Rotavirus	86.37%	84.67%	-1.7%
Influenza	43.07%	39.17%	-3.9%
Combination #2	NA	NA	NA
Combination #3	84.43%	81.02%	-3.41%
Combination #4	NA	NA	NA
Combination #5	NA	NA	NA
Combination #6	NA	NA	NA
Combination #7	68.86%	70.56%	1.70%
Combination #8	NA	NA	NA
Combination #9	NA	NA	NA
Combination #10	36.50%	32.85%	-3.65%
Immunizations for Adolescents (ima)			
Meningococcal	60.83%	58.88%	-1.95%

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Tdap/Td	83.94%	83.21%	-0.73%
HPV	22.38%	23.36%	0.98%
Combination #1	60.34%	58.64%	-1.70%
Combination #2	21.17%	22.38%	1.21%
Lead Screening in Children (lsc)	68.13%	66.67%	-1.46%
Chlamydia Screening in Women (chl)			
16-20 Years	37.92%	37.92%	0.00%
21-24 Years	NA	NA	NA
Total	37.92%	37.92%	0.00%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	77.8%	76.89%	-0.91%
18-64 years	71.12%	79.12%	8.00%
65+ years	NA	NA	NA
Total	77.55%	77.00%	-0.55%
Asthma Medication Ratio (amr)			
5-11 Years	83.50%	86.74%	3.24%
12-18 Years	75.11%	79.18%	4.07%
19-50 Years	NA	NA	NA
51-64 Years	NA	NA	NA
Total	79.21%	82.48%	3.27%
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	NA	NA	NA
Comprehensive Diabetes Care (cdc)			
Comprehensive Diabetes Care - HbA1c Testing	NA	NA	NA
Comprehensive Diabetes Care - Poor HbA1c Control	NA	NA	NA
Comprehensive Diabetes Care - HbA1c Control (<8%)	NA	NA	NA
Comprehensive Diabetes Care - Eye Exams	NA	NA	NA
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (65-74)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Statin Therapy for Patients With Diabetes (spd)			
Statin Therapy for Patients With Diabetes - Received Statin Therapy	NA	NA	NA
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	NA	NA	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	NA	NA	NA
Effective Continuation Phase Treatment	NA	NA	NA
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	46.44%	36.52%	-9.92%
Continuation and Maintenance (C&M) Phase	66.22%	51.79%	-14.43%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	67.52%	66.51%	-1.01%
6-17 years - 7-Day Follow-Up	40.76%	35.81%	-4.95%
18-64 years - 30-Day Follow-Up	NA	50.00%	0.00%
18-64 years - 7-Day Follow-Up	NA	20.00%	-5.00%
65+ years - 30-Day Follow-Up	NA	0.00%	0.00%
65+ years - 7-Day Follow-Up	NA	0.00%	0.00%
Total-30-day Follow-Up	65.90%	65.78%	-0.12%
Total-7-day Follow-Up	39.31%	35.11%	-4.20%
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
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use	NA	NA	NA

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Disorder - 30 days (65+)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
Pharmacotherapy for Opioid Use Disorder (16-64)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	NA	NA	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (ssd)	NA	NA	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NA	NA	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	30.34%	32.00%	1.66%
Cholesterol Testing (1-11)	23.60%	21.33%	-2.27%
Blood Glucose and Cholesterol Testing (1-11)	21.35%	21.33%	-0.02%
Blood Glucose Testing (12-17)	36.47%	58.64%	22.17%
Cholesterol Testing (12-17)	23.53%	29.63%	6.10%
Blood Glucose and Cholesterol Testing (12-17)	20.59%	29.01%	8.42%

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
Blood Glucose Testing (Total)	34.36%	50.21%	15.85%
Cholesterol Testing (Total)	23.55%	27.00%	3.45%
Blood Glucose and Cholesterol Testing (Total)	20.85%	26.58%	5.73%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.02%	1.11%	0.09%
Appropriate Treatment or Children with URI (uri)			
3 months-17 Years	67.17%	66.47%	-0.70%
18-64 Years	53.69%	59.65%	5.96%
65+ Years	NA	NA	NA
Total	66.71%	66.23%	-0.48%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	33.09%	28.13%	-4.96%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	32.93%	28.21%	-4.72%
Use of Imaging Studies for Low Back Pain (lbp)	NA	NA	NA
Use of Opioids at High Dosage (hdo)	NA	NA	NA
Use of Opioids From Multiple Providers (uop)			
Use of Opioids From Multiple Providers - Multiple Prescribers	NA	NA	NA
Use of Opioids From Multiple Providers - Multiple Pharmacies	NA	NA	NA
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies	NA	NA	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	0.00%	2.00%	2.00%
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	0.00%	2.00%	2.00%
Total - >=31 Days covered	0.00%	0.00%	0.00%
Access/Availability of Care			
Annual Dental Visit (adv)			
2-3 Years	45.15%	51.81%	6.66%
4-6 Years	64.54%	71.11%	6.57%
7-10 Years	70.36%	76.82%	6.46%

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
11-14 Years	66.76%	72.76%	6.00%
15-18 Years	59.17%	63.96%	4.79%
19-20 Years	44.52%	55.45%	10.93%
Total	63.37%	69.56%	6.19%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NA	NA	NA
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	62.86%	58.97%	-3.89%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	5.71%	7.69%	1.98%
Total Initiation of AOD Treatment: 13-17 years	64.10%	56.10%	-8.00%
Total Engagement of AOD Treatment: 13-17 years	5.13%	7.32%	2.19%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA
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	53.57%	52.83%	-0.74%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	7.14%	5.66%	-1.48%
Initiation of AOD Treatment: Total	53.85%	51.61%	-2.24%
Engagement of AOD Treatment: Total	6.15%	4.84%	-1.31%

Measure/Data Element	HEDIS MY 2020 CHIP Rates	HEDIS MY 2021 CHIP Rates	Change
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	59.52%	57.50%	-2.02%
12-17 Years	60.87%	61.29%	0.42%
Total	60.36%	60.15%	-0.21%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	64.93%	68.93%	4.00%
15 Months-30 Months	72.09%	73.46%	1.37%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	40.02%	44.35%	4.33%
12-17 Years	36.37%	40.16%	3.79%
18-21 Years	19.64%	25.34%	5.70%
Total	36.97%	41.11%	4.14%

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

The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose Testing (12-17) indicator and Blood Glucose Testing (Total) improved by 22.17 and 15.85 percentage points respectively.

The HEDIS MY 2021 measure rate for Follow-up care for children prescribed ADHD Medication (ADD), Continuation and Maintenance (C&M) Phase indicator had a decline of 14.43 percentage points.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for MY 2021 and the previous year (2020). The change from 2020 to 2021 are reported in the tables that follows. Rate changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 26: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate	MY 2021 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
Colorectal Cancer Screening (COL-AD)			

Measure	MY 2020 Rate	MY 2021 Rate	Change
Ages 50 - 64	-	42.01%	-
Ages 65 - 75	-	39.06%	-
Total	-	41.99%	-
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.50%	0.54%	0.04%
Ages 65+	0.47%	0.96%	0.49%
Total	0.50%	0.54%	0.04%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception - 3 days	13.51%	11.46%	-2.05%
Most or moderately effective contraception - 60 days	46.22%	43.33%	-2.89%
LARC - 3 Days	0.58%	0.61%	0.03%
LARC - 60 Days Reported	8.54%	8.37%	-0.17%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception rate	25.13%	24.55%	-0.58%
LARC rate	3.37%	2.75%	-0.62%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	26.06	22.50	-3.56
Ages 65+	0.00	0.00	0.00
Total	26.01	22.47	-3.55
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	39.01	44.42	5.41
Ages 65+	115.61	0.00	-115.61
Total	39.34	44.25	4.91
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	44.35	46.46	2.11
Ages 65+	115.61	381.68	266.07
Total	44.46	46.94	2.48
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	0.88	1.45	0.57
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	12.00%	19.22%	7.22%
Ages 65+	NA	NA	NA

Measure	MY 2020 Rate	MY 2021 Rate	Change
Total	11.79%	19.13%	7.34%
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	1.03%	0.84%	-0.19%
Ages 65+	NA	NA	NA
Total	1.03%	0.84%	-0.19%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	4.82%	3.83%	-1.00%
Ages 65+	NA	NA	NA
Total	4.82%	3.82%	-1.00%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	54.63%	39.98%	-14.65%
Prescription for Buprenorphine	53.24%	38.63%	-14.61%
Prescription for Oral Naltrexone	2.31%	0.87%	-1.44%
Prescription for Long-acting, injectable naltrexone	0.00%	0.00%	0.00%
Prescription for Methadone	0.00%	0.77%	0.77%
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%	0.92%	0.13%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	25.75%	29.25%	3.50%
Age 2 Screening	41.74%	41.80%	0.06%
Age 3 Screening	42.13%	41.03%	-1.10%
Total Screening	35.96%	36.43%	0.47%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception - 3 days	2.00%	1.78%	-0.22%
Most or moderately effective contraception - 60 days	51.59%	46.52%	-5.07%
LARC - 3 Days	0.47%	0.97%	0.50%
LARC - 60 Days Reported	12.13%	10.21%	-1.92%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	30.09%	28.77%	-1.32%

Measure	MY 2020 Rate	MY 2021 Rate	Change
LARC Rate	2.66%	2.58%	-0.08%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	34.80%	29.25%	-5.55%
Numerator 2 All Four Molars Sealed	20.85%	17.32%	-3.53%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	-	0.20%	-
Ages 1-2	-	4.22%	-
Ages 3-5	-	11.52%	-
Ages 6-7	-	12.44%	-
Ages 8-9	-	12.46%	-
Ages 10-11	-	12.14%	-
Ages 12-14	-	10.98%	-
Ages 15-18	-	8.89%	-
Ages 19-20	-	5.02%	-
Total Ages <1-20	-	9.87%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	-	10.77%	-
Ages 3-5	-	24.97%	-
Ages 6-7	-	29.55%	-
Ages 8-9	-	29.31%	-
Ages 10-11	-	27.26%	-
Ages 12-14	-	24.26%	-
Ages 15-18	-	17.42%	-
Ages 19-20	-	8.10%	-
Total Ages 1-20	-	22.70%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	-	0.92%	-
Ages 3-5	-	2.47%	-
Ages 6-7	-	2.75%	-
Ages 8-9	-	2.62%	-
Ages 10-11	-	2.00%	-
Ages 12-14	-	2.06%	-
Ages 15-18	-	1.54%	-
Ages 19-20	-	0.43%	-

Measure	MY 2020 Rate	MY 2021 Rate	Change
Total Ages 1-20	-	2.00%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	-	3.62%	-
Ages 3-5	-	0.40%	-
Ages 6-7	-	0.00%	-
Ages 8-9	-	0.00%	-
Ages 10-11	-	0.00%	-
Ages 12-14	-	0.00%	-
Ages 15-18	-	0.00%	-
Ages 19-20	-	0.00%	-
Total Ages 1-20	-	0.44%	-

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate; -: New measure, no prior year or change data available for reporting.

For the CAN measures, the Heart Failure Admission Rate (PQI-08), Ages 65+ indicator improved by 266.07 member months per 100,000 member months.

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

- The Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission rate (PQI-05), Ages 65+ indicator declined by 115.61 member months per 100,000 member months.
- The Use of Pharmacotherapy for Opioids Use Disorder (OUD-AD), Overall indicator and Prescription for Buprenorphine indicators declined by over 14 percentage points.

For the CHIP non-HEDIS measures, there were several measures not reported by United or not enough data was available for reporting. None of the measures that could be compared showed a substantial increase or decrease, as noted in *Table 27: CHIP Non-HEDIS Performance Measure Rates*.

Table 27: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2020 Rate	MY 2021 Rate	Change
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	NR	0.41%	-

Measure	MY 2020 Rate	MY 2021 Rate	Change
Total	NR	0.41%	-
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	NR	29.83%	-
Total	NR	29.83%	-
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	NR	0.00%	-
Total	NR	0.00%	-
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	NR	0.00%	-
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	NR	NA	-
Total	NR	NA	-
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NR	NA	-
Total	NR	NA	-
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NR	NA	-
Total	NR	NA	-
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	NR	NA	-
Prescription for Buprenorphine	NR	NA	-
Prescription for Oral Naltrexone	NR	NA	-
Prescription for Long-acting, injectable naltrexone	NR	NA	-
Prescription for Methadone	NR	NA	-
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%	0.63%	-0.08%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	NA	38.10%	NA
Age 2 Screening	48.41%	47.82%	-0.59%
Age 3 Screening	43.78%	44.83%	1.05%
Total Screening	46.04%	45.83%	-0.31%

Measure	MY 2020 Rate	MY 2021 Rate	Change
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception - 3 days	NA	18.18%	NA
Most or moderately effective contraception - 60 days	NA	45.45%	NA
LARC - 3 Days	NA	0.00%	NA
LARC - 60 Days	NA	0.00%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	29.82%	29.04%	-0.78%
LARC Rate	2.49%	2.48%	-0.01%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	35.32%	28.63%	-6.69%
Numerator 2 All Four Molars Sealed	21.12%	17.88%	-3.24%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	-	0.00%	-
Ages 1-2	-	6.66%	-
Ages 3-5	-	11.26%	-
Ages 6-7	-	12.97%	-
Ages 8-9	-	13.62%	-
Ages 10-11	-	12.59%	-
Ages 12-14	-	11.96%	-
Ages 15-18	-	9.71%	-
Ages 19-20	-	5.48%	-
Total Ages <1-20	-	11.21%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	-	19.29%	-
Ages 3-5	-	30.71%	-
Ages 6-7	-	35.77%	-
Ages 8-9	-	37.19%	-
Ages 10-11	-	35.17%	-
Ages 12-14	-	30.63%	-

Measure	MY 2020 Rate	MY 2021 Rate	Change
Ages 15-18	-	21.61%	-
Ages 19-20	-	13.93%	-
Total Ages 1-20	-	29.41%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	-	1.61%	-
Ages 3-5	-	2.77%	-
Ages 6-7	-	2.88%	-
Ages 8-9	-	3.03%	-
Ages 10-11	-	2.22%	-
Ages 12-14	-	2.46%	-
Ages 15-18	-	1.98%	-
Ages 19-20	-	0.82%	-
Total Ages 1-20	-	2.40%	-
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	-	0.05%	-
Ages 3-5	-	0.00%	-
Ages 6-7	-	0.00%	-
Ages 8-9	-	0.00%	-
Ages 10-11	-	0.00%	-
Ages 12-14	-	0.00%	-
Ages 15-18	-	0.00%	-
Ages 19-20	-	0.00%	-
Total Ages 1-20	-	0.20%	-

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting; BR: Biased Rate; -: New measure, no prior year or change data available for reporting

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

For this review, the same four CAN PIPs submitted for the 2021 EQR were also submitted and validated for this EQR. Topics for PIPs include Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness. 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.

Table 28: CAN Behavioral Health Readmissions PIP

Behavioral Health Readmissions	
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 no improvement in the latest readmission rate from 17.7% in 2020 to 21.4% in 2021 with a goal of 14.2%. The case management enrollment indicator had a decline from 38% in 2020 to 28% in 2021. Individual facility rates were reported as well for each of the five facilities.	
Previous Validation Score	**Current Validation Score**
79/80=99% High Confidence in Reported Results	74/75=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. • Direct referrals to Genoa Pharmacy • Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from Inpatient level of care.	

Table 29: CAN 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 and received a prenatal care visit in the first trimester or within 42 days of enrollment. For this validation, this PIP showed some improvement. The baseline rate was 92.21% and the remeasurement one rate was 91.48%. The most recent remeasurement improved to 93.67% which is above the DOM goal rate of 93.62%. This rate reflects an improvement in the visit rate.	
Previous Validation Score	**Current Validation Score**
79/80=99% High Confidence in Reported Results	80/80=100% 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. • Provider education with OB Toolkits. • Weekly data analysis with risk stratification. • Healthy Starts Program to address social needs.	

Table 30: CAN 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. For this validation, the PIP showed no improvement. The rate was 26.43% in 2020 and increased to 28.50% in 2021. The goal is to reduce it to 25.64%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	

Sickle Cell Disease Outcomes
• 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. • Weekly interdisciplinary rounds for Case Management. • Provider education with the After Hour Care newsletter.

Table 31: CAN Respiratory Illness: COPD/Asthma PIP

Respiratory Illness: COPD/Asthma	
The Respiratory Illness PIP examines the COPD exacerbations and pharmacotherapy management HEDIS rate. The bronchodilators baseline rate was 75.13%% which improved to 76.36%% although it is still below the DOM goal rate of 77.38%. The corticosteroids baseline rate was 54.02% at remeasurement one and declined to 49.89% for 2021. It is below the goal rate of 55.62% for DOM. The AMR rate for 2021 was 73.36% which is a decline from the remeasurement one rate of 74.08%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% 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 Behavioral Health Readmission, Respiratory Illness, and Sickle Cell PIPs. They are displayed in *Table 32: CAN Performance Improvement Project Recommendations*.

Table 32: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The readmission rate overall showed no improvement in the latest rate from 17.7% in 2020 to 21.4% in 2021 with a goal of 14.2%. The case management enrollment indicator had a decline from 38% in 2020 to 28% in 2021.	Evaluate the impact of Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from inpatient level of care to determine if this additional intervention improves readmissions. Determine if additional steps should be taken to ensure re-admitters are enrolled in high-risk case management.
Respiratory Illness	Was there any documented, quantitative improvement in processes or outcomes of care?	The corticosteroids baseline rate was 54.02% at remeasurement one and declined to 49.89% for 2021. This rate is below the goal rate of 55.62%. The AMR rate for 2021 was 73.36% which is a decline from the remeasurement one rate of 74.08%.	Assess the impact of patient care opportunity reports, provider education, the Community Plan Incentive program using interim rate monitoring.
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate was 26.43% in 2020 and increased to 28.50% in 2021. The goal is to reduce this rate to 25.64%.	Continue weekly interdisciplinary rounds for CM, Sickle Cell Disease Program and monitor interim rates for monitoring the success of these interventions

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. 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.

Table 33: CHIP Adolescent Well Child Visits / Child and Adolescent Well Care Visits PIP

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	
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. The rate for the 12-17-year-olds improved from 36.37% to 40.16%. This is above the goal rate of 37.46%. The rate for 18–21-year-olds also improved from 19.64% to 25.34% which is above the goal rate of 24.63%.	
Previous Validation Score	**Current Validation Score**
73/73/=100% Hight Confidence in Reported Results	80/80 = 100% High 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.	

Table 34: CHIP 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 remained about the same over the last 2 measurement periods, with a rate of 65.9% in 2020 and 65.8% in 2021. The 7-day follow up rate declined from 39.31% to 35.11% in 2021. The goal rate for United is 38.95%.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	

Follow Up After Hospitalization for Mental Illness
• 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 35: CHIP 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. BMI percentile documentation improved from 64.23% in 2020 to 70.07% in 2021. The goal rate is 76.64%. Counseling on nutrition improved slightly from 52.07% to 53.04% with a goal of 70.11%. Counseling for physical activity improved slightly from 49.15% to 49.88% with a goal of 66.18%.	
Previous Validation Score	**Current Validation Score**
99/100 = 99% High Confidence in Reported Results	100/100=100% 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 36: CHIP 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 regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. For this review the rate improved from 82.3% to 90.3% which is above the goal of 79.8%.	
Previous Validation Score	**Current Validation Score**

Getting Needed Care CAHPS	
99/100=99% High Confidence in Reported Results	100/100=100% 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 37: CHIP Performance Improvement Project Recommendations*.

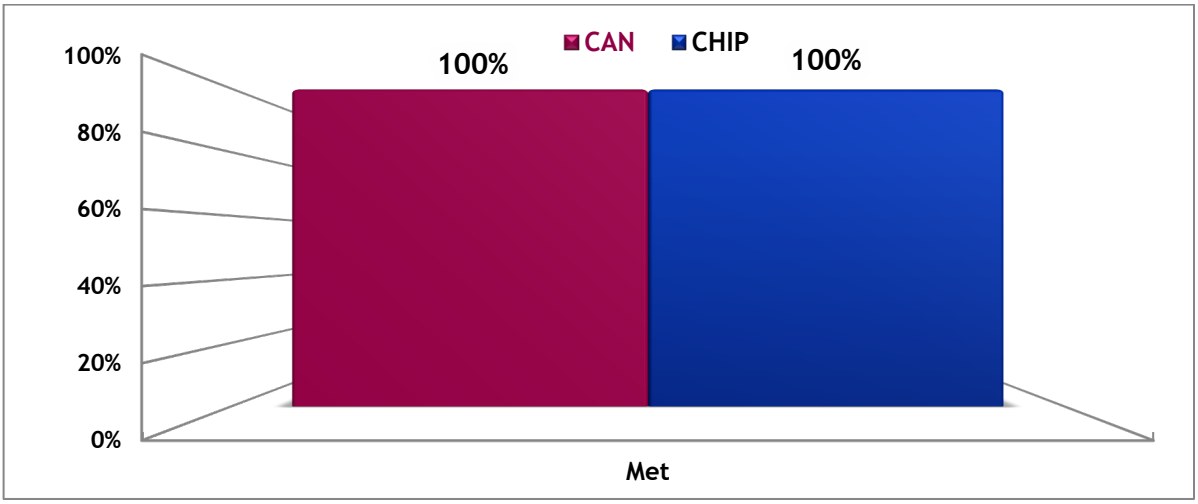
Table 37: CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Follow-Up After Hospitalization	Was there any documented, quantitative improvement in processes or outcomes of care?	The 30-day follow up rate remained about the same over the last 2 measurement periods, with a rate of 65.9% in 2020 and 65.8% in 2021. The 7-day follow up rate declined from 39.31% to 35.11% in 2021.	Determine if there are ways to identify the most impactful interventions and if those are identified, focus efforts on those methods and processes.

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 was fully compliant with all information system standards and submitted valid and reportable rates for all HEDIS measures in the scope of the 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. United followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.
- The following CAN HEDIS MY 2021 measure rates and CAN non-HEDIS Adult Core Set measure rates were strengths for United since their rates had a greater than 10% improvement:
    - The Initiation and Engagement of AOD Dependence Treatment (IET), Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years indicator improved by 10.28 percentage points.
    - The Heart Failure Admission Rate (PQI-08), Ages 65+ indicator improved by 266.07 member months per 100,000 member months.
- The following CHIP HEDIS MY 2021 measure rates were strengths for United since their rates had a greater than 10% improvement:
    - The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose Testing (12-17) indicator and Blood Glucose Testing (Total) improved by 22.17 and 15.85 percentage points respectively.
    - The Annual Dental Visit (ADV), 19-20 Years indicator improved by over 10 percentage points.

- PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and rationale for each topic was documented.
- All PIPs were validated in the High Confidence range.

Weaknesses

- The CAN 2021 Health Equity Program Evaluation included errors for the results reported for diabetic eye exams. Also, the results for Jackson County were missing with no explanation regarding why this county was excluded.
- The 2022 CAN work plan, under the Objectives tab, incorrectly included an objective to reduce hospital admissions. Also, the HEDIS rates had not been updated and were listed as pending in the 2021 CAN and CHIP work plans.
- The following CAN HEDIS MY 2021 measure rates and CAN non-HEDIS Adult Core Set measure rates were determined to be areas of opportunity for United since their rates had a greater than 10% decline:
    - The Childhood Immunization Status (CIS), Rotavirus indicator and Combination #7 indicator had a greater than 10 percentage point decline.
    - The Follow-Up Care for Children Prescribed ADHD Medication (ADD), both the Initiation Phase indicator and the Continuation and Maintenance (C&M) Phase indicator had more than an 11 percentage point decline.
    - The Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission rate (PQI-05), Ages 65+ indicator declined by 115.61 member months per 100,000 member months.
    - The Use of Pharmacotherapy for Opioids Use Disorder (OUD-AD), Overall indicator and Prescription for Buprenorphine indicators declined by over 14 percentage points.
- The following CHIP HEDIS MY 2021 measure rates were determined to be areas of opportunities for United since their rates had a greater than 10% decline:
    - The Follow-up care for children prescribed ADHD Medication (ADD), Continuation and Maintenance (C&M) Phase indicator had a decline of 14.43 percentage points.
- The Behavioral health Readmission, Respiratory Illness, and Sickle Cell Disease CAN PIPs demonstrated no quantitative improvement in process or care.
- The Follow Up After Hospitalization CHIP PIP demonstrated no quantitative improvement in process or care.

Recommendations

- Correct the errors identified in the CAN 2021 Health Equity Program Evaluation.
- Correct the objectives regarding hospital admissions in the 2022 CAN Work Plan and update the HEDIS rates in the 2021 CAN and CHIP Work Plans.
- Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement and verification of the rates reported.
- Continue working on provider and member interventions for the performance improvement projects that demonstrated no quantitative improvements in process or care. Determine if there are ways to identify the most impactful interventions and focus efforts on those methods and processes.

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 assessment for utilization management (UM) includes reviews of program descriptions and evaluations, policies, Member Handbooks, Provider Manuals, approval, denial, appeal and case management files, and United's website. The UM Program Descriptions and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services.

The CAN and CHIP 2022 Utilization Management Program Descriptions include the programs' objectives, scope, and structure. Optum is responsible for the management of behavioral health care services. Optum's Behavioral Health Utilization Management Program description includes the scope, program structure, and processes used to make UM decisions.

United's Chief Medical Officer (CMO) is responsible for providing clinical consultation and oversight for all clinical activities. The CAN and CHIP UM Program Descriptions provide a descriptive overview of the CMOs roles and responsibilities, such as clinical supervision, training, case review, oversight of clinical review criteria and implementation, clinical input in coverage determinations, etc. Additionally, the CMO chairs and serves on various committees such as the Provider Advisor Committee, Service Quality Improvement Committee, and Utilization Management Program Committee. The Behavioral Health Regional Medical Director is responsible for the clinical oversight of the Behavioral Health Utilization Management Program. The Pharmacy Director works directly with the CMO, other medical directors, and clinical staff to promote appropriate, cost-effective drug utilization.

Coverage and Authorization of Services

42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228

Non-clinical staff or licensed health professionals may conduct nonclinical initial screening of requests for authorization. United mentioned during onsite discussion that the non-clinical staff responsibilities include conducting intake, case routing, and information requests from providers. Clinical reviews are conducted by actively licensed health care professionals who hold current licensure as a Registered Nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN), or other appropriately licensed health professionals. The licensed health professionals have access to licensed clinical medical directors if a Level II medical necessity review is needed. Review of the denial and approval files reflect decisions are made by appropriate clinical staff, such as nurses or behavioral health specialists.

External and internal clinical review criteria, such as InterQual and Milliman Care Guidelines, are used to determine medical necessity. During the previous EQR (2021), United mentioned the health plan was transitioning from Milliman to InterQual criteria. Policy UCSMM.06.10, Clinical Review Criteria (UCSMM 06.10 Rider 1), received for this review was not updated to reflect the review criteria currently being used by United. This policy still references Milliman as the review criteria being used.

United's CAN and CHIP UM Program Descriptions define the timeline for completing UM decisions. Page 17 of both UM Program Descriptions contained a table regarding notifications for a suspended review. However, the program descriptions do not include an explanation regarding what is considered a suspended review.

Timeframes for completing authorization requests are included in the CAN and CHIP UM Program Descriptions. The UM Program Descriptions indicate that United may request an extension for completing authorization requests. The notice sent to members when United requests an extension is missing information regarding the member's right to file a grievance regarding the extension, as required by *42 CFR § 438.408 (c)*. This requirement is also not specifically mentioned in the CAN and CHIP UM Program Descriptions, policy, the CAN and CHIP Provider Manuals, or in the CAN and CHIP Member Handbooks.

OptumRx is the pharmacy benefit manager 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 PDL and a listing of over the counter (OTC) medicines results in an error message indicating "page not found." During the previous EQR, CCME alerted United to the failed links and recommended this issue be resolved. However, the links were found not working during this EQR.

The sample of CAN and CHIP UM decisions reviewed reflect that physical health and behavioral health utilization determinations are made within required timeframes and

are consistent with Policy UCSMM.06.16, Initial Review Timeframes, and the UM Program Descriptions. Consultation with Medical Directors was utilized appropriately. Denial files reflected attempts to obtain additional clinical information when needed. Final adverse determinations were reviewed by appropriate physicians when requests did not meet medical necessity criteria. Additionally, pharmacy denials were initially rendered by a pharmacist, and subsequently, a health plan medical director provided the final determination. An offer for a peer-to-peer discussion by telephone was communicated appropriately to providers when notified of an adverse determination.

Denial decisions were communicated timely to members and providers, and adverse benefit determination notices included the rationale for the denial and instructions for filing an appeal. However, most of the adverse benefit notices (2022 decisions) found in the sample of CAN and CHIP denial decisions reviewed by CCME, and the adverse benefit determination notice letter templates titled "CAN UHCCP NABD DENIAL," "CAN UHCCP NABD REDUCTION IN SERVICE," "CHP UHCCP INITIAL REVIEW," and "CHP UHCCP TERM RED" incorrectly state the member is required to submit the oral appeal in writing. Updated adverse benefit determination notices were provided by United and include the correct information regarding the submission of an appeal.

Annually, United evaluates and makes necessary updates to the UM Program. This includes evaluating the program structure, scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program. Member and practitioner experience data are also considered in the UM Evaluation.

Appeals

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

United addresses the process for filing and handling member appeals in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. Information is also provided on United's website, the CAN and CHIP Member Handbooks, and in the Provider Manuals. However, the website, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals incorrectly require the member to follow a verbal appeal with a written appeal.

The appeal policy indicates that United may extend the appeal resolution timeframe and the health plan will notify the member in writing of the delay. United provided a copy of the notice sent to members if an extension is needed. This notice, the CAN and CHIP Member Handbooks, Provider Manuals, and United's website do not inform the member of their right to file a grievance if they disagree with this extension as required by the *CAN Contract, Section 6,* the *CHIP Contract, Section 6,* and *42 CFR § 438.408 (c).*

During the previous EQR, CCME noted the "Your Additional Rights" document provided to members when an appeal is upheld did not include the requirement that members have the right to request and receive benefits while an Independent External Review is pending. *Table 38: Previous CHIP Appeals CAP Items* provides an overview of United's response.

Table 38: Previous CHIP Appeals CAP Items

Standard	EQR Comments
V C. Appeals – CHIP	
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: 1.6 Written notice of the appeal resolution;	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 held liable for the cost, according to CHIP Contract Section E (14)(d).*
United's Response: UHC has made the recommended edits to the "Your Additional Rights" letter and is currently in the process of having the letter vetted by the Division. SUPPORTING DOCUMENTATION: • MS_Addl Rights Member CHIP	

During this EQR, CCME found the "Your Additional Rights" document was not corrected. This document does not include the requirement that members have right to request and receive benefits while an Independent External Review is pending, and that the member can be held liable for the cost.

During the previous EQR, CCME noted that United did not consistently follow guidelines in the appeal policy. There were also issues with the language in appeal resolution letters. United addressed these issues with a corrective action plan as noted in the tables that follow. For this review, these deficiencies were corrected.

Table 39: Previous CAN Appeals CAP Item

Standard	EQR Comments
V C. Appeals – CAN	
2. The CCO applies the appeal policies and procedures as formulated.	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 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 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:* *•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."*
United's Response: UHC believes that the appeal files that reflect a breach of appeal review timeframe policy are files in which UHC was awaiting consent of the member to proceed with investigating the appeal. UHC reached out to the Division of Medicaid for clarification on when the Division of Medicaid considers an appeal request complete/received. UHC received the following explanation from Lucretia Causey, Deputy Director of Managed Care, Office of Coordinated Care, Division of Medicaid: "I have read various sections of 42 CFR Subpart F - Grievance and Appeal System and I have not found anything that gives specific level of guidance for this instance. However, based on previous experience with appeals the appeal clock begins once the appeal is received if it is determined additional information is needed the information is requested and the clock stops. The CCO should make reasonable requests to get the necessary information and once the information is received the clock resumes." UHC implemented this exposition in the fourth quarter of 2021 by marking the received date across resolution, standard acknowledgement, and verbal acknowledgment letters to reflect the date the verbal request was received by the call center. Per this exposition, UHC would not be in excess of the appeal review timeframe if a "pause" for additional information occurred as the clock on the timeframe would stop until the requested information/consent was received.	

Standard	EQR Comments
V C. Appeals – CAN	
Regarding the use of "previously upheld" and "previously denied," these isolated occurrences were typographical errors. On 1/11/2022, UHC provided education and coaching to the appeal analysts to correct this issue moving forward. UHC's Follow-up Response: UHC acknowledges the findings regarding received dates and has identified a need to clarify our response based on the overall finding to each scenario identified by CCME. To help clarify and align our response, we will distinguish between the received date discrepancies on the acknowledgement and resolution letters, and the received date for member consent. Received Date Discrepancy on the Acknowledgement and Resolution Letters: Previously, UHC was incorrectly changing the appeal received date from the date a verbal appeal was received from the member to the date written confirmation of the appeal request was received from the member. This was not in line with our policy and believe it is what caused the discrepancy of received dates between acknowledgement and resolution letters. UHC has ceased this practice and provided education to our resolution analysts in Q4 2021. Moving forward, analysts will use the date a member verbally requested an appeal as the received date in our tracking system and on corresponding letters. Additionally, UHC does not believe that USCMM.7.11 requires amendment as the issues were related to staff training and not policy. Received Date for Member Consent: In the instance that a person/representative other than the member submits a request for appeal, verbal or written, UHC cannot validate the request until consent from the member is received. As a result, UHC lists this request as an inquiry until such time as the member's consent is received. UHC then documents the appeal received date as the date member consent was given. This is the equivalent of waiting or pausing the process until the consent is received. This process would be addressed in policy POL2015-021, Rider 1. A draft of the rider is attached to this response.	

Table 40: Previous CHIP Appeals CAP Item

Standard	EQR Comments
V C. Appeals – CHIP	
2. The CCO applies the appeal policies and procedures as formulated.	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

Standard	EQR Comments
V C. Appeals – CHIP	
	denied" when referencing the adverse benefit determination for the original service authorization request. *Corrective Action: 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".*
United's Response: UHC believes that the appeal files that reflect a breach of appeal review timeframe policy are files in which UHC was awaiting consent of the member to proceed with investigating the appeal. UHC reached out to the Division of Medicaid for clarification on when the Division of Medicaid considers an appeal request complete/received. UHC received the following explanation from Lucretia Causey, Deputy Director of Managed Care, Office of Coordinated Care, Division of Medicaid: "I have read various sections of 42 CFR Subpart F - Grievance and Appeal System and I have not found anything that gives specific level of guidance for this instance. However, based on previous experience with appeals the appeal clock begins once the appeal is received if it is determined additional information is needed the information is requested and the clock stops. The CCO should make reasonable requests to get the necessary information and once the information is received the clock resumes." UHC implemented this exposition in the fourth quarter of 2021 by marking the received date across resolution, standard acknowledgement, and verbal acknowledgment letters to reflect the date the verbal request was received by the call center. Per this exposition, UHC would not be in excess of the appeal review timeframe if a "pause" for additional information occurred as the clock on the timeframe would stop until the requested information/consent was received. Regarding the use of "previously upheld" and "previously denied," these isolated occurrences were typographical errors. On 1/11/2022, UHC provided education and coaching to the appeal analysts to correct this issue moving forward. **UHC's Follow-up Response:** UHC acknowledges the findings regarding received dates and has identified a need to clarify our response based on the overall finding to each scenario identified by CCME. To help clarify and align our response, we will distinguish between the received date discrepancies on the acknowledgement and resolution letters, and the received date for member consent. **Received Date Discrepancy on the Acknowledgement and Resolution Letters:** Previously, UHC was incorrectly changing the appeal received date from the date a verbal appeal was received from the member to the date written confirmation of the appeal request was received from the member. This was not in line with our policy and believe it is what caused the discrepancy of received dates between acknowledgement and resolution letters. UHC has ceased this practice and provided education to our resolution analysts in Q4 2021. Moving forward, analysts will use the date a member verbally requested an appeal as the received date in our tracking system and on corresponding letters. Additionally, UHC does not believe that USCMM.7.11 requires amendment as the issues were related to staff training and not policy. **Received Date for Member Consent:** In the instance that a person/representative other than the member submits a request for appeal, verbal or written, UHC cannot validate the request until consent from the	

Standard	EQR Comments
V C. Appeals – CHIP	
member is received. As a result, UHC lists this request as an inquiry until such time as the member's consent is received. UHC then documents the appeal received date as the date member consent was given. This is the equivalent of waiting or pausing the process until the consent is received. This process would be addressed in policy POL2015-021, Rider 1. A draft of the rider is attached to this response.	

For this EQR, a sample of CAN and CHIP appeal files was reviewed. The following issues were identified:

- The rationale in the resolution notices in five CAN files and four CHIP files was not written in language clear and understandable to members. The rationale was confusing regarding the physician who made the appeal decision. For example, the verbiage in one of the notices mentions the reviewer that made the appeal decision specializes in Plastic Surgery. The next paragraph indicates the decisions were made by a physician Board-Certified in Internal Medicine.
- None of the CHIP resolution letters sent when the denials were upheld contained the requirement that members have a right to request and receive benefits while the Independent External Review is pending.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

An overview of United's Care Management Program, including the program's scope, purpose, and goals, is found in the 2022 Care Management Model Program Description and Addenda for CAN and CHIP. Population Health Management is also addressed in the QI Program Descriptions. Optum's Behavioral Health Complex Case Management Program Description provides this information specific to behavioral health care management. Related policies and procedures provide additional detailed information to guide staff in conducting Care Management activities.

United used multiple methods to identify members who may benefit from care management, including self-referrals by members/caregivers, new enrollee health risk screenings, claims and encounter data, hospital admission/discharge data, pharmacy and laboratory data, and other data collected through UM processes. Members may also be referred for care management services by internal health plan departments and programs, information from DOM, and providers. Initial health risk assessments (HRAs) are conducted no later than 30 calendar days from member identification or as quickly as the member's condition requires, as described in Policy NCM 002, Case Management Process, and Policy MS 002 Rider, Case Management Process.

The completed HRA is used in the development of a member-centered care plan, which is developed in collaboration with members, caregivers, and the Interdisciplinary Care Team (ICT), including the PCP, other medical and behavioral health providers, and any external case managers. Care Managers, along with the ICT, ensure care plans address medical, behavioral, and social/environmental needs. Care plans are completed within 30 days of the completion of the HRA and are modified based on member progress. Reassessments are completed at least annually and with significant condition changes.

Review of a sample of CAN and CHIP care management files confirmed United staff conduct care management activities appropriately. Multiple attempts are made to contact members when the initial attempt is unsuccessful.

Policy NCM 002, Case Management Process, addresses requirements and processes for continuity of care when the member disenrolls from the CCO. Policy MS 021, Transitional Care Management, includes processes for coordinating and managing transitions of care across healthcare settings and providers.

As noted in *Figure 7: Utilization Management Findings*, United achieved a "Met" score for 91% of the UM standards for both CAN and CHIP. The plan received a "Partially Met" score of 9% of the UM standards for both CAN and CHIP.

Figure 7: Utilization Management Findings

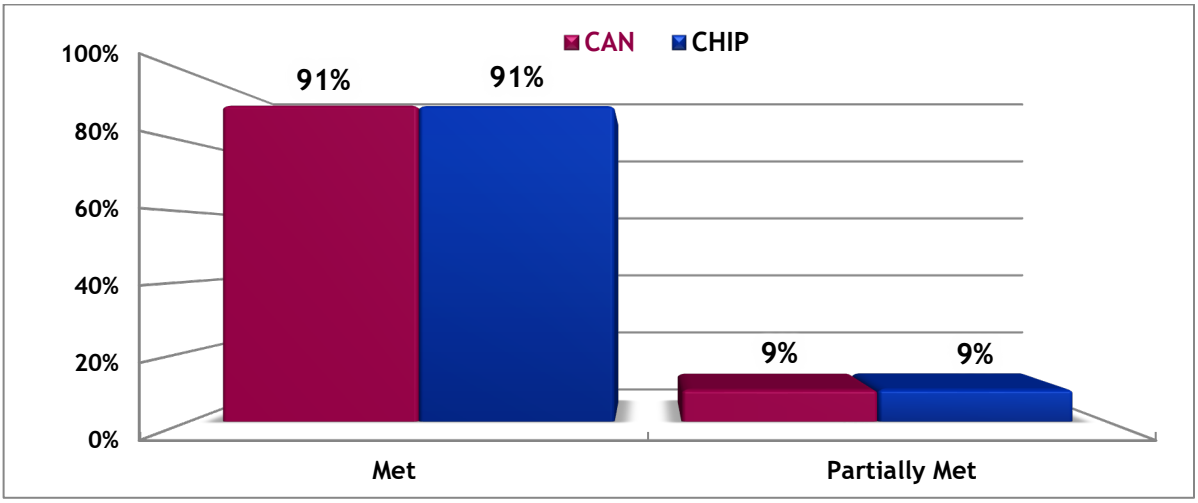


Table 41: Utilization Management

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Utilization Management (UM) Program	The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Partially Met
Pharmacy Requirements	The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Partially Met	Met
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: The procedure for filing an appeal	Partially Met	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Partially Met
	Written notice of the appeal resolution	Met	Partially Met
	The CCO applies the appeal policies and procedures as formulated	Partially Met	Partially Met

Strengths

- Clinical reviews are conducted by health care professionals that hold current licensure.
- UM decisions are completed timely.
- The overall InterQual Interrater Reliability scores were 99.85%, exceeding the goal of 90%.
- Adverse determinations were rendered by appropriate physicians when requests did not meet medical necessity.
- Care management staff conduct appropriate care management activities for members in all risk levels.

Weaknesses

- United's CAN and CHIP UM Program Descriptions do not include an explanation regarding what is considered a suspended review.

- The notice sent to members when United requests an extension for completing a UM decision is missing information about the member's right to file a grievance regarding the extension, as required by *42 CFR § 438.408 (c)*. This requirement is also not specifically mentioned in the CAN and CHIP UM Program Descriptions, policy, the CAN and CHIP Provider Manuals, or in the CAN and CHIP Member Handbooks.
- During the previous EQR (2021), United mentioned the health plan was transitioning from Milliman to InterQual review criteria. Policy UCSMM.06.10, Clinical Review Criteria (UCSMM 06.10 Rider 1), received for this review was not updated to reflect the review criteria currently being used and still references Milliman as the review criteria.
- Links provided in the CAN Member Handbook to access the PDL and a listing of OTC medicines results in an error message indicating "Page Not Found.
- Most of the adverse benefit determination notices (2022 decisions) found in the sample of CAN and CHIP denial decisions and the adverse benefit determination letter templates titled "CAN UHCCP NABD DENIAL," "CAN UHCCP NABD REDUCTION IN SERVICE," "CHP UHCCP INITIAL REVIEW," and "CHP UHCCP TERM RED" incorrectly state the member is required to submit a verbal appeal in writing.
- The website, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals incorrectly require the member to follow a verbal appeal with a written appeal.
- United's notice that is sent to members if an extension is needed for resolving an appeal, the CAN and CHIP Member Handbooks, Provider Manuals, and United's website do not inform the member of their right to file a grievance if they disagree with the extension, as required by the *CAN Contract, Section 6,* the *CHIP Contract, Section 6*, and *42 CFR § CRF 438.408 (c)*.
- The "Your Additional Rights" document (CHIP) provides information and instructions for requesting an Independent External Review. However, it does not include the requirement that members have the right to request and receive benefits while an Independent External Review is pending, and that the member can be held liable for the cost. <u>This was an issue identified during the 2021 EQR and not corrected.</u>
- The following issues were identified in the sample of CAN and CHIP appeal files reviewed for this EQR:
    - The rationale in the resolution notices in five CAN files and four CHIP files was not written in language clear and understandable to members. The rationale was confusing regarding the Physician who made the appeal decision.
    - None of the CHIP resolution letters sent when the denials were upheld contained information that members have a right to request and receive benefits while an Independent External Review is pending.

Corrective Actions

- Update the notice sent to members when United requests an extension for completing UM decisions to include the member's right to file a grievance, as required by *42 CFR §* 438.408 (c). Also, update the CAN and CHIP UM Program Descriptions, policy, the CAN and CHIP Provider Manuals, and the CAN and CHIP Member Handbooks regarding the member's right to file a grievance.
- Ensure links in the CAN Member Handbook to access the Preferred Drug List and the over-the-counter medications list are functional.
- Correct the appeal information found on United's website, the CAN and CHIP Member Handbooks, and the CAN and CHIP Provider Manuals to remove the requirement that a verbal appeal must be followed with a written appeal.
- Include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal in the member notice, CAN and CHIP Member Handbooks, CAN and CHIP Provider Manuals, and United's website.
- Edit the "Your Additional Rights" enclosure for CHIP appeal resolution notifications to include the requirement that members have the right to request and receive benefits and can be held liable for the cost, according to *CHIP Contract, Section E (14)(d)*.
- Continue working on a solution to improve the appeal resolution notifications for CAN and CHIP. Develop a plan to monitor and edit the notifications before sending the notices to members.

Recommendations

- Update the CAN and CHIP UM Program Descriptions to include an explanation of what is considered a suspended review.
- Update Policy UCSMM.06.10, Clinical Review Criteria (UCSMM 06.10 Rider 1), to address the current criteria used for making utilization management decisions.
- Remove the information in the Adverse Benefit Determination Notices requiring a member to submit an oral appeal request in writing.

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 19 current delegation agreements, as shown in *Table 42, 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 42: Delegated Entities and Services

Delegated Entities	Delegated Services
Optum Behavioral Health	Behavioral health case management, utilization management, quality management, network contract management, claims processing
Dental Benefit Providers (SKYGEN)	Dental network services and 3rd party dental administrator
Medical Transportation Management (MTM) (CAN Only)	Non-Emergency Transportation (NET) benefit services broker, provider network, claims processing, quality management, and call center operations
eviCore National	Radiology and cardiology management services, prior authorization handling
MARCH Vision Care	Vision and eye care benefit administration services, vision network contract management, call center operations, claims processing
Optum RX	Pharmacy benefit administration services
Hattiesburg Clinic, PA Ochsner Health Premier Health, Inc. University Physicians, PLLC HubHealth Memorial Hospital at Gulfport River Region Health System Health Choice, LLC North Mississippi Medical Clinics, Inc. (Health Link) UT Medical Group, Inc. HCA Physician Services Optum Physical Health Optum Behavioral Health	Credentialing and recredentialing

Processes for delegation of activities and requirements for oversight of delegates are found in the UnitedHealthcare Credentialing Plan 2021–2023, Policy ID-5714, Pharmacy Delegated Entity Oversight, Optum® Behavioral Health's Delegated Credentialing policy, and the United Behavioral Health Credentialing Plan 2022 – 2023.

Oversight documentation submitted for review confirmed each delegate submits routine reports and United holds routine meetings with the delegates to discuss performance and any needs.

The documentation confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated are subjected to an annual evaluation process.

As noted in the 2022 MS DOM EQRO AUDIT NARRATIVE #18 document submitted after the onsite, "The oversight for all non-credentialing delegated entities occurs through routine established reports to facilitate performance monitoring on a monthly and annual basis. This oversight measures the operational component of these delegated entities and their performance measures. Evaluations pertaining to utilization, clinical, and quality are measured separately."

Issues noted with documentation of delegation oversight include:

- Optum Behavioral Health — routine monitoring was provided as noted on the DVOC Scorecard for 2021-2022, but there was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities.
- Medical Transportation Management (MTM) — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents. However, there was no documentation of a formal annual evaluation of delegated services.
- eviCore National — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for delegated services.
- MARCH Vision Care — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing.
- Optum RX — routine monitoring was provided as noted on the DVOC Scorecard document, but there was no documentation of a formal annual evaluation of delegated services.

As indicated in *Figure 8, Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met" for both CAN and CHIP.

Figure 8: Delegation Findings

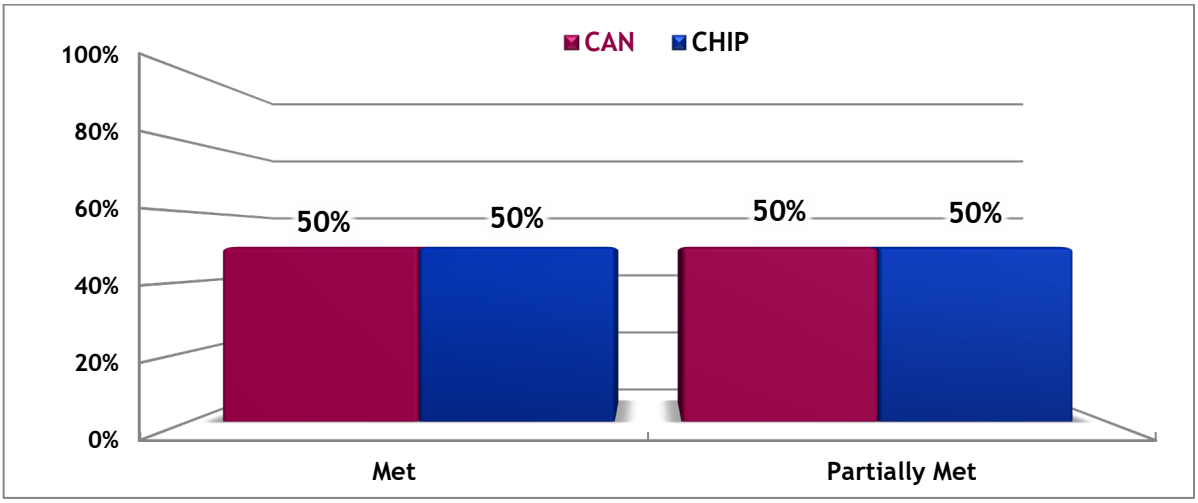


Table 43: Delegation

Section	Standard	CAN 2022 Review	CHIP 2022 Review
Delegation	The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions	Partially Met	Partially Met

Strengths

- Oversight documentation submitted for review confirmed each delegate submits routine reports and United holds routine meetings with the delegates to discuss their performance and any needs.

Weaknesses

- Although formal annual evaluations are conducted for some delegated activities, the submitted oversight documentation reflected that not all delegated activities are subjected to an annual evaluation process. Issues noted with documentation of delegation oversight include:
    - Optum Behavioral Health – routine monitoring was provided in a file labeled "35_MSCAN_DVOC_Scorecard_OBH_MS 2021-2022," but there was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities.
    - Medical Transportation Management (CAN only) – routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents. However,

there was no documentation of a formal annual evaluation of delegated services.

- eviCore National — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for the delegated services.
- MARCH Vision Care—routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing.
- Optum RX—routine monitoring was provided as noted on the DVOC Scorecard document, but there was no documentation of a formal annual evaluation of delegated services.

Corrective Actions

- Ensure each entity delegated to conduct any service or activity that is ultimately a health plan responsibility is subjected to a formal evaluation at least once a year and that the formal annual evaluation includes all activities delegated to the entity. Refer to the *CAN Contract, Section 15 (B)* and the *CHIP Contract, Section 14 (B)*.

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

June 23, 2022

J. Michael Parnell
Chief Executive Officer
UnitedHealthcare Community Plan - Mississippi
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Mr. Parnell:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2022 External Quality Review (EQR) of UnitedHealthcare Community Plan – Mississippi is being initiated. The review will include the MississippiCAN (MSCAN) and Mississippi CHIP (MS CHIP) Programs 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 a virtual 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 virtual onsite visit will be conducted on **September 21, 2022,** and **September 22, 2022,** 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 **July 25, 2022**.

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 2022 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 that 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. If applicable, identify staff members who are assigned to only to MSCAN and staff members who are assigned only 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 Program, 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 2021 and 2022.

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.
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.

12. Minutes of all committee meetings within the past year for 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 2021 and 2022.

18. A complete list of all MSCAN members enrolled in the Care Management program from August 2021 through July 2022. 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. Include 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. Include any training plans for educating providers on MSCAN Program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Include 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 August 2021 through July 2022.

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 (Geo Access) reports and provider appointment and after-hours access monitoring.

27. Preventive health 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 the 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 August 2021 through July 2022.

33. Provide a listing of delegates conducting activities for the MSCAN Program. Please include both local health plan delegates and corporate delegates that conduct activities for Mississippi using the following format:

Date of Initial Delegation	Name of Delegated Entity	Functions Delegated	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management contract, a sample credentialing contract, etc.).

35. Results of the most recent monitoring conducted for all delegated entities. Include a full description of the procedure and/or methodology used, a copy of any tools used, and any reports of activities submitted by the subcontractor to the CCO.

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

Folder	Requested Document	Description
a.	HEDIS® Measurement Year 2021 (MY 2021) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2021 [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 all supplemental data sources that are utilized for all measures included under PMV review. If the CCO 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 for MY 2021.
c.	HEDIS MY 2021 Final Audit Report (FAR) from the Licensed Organization for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.

Folder	Requested Document	Description
d.	NCQA certification for certified measure code used to generate each of the HEDIS measures	• If your CCO contracted directly with NCQA for automated source code review (ASCR) to have measure logic certified, please provide a copy of your NCQA ASCR final measure certification for the HEDIS measures reported. • 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.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each non-HEDIS measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor 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 36 f) a list of the first 100 numerator compliant records that are identified through claims data. CCME will select a random sample from this list of 100 compliant records to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the site review.
g.	List of exclusions and numerator compliant records via medical record review (MRR) for the 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 36 g) a list of the first 100 numerator compliant records and exclusions/valid data errors 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 both the CMS Adult and Child Core Set non-HEDIS measures which must be populated by the CCO with final data (denominators, numerators, and rates) for each measure for the MSCAN population.

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 electronic copies of the following files for the MSCAN Program:
    a. Credentialing files (<u>including provider office site visits as appropriate</u>) for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and

vi. One file for each additional type of facility in the network.

b. Recredentialing files for:
    i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
    ii. Two OB/GYNs;
    iii. Two specialists;
    iv. Two behavioral health providers
    v. Two network hospitals; and
    vi. 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 August 2021 through July 2022. 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 August 2021 through July 2022, 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 2022 for Mississippi CHIP

Materials Requested for Desk Review

1. Copies of all current policies and procedures for the Mississippi CHIP (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. If applicable, identify staff members who are assigned only to MSCAN and staff members who are assigned only 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 CHIP members.

7. A copy of the current Fraud, Waste & Abuse/Compliance Plan for the CHIP Program, 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 2021 and 2022.

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.).

d. For all projects with non-HEDIS measures:
    - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
e. For projects with measures derived from medical record abstraction:
    - full documentation of the abstraction process and tool used during abstraction.
f. For projects with measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP.

12. Minutes of all committee meetings within the past year for 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 2021 and 2022 .

18. A complete list of all CHIP members enrolled in the Care Management program from August 2021 through July 2022. 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. Include 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. Include any training plans for educating providers on the CHIP Program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Include 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 August 2021 through July 2022.

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 (Geo Access) reports and provider appointment and after-hours access monitoring.

27. Preventive health 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 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.

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    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 August 2021 through July 2022.

33. Provide a listing of delegates conducting activities for the CHIP Program. Please include both local health plan delegates and corporate delegates that conduct activities for Mississippi using the following format:

Date of Initial Delegation	Name of Delegated Entity	Functions Delegated	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management contract, a sample credentialing contract, etc.).

35. Results of the most recent monitoring conducted for all delegated entities. Include a full description of the procedure and/or methodology used, a copy of any tools used, and any reports of activities submitted by the subcontractor to the CCO.

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

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b.	IDSS (CSV and Excel workbooks) for MS CHIP	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MS CHIP for MY 2021.
c.	HEDIS MY 2021 Final Audit Report from the Licensed Organization for MS CHIP	Please submit the MS CHIP Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.

Folder	Requested Document	Description
d.	NCQA certification for certified measure code used to generate each of the HEDIS measures	• If your CCO contracted directly with NCQA for automated source code review (ASCR) to have measure logic certified, please provide a copy of your NCQA ASCR final measure certification for the HEDIS measures reported. • 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.
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 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 36 f) a list of the first 100 numerator compliant records that are identified through claims data. CCME will select a random sample from this list of 100 compliant records to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the site review.
g.	List of exclusions and numerator compliant records via medical record review (MRR) for the 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 to upload (via CCME portal, folder 36.g) a list of the first 100 numerator compliant records and exclusions/valid data errors 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 both the CMS Adult and Child Core Set non-HEDIS measures which must be populated by the CCO with final data (denominators, numerators, and rates) for each measure for the MS CHIP population.

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2. HEDIS Certified Measures [SM] is a service mark of the NCQA.

37. 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 behavioral health providers
        v. Two network hospitals; and
        vi. 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);
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    iii. Two specialists;
    iv. Two behavioral health providers
    v. Two network hospitals; and
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c. Twenty-five medical necessity denial files for the CHIP program made in the months of August 2021 through July 2022. 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 August 2021 through July 2022, 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 2022

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. **CHIP** Policy MS 002 Rider, Case Management Process
    b. Policy DOV-01, Delegated Vendor Oversight Strategy

3. Copy of the quarterly EPSDT and Well-Baby, Well-Child referral tracking report.

4. Copy of Provider Newsletters for Fall and Winter 2021 and all newsletters for 2022.

5. Copy of the Healthy First Steps™ (HFS) Program Description.

6. Evidence of annual evaluation for all delegates for all delegated functions.

Materials should be uploaded to the secure CCME EQR File Transfer site at https://eqro.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	2021
Review Performed	2022

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 2021
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 2021
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 2021

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 2021
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 2021

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 2021
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 2021
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 2021
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 2021
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 2021

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 are in accordance with standards. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2021
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 is reported and bias in generalizability is documented. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2021

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 is documented. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2021
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 2021
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 2021

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 2021
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* United Healthcare Provider Satisfaction Survey Results report- December 2021
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 2021

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:* United Healthcare Provider Satisfaction Survey Results report-December 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Of the 2730 sample providers, only 33 responded, creating a response rate of 1.3%. This is a decrease from last year's rate of 1.9%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. *Documentation:* United Healthcare Provider Satisfaction Survey Results report-December 2021 ***Recommendation**: Although this is in line with the national response rate range, continued efforts should be made to gather a better representation of the providers. Additional reminders may be appropriate, as well as other interventions that incentivize providers to respond to the survey.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* United Healthcare Provider Satisfaction Survey Results report-December 2021
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 2021

CCME EQR Survey Validation Worksheet

Plan Name	**United Healthcare CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2021
Review Performed	2022

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:* 2022 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:* 2022 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:* 2022 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 has been tested for validity. *Documentation:* 2022 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 has been tested for reliability. *Documentation:* 2022 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:* 2022 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:* 2022 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:* 2022 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:* 2022 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:* 2022 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 are in accordance with standards. *Documentation:* 2022 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 is reported and bias in generalizability is documented. *Documentation:* 2022 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 is documented. *Documentation:* 2022 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:* 2022 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:* 2022 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:* 2022 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:* 2022 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:* 2022 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 are in place to address response issues. *Documentation:* 2022 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 generalizability of the survey results is difficult to discern due to low response rates. The response rate was 14.4% with 231 out of 1603 completed. This is a slight decrease from last year's response rate of 14.7%. *Documentation:* 2022 SPH Analytics Research Final CAHPS 5.1H Report Adult Medicaid **Recommendation:** The oversampling rate of 20% is still not impacting the response rate. Additional reminders for awareness and member Incentives may need to be considered.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* 2022 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:* 2022 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	2021
Review Performed	2022

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:* 2022 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:* 2022 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:* 2022 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 has been tested for validity. *Documentation:* 2022 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 has been tested for reliability. *Documentation:* 2022 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:* 2022 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:* 2022 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:* 2022 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:* 2022 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:* 2022 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 are in accordance with standards. *Documentation:* 2022 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 is reported and bias in generalizability is documented. *Documentation:* 2022 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 is documented. *Documentation:* 2022 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:* 2022 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H

Survey Element		Element Met / Not Met	Comments and Documentation
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:* 2022 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:* 2022 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:* 2022 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:* 2022 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 are in place to address response issues. *Documentation:* 2022 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. The response rate was 10.3% with 203 out of 1968 completed. This is a slight decline from last year's rate of 10.8%. *Documentation:* 2022 SPH Analytics Research Final Report Child CCC Medicaid CAHPS 5.1H ***Recommendation:*** *The oversampling rate of 20% is still not impacting the response rate. Additional reminders for awareness and member Incentives may need to be considered.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* 2022 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:* 2022 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	2021
Review Performed	2022

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 MY2021 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 MY2021 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 MY2021 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 has been tested for validity. *Documentation:* SPH Analytics MY2021 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 has been tested for reliability. *Documentation:* SPH Analytics MY2021 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 MY2021 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 MY2021 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 MY2021 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 MY2021 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 MY2021 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 are in accordance with standards. *Documentation:* SPH Analytics MY2021 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 is reported and bias in generalizability is documented. *Documentation:* SPH Analytics MY2021 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 is documented. *Documentation:* SPH Analytics MY2021 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 MY2021 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 MY2021 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 MY2021 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 MY2021 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 MY2021 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 MY2021 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 1,962 with 255 completed surveys for a response rate of 13.0%. This is a decline from the previous rate of 15.9%. The response rates are below the NCQA target rate is 40%, but higher than the average national response rate of 10.2%. *Documentation:* SPH Analytics MY2021 CAHPS 5.1H Medicaid Child with CCC Report ***Recommendation:*** *Identify additional methods that might be appropriate to improve response rates, including incentives and various modes of reminders (paper, email, text, in person).*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics MY2021 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 MY2021 CAHPS 5.1H Medicaid Child with CCC Report

CCME EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**COLORECTAL CANCER SCREENING (COL-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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 N/A**

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:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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.		

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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 N/A**

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

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:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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
NOT APPLICABLE

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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: AGE 18 AND OLDER (CDF-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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
NOT APPLICABLE

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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 N/A**

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:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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
NOT APPLICABLE

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:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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
NOT APPLICABLE

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:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
ADULT CORE SET MEASURES

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 N/A**

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:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2022**
Review Performed:	**9/21/2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CHILD CORE SET MEASURES

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:	**2021**
Review Performed:	**2022**

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 has 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 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**	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.
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.

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 are 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 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 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 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**	Report includes 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)**	**NOT MET**	The inpatient readmissions PIP showed no improvement in the latest rate from 17.7% in 2020 to 21.4% in 2021 with a goal of 14.2%. The case management enrollment indicator had a decline from 38% in 2020 to 28% in 2021. Individual facility rates were reported as well for each of the five facilities *Recommendation: Evaluate the impact of Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from Inpatient level of care to determine if these additional interventions improve readmissions.* *Determine if additional steps should be taken to ensure readmitters are enrolled in high-risk case management.*

Component / Standard (Total Points)	Score	Comments
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 found.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are 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	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 CAN**
Name of PIP:	**RESPIRATORY ILLNESS**
Reporting Year:	**2021**
Review Performed:	**2022**

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 are clearly defined. Using HEDIS measures: Pharmacotherapy of COPD Exacerbation and Asthma Medication Ratio.
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.
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.

Component / Standard (Total Points)	Score	Comments
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.
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 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 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**	Report includes 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 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)**	**NOT MET**	The bronchodilators baseline rate was 75.13%% which improved to 76.36%% although it still below the DOM goal rate of 77.38%. The corticosteroids baseline rate was 54.02% at remeasurement 1 and declined to 49.89% for 2021. It is below the goal rate of 55.62% for DOM. The AMR rate for 2021 was 73.36% which is a decline from the Remeasurement 1 rate of 74.08%. The goal rate is listed as 76.28%. ***Recommendation**: Assess the impact of patient care opportunity reports, provider education, Community Plan Incentive program using interim rate monitoring.*

Component / Standard (Total Points)	Score	Comments
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**	Improvement occurred for only one of three measured indicators.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical values are reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to determine.

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:	**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 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**	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 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.

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 are 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 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)**	**NOT MET**	The sickle cell disease PIP measures the rate of ER super users for members diagnosed with sickle cell anemia. The rate was 26.43% in 2020 and increased to 28.50% in 2021. The goal is to reduce it to 25.64%. *Recommendation: Continue weekly interdisciplinary rounds for CM, Sickle Cell Disease Program and monitor interim rates for monitoring the success of these interventions.*
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**	Improvement did not occur.
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	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 CAN**
Name of PIP:	**IMPROVING PREGNANCY OUTCOMES (CLINICAL)**
Reporting Year:	**2021**
Review Performed:	**2022**

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 is 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 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**	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**	Indicators measure 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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 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 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 are 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 includes 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 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 Improved Pregnancy outcomes has a DOM goal rate of 93.62% for the HEDIS Timeliness of Prenatal care rate. The baseline rate was 92.21% and the remeasurement #1 rate was 91.48%. The most recent remeasurement improved to 93.67% which is above the DOM goal rate. This rate reflects an improvement in the visit rate.
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 interventions of education and programs for members.
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	1	1
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:	**REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	**2021**
Review Performed:	**2022**

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 is 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 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)**	**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 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 measure 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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 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 and interim rates are monitored.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are 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 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**	Report includes 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**	BMI percentile documentation improved from 64.23% in 2020 to 70.07% in 2021. The goal rate is 76.64%. Counseling on nutrition improved slightly from 52.07% to 53.04% with a goal of 70.11%. Counseling for physical activity improved slightly from 49.15% to 49.88% with a goal of 66.18%.
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 was likely due to interventions for HEDIS measures.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing is 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	NA	5
4.2	NA	10
4.3	NA	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	1
9.2	1	1
9.3	1	1
9.4	NA	NA

Project Score	100
Project Possible Score	100
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:	**2021**
Review Performed:	**2022**

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 is below the target rate of 66.6% for 30-day 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 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 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 measure 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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 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 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 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**	Report includes 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)**	**NOT MET**	The follow-up after hospitalization PIP report showed that the 30-day follow up rate remained about the same over the last 2 measurement periods, with a rate of 65.9% in 2020 and 65.8% in 2021. The 7-day follow up rate declined from 39.31% to 35.11% in 2021. The goal rate for United is 38.95%. *Recommendation: Determine if there are ways to identify the most impactful interventions and if those are identified, focus efforts on those methods and processes.*
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 in 7 or 30-day rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing is documented.

Component / Standard (Total Points)	Score	Comments
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:	**2021**
Review Performed:	**2022**

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**	Preventive visits were below target goal for United CHIP.
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**	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**	Measure is administrative.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 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 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 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**	Report includes 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 WCV (adolescence well care visits) PIP showed the rate from 12 to 17 year-olds improved from 36.37% to 40.16% - this is above the goal rate of 37.46%. The rate for 18-21 year-olds also improved from 19.64% to 25.34% which is above the goal rate of 24.63%.
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**	The improvement appears to be a result of the interventions to improved preventive care.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Chi-square tests 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	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:	**2021**
Review Performed:	**2022**

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 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)**	**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 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 measure 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 are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are 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 are 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 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 and interim rates are monitored.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are 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 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**	Report includes 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)**	**NOT MET**	Regarding getting needed care – easy to see a specialist CAHPS child survey item. The rate improved from 82.3% to 90.3% which is above the goal of 79.8%. ***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 is 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.*

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**UnitedHealthcare MS CAN**
Review Performed:	2022

I. ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, addresses United's guidelines for developing, reviewing, revising, and implementing policies, procedures, and standard operating procedures. Department Managers are responsible for adopting national policies. Riders or addenda are developed and added to the national policy when needed to address state-specific requirements. Standard Operating Procedures are created, when possible, to outline processes and provide detailed instructions. New and revised policies are reviewed by the Policy and Review Steering Committee before being presented to other committees such as the Health Quality Utilization Management (SQUM) Committee and Service Quality Improvement Subcommittee (SQIS). All policies are ultimately

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						presented to the Quality Management Committee (QMC) for final review and approval. Policies are reviewed annually and are accessible to all employees via SharePoint and a shared file folder. Staff are informed of new and revised policies during routine team meetings and as needed during ad hoc meetings and/or email.
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					Michael Parnell is United's Chief Executive Officer.
1.2 *Chief Operating Officer;	X					United's Chief Operating Officer is Latrina McClenton.
1.3 Chief Financial Officer;	X					Chandler Ewing is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Glennis Johnson is United's Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Jason Bell is the Claims Administrator.
1.6 *Provider Services Manager;	X					Rhona Waldrep, Provider Services Director, oversees the Provider Relations, Provider Services, and Network Management Teams.
1.6.1 *Provider credentialing and education;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Member Services Manager;	X					Randy Knoll is the Member Outreach Director and oversees the Member Services and Marketing Teams. Dawn Jewell is the Member Services Manager.
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					Alicia Fields is the Delegated Services & Appeals Manager. Jennie Jenkins is the Complaint/Grievance/Appeal Coordinator.
1.9 Utilization Management Coordinator;	X					Kim Bollman, Health Services Director, oversees the Prior Authorization, Utilization Management, and Case Management Teams. Kristi Plotner is the Behavioral Health Director and Heather Odem is the Pharmacy Director. Jennifer Brumfield, Population Health Director, oversees Housing & Employment Navigators.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson, Quality Management Director, oversees the Quality Management, Accreditation, and Wellness Teams.
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Dr. Dana Carbo-Bryant is the Chief Medical Officer. Medical Directors include Dr. Yolanda Wilson, Dr. Kia Tillis, and Dr. Jack Sariego.
1.13 *Compliance Officer.	X					Eric Sandkuhl is the Interim Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO processes provider claims in an accurate and timely fashion.	X					United's percent paid averages for 30 and 90 days exceed Mississippi's claims payment 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					Information Systems Capability Assessment (ISCA) documentation and onsite discussion confirmed United collects enrollment and member demographics using HIPAA compliant transaction formats and code sets. The data is processed and stored by United's encounter data submission and reporting system. The system tests the data for accuracy, completeness, logic, and consistency. 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					ISCA documentation and onsite discussion confirmed United appropriate capabilities to perform required data collection and reporting functions.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United has business continuity and disaster recovery plans in place to mitigate potential incidents and restore service in the event of an incident. These 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. The business continuity plans are updated twice a year.
I D. Compliance/Program Integrity						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2021-2022 (FWA Plan) describes processes to prevent, detect, correct, and report instances of fraud, waste, and abuse (FWA) "to protect the ethical and fiscal integrity of its health care plans and programs." Information specific to Mississippi is found in the UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2021-2022 (FWA Plan Addendum).
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The UnitedHealth Group Code of Conduct (Code of Conduct) provides employees with information about the company's principles of ethics and integrity, and consequences of violating the Code of Conduct. It includes information about whom employees may contact for questions or concerns, and contact information for reporting instances of compliance, ethics, safety, and FWA violations. Each section of the Code of Conduct includes a reference to related policies that provide additional information.
2.2 Identification of the Compliance Officer;						The FWA Plan Addendum includes information about the CCO's Compliance Officer and states the Compliance Officer serves as the primary point of contact for the State.
2.3 Information about the Compliance Committee;						The corporate FWA Plan includes information about the corporate UHC Compliance Program Integrity Oversight Committee. However, the FWA Plan Addendum (for Mississippi) does not include information about the local health plan

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Compliance Oversight Committee. Information about the local committee was noted in the QI Program Description. *Recommendation: Revise the Mississippi FWA Plan Addendum to include information about the health plan's Compliance Oversight Committee.*
2.4 Compliance training and education;						Policy ID-6069, UnitedHealthcare Compliance Training & Education Policy, addresses compliance training requirements. Compliance training is required at the time of employment and annually for all employees and applicable delegated vendors/subcontractors. Compliance training topics include the Code of Conduct, Privacy and Security Awareness, Intellectual Property, Conflicts of Interest, Anti-Corruption, Harassment Prevention, and FWA Prevention. Additional role-focused or specialized compliance training may be required based on areas of business functions/operations or on individual job function. The company uses an online Learning Management System and specialized interactive training may be conducted by web-based tools, live or videotaped presentations, written materials, or a combination of these to provide training. Compliance training records are maintained.
2.5 Lines of communication;						Lines of communication include designated web portals, call centers, databases, and anonymous hotlines, tip lines and portals. Specific

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						communication channels include, but are not limited to: •UnitedHealth Group Compliance & Ethics Help Center •UnitedHealthcare Fraud Tip Line •UnitedHealthcare External Fraud Hotline •UnitedHealthOne Fraud Tip Line •Member Call Center(s) •Provider Call Center(s) •Optum Fraud, Waste and Abuse Hotline
2.6 Enforcement and accessibility;						The Code of Conduct informs employees that violations of the Code of Conduct, policies, laws, regulations, and contractual obligations may have legal and regulatory consequences. It states that all violations are taken seriously and may 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 FWA Plan describes routine monitoring and auditing activities, which include pre- and post-payment data analytics and data mining; analysis of aberrant billing patterns, payment errors, and industry trends; review of provider quality care complaints and provider audits; exclusion and sanction monitoring and verification; monitoring and oversight of delegated entities; and FWA Program compliance and performance audits.
2.8 Response to offenses and corrective action;						Mechanisms for prompt response to detected offenses and corrective action include provider notification, education and recovery efforts, termination from the network; and referral to law enforcement, regulatory, and administrative

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						agencies pursuant to state and federal laws and regulatory requirements When investigative activity indicates credible evidence of fraudulent, wasteful, and/or abusive activity, retrospective affirmative recovery actions against paid claims are taken in in accordance with applicable contract, regulatory and legal requirements.
2.9 Exclusion status monitoring.						Policy ID-5881, New Hire and Periodic Employee Sanction Review, and Policy PDM-1, Provider Disclosures/National Disclosure Program, describe processes followed for exclusion status monitoring for employees, contractors, and suppliers. United conducts initial sanctions checks and background checks on new employees prior to the first day of work. Monthly checks are conducted of the CMS Precluded Provider List, OIG/GSA List of Excluded Individuals/Entitles (LEIE), General Services Administration's System for Award Management (SAM), Social Security Administration's Death Master File, National Plan & Provider Enumeration System (NPPES) Registry, etc., as applicable. Optum's Provider Sanctions Monitoring Policy and Procedure states the Optum Sanctions team conducts monthly review of sanction sources for changes or updates to sanction records monthly. Sanction sources monitored are specified in the policy.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Oversight Committee assists the Compliance Officer and CEO in developing and implementing the Compliance Program. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						committee is chaired by the Compliance Officer and CEO and meets quarterly and as needed. Committee membership includes the Compliance Officer, CEO, and senior executive leaders. A minimum of 51% of the committee membership constitutes a quorum. Members may designate surrogate attendees with voting privileges. The Community and State Health Plan Compliance Oversight Committee Charter defines the purpose and primary objective of the committee, committee composition and membership, roles and responsibilities, and structure and operation. The charter was most recently adopted on May 24, 2022.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes for payment suspensions, recoupments, etc. are included in the FWA Plan.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					The 2021-2022 UnitedHealthcare Community and State Pharmacy Program Description (Pharmacy Program Description), provides information about the High Prescription Utilization Program (Lock-In Program) that has been implemented to minimize drug abuse and diversion by identifying and managing members who have a potential for misuse or abuse of certain drugs. The information includes methods of member identification for inclusion in the program,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members who would be excluded, processes for member notification of inclusion and the contents of the notification, member monitoring processes. Of note, the documentation indicates United has noted an improvement in utilization during member lock-in that continues after the lock-in period has expired. Additional information about the program is included in Policy ID-31884, C&S High Prescription Utilization Program. Brief information is also included in the Care Provider Manual and Member Handbook.
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					United's processes for maintaining confidentiality of protected information are documented throughout the materials reviewed. Employees are trained on principles and expectations for maintaining the confidentiality of applicable information. External committee members sign confidentiality agreements.

II. PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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 provider credentialing and recredentialing are found in the UnitedHealthcare Credentialing Plan 2021-2023 (Credentialing Plan). Additional state-specific requirements are listed in the State and Federal Regulatory Addendum Attachment E to the UnitedHealthcare Credentialing Plan (Credentialing Plan Addendum). The Credentialing Plan, Section 4.2 (B) (6) addresses conducting queries for sanctions and exclusions and lists the queries conducted. The Credentialing Plan did not address querying the Social Security Administration's Death Master File (SSDMF). Onsite discussion confirmed the SSDMF is checked by another department within the organization prior to completing initial credentialing. *Recommendation: Update the Credentialing Plan to include information about querying the SSDMF at initial credentialing.*
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 Board of Directors delegates overall responsibility for credentialing and recredentialing to the National Credentialing Committee (NCC). The health plan's Medical Director administers the Credentialing Plan and credentialing activities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						United's Provider Advisory Committee (PAC) reviews and approves credentialing determinations made by the NCC. The Medical Director can approve initial credentialing and recredentialing files that meet all required criteria. The PAC is chaired by the Chief Medical Officer and membership includes practicing network providers with specialties of OB GYN, Internal Medicine, Psychiatry, Pediatrics, and Family Medicine. Additional voting members include a Dentist and a Nurse Practitioner specializing in Internal Medicine. Voting is restricted to network providers, and the Chair votes only in case of a tie vote. The PAC meets at least four times each year and reports to the QMC. Review of PAC meeting minutes confirmed the quorum was established for each meeting and attendance was satisfactory.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					A sample of initial credentialing files was reviewed for CAN. All files were compliant with initial credentialing requirements.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					A sample of recredentialing files was reviewed for CAN. All files were compliant with recredentialing requirements.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
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					

Standard	Score					Comments
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4.3 Provider office site reassessment, when applicable.	X					None of the provider files required office site reassessment.
4.4 Review of practitioner profiling activities.	X					
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					As stated in the Credentialing Plan, Regional Peer Review Committees, comprised of practitioners, Medical Directors, and clinical staff, conduct peer reviews and investigate Quality of Care (QOC) complaints and referrals. This committee makes recommendations to the National Peer Review and Credentialing Policy Committee (NPRCPC) regarding any action that should be taken related to complaints or referrals. The NPRCPC has ultimate decision-making authority on all disciplinary actions that affect restriction, suspension, or termination of participation status of physicians or health care professionals. When provider participation is terminated, the provider receives written notification of the reason(s) and any appeal process that is available.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					A sample of initial credentialing and recredentialing files for organizational providers was reviewed for CAN. All files were compliant with credentialing and recredentialing requirements.
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)*						
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.						Geographic access standards for CAN providers are documented in Policy PS3, Geographic Access Standards, and are compliant with contractual requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As noted in Policy PS10, PCP Panel Notification, United notifies PCPs of assigned enrollees and other panel changes within five business days of receipt of the Member Listing Report from DOM. Participating providers may access panel information on the secure provider portal. Within five days of receiving the Member Listing Report from DOM, United identifies PCPs with panel changes and notifies the providers via a mailed postcard.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, indicates all providers, including non-participating providers, may call the toll-free telephone number listed on the member ID card to verify member enrollment. Participating providers may access member enrollment information via the secure, password-protected online provider portal.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Policy PS3, Geographic Access Standards, states United performs quarterly geographic access studies to evaluate network adequacy. The Quarterly Report on Accessibility of MississippiCAN Members dated 7/11/22 indicates 99.2% of members have appropriate access to adult PCPs and 98.5% of members have appropriate access to pediatric PCPs.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					The Quarterly Report on Accessibility of MississippiCAN Members, dated 7/11/22, indicates goals were met for most specialties; however, there are a few gaps identified, including pediatric specialists and other specialties. Onsite discussion included United's ongoing efforts to mitigate the identified gaps.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Policy PS3, Geographic Access Standards, states United performs quarterly geographic access studies to evaluate network adequacy. If areas of noncompliance are discovered, resulting actions will include conducting further analysis to specify the geographic area and impacted membership, conducting research to identify opportunities for network development to engage identified provider targets and close gaps, and working with affected members to ensure necessary services are accessible and to maintain continuity of care.
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					As noted in the 2021 Quality Improvement Program Description, United's Multicultural Health Care Program (MHCP) is in place to reduce health disparity and improve culturally and linguistically appropriate services. United evaluates the effectiveness of services provided to members by: •Assessing member and practitioner race, ethnicity, and languages at least every three years. •Assessing for language and cultural gaps in the network every 3 years.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Monitoring member satisfaction, including experience with physicians and other providers.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy PS2, Access Standards – Appointment Availability Requirements, defines appointment availability requirements for network providers. The appointment availability standards defined in the policy comply with contractual requirements. United has contracted with DialAmerica to conduct quarterly assessments of PCPs, OBGYNs, and behavioral health providers to assess compliance with appointment access standards. Quarterly and annual assessments are conducted to assess the level of compliance for high-volume specialty providers. Failure to meet access requirements results in direct outreach to the provider. The Service Quality Improvement Subcommittee monitors, tracks, and trends the results and uses them to identify opportunities for improvement. Review of the MSCAN_2022 2nd Quarter Appointment Availability Analysis document reflected low success rates for contacting providers. Onsite discussion revealed United continues efforts to determine barriers to successful contacts and implement interventions to improve the success rates.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy PS14, Provider Orientation Plan, describes United's processes for new provider. A Provider Advocate is assigned to each new provider and contacts the provider within the first 30 days of the contract effective date. During the welcome call, the advocate answers any immediate questions and schedules an orientation session. New provider orientation sessions are conducted according to the UnitedHealthcare Provider Orientation Plan, as documented in SOP-PS14, Standard Operating Procedure – Provider Orientation Plan Summary & Checklist.
2. Initial provider education includes:						Per the CAN Provider Manual, the Provider Services Call Center hours of operation are Monday – Friday, 7 a.m. to 5 p.m. However, during onsite discussion, United staff confirmed the Provider Services Call Center operates from 7:30 a.m. to 5:30 p.m. to comply with the *CAN Contract, Section 7 (H) (1)*. *Recommendation: Revise the CAN Provider Manual to include the correct hours of operation for the Provider Services Call Center.*
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					The CAN Care Provider Manual includes information about claims and billing processes,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						including claims format, claim processing time, submission rules, electronic submission, etc.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;		X				A listing of covered and excluded benefits is found in the CAN Provider Manual. Issues noted with documentation of benefits included: •The benefits grid in the CAN Provider Manual, page 11, indicates well child care is not covered. However, information about well child care is found elsewhere in CAN Provider Manual. This is an issue identified during the previous 2021 EQR. •The behavioral health benefits grid in the CAN Provider Manual, page 12, lists peer support services but does not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. This is an issue that was identified during the previous 2021 EQR. *Corrective Action: Revise the CAN Care Provider Manual to correct the issues identified with documentation of benefits for well child care and peer support services.*
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					The CAN Care Provider Manual correctly documents appointment access standards.
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					Page 56 of the CAN Care Provider Manual lists services included under EPSDT. Page 57 states it is a provider responsibility to contact members who are non-compliant with EPSDT services and to report repeated non-compliance to the DOM and to United.
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The CAN Care Provider Manual includes information about covered medications, prior authorization processes, prescription limitations, the Preferred Drug List (PDL), and the availability of a 3-day emergency supply of medication.
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					Information about the Quality Improvement Program and expectations for provider participation in Quality Management are addressed in the CAN Care Provider Manual.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				The printed CAN Provider Directory and the online "Doctor Lookup" tool include all required elements. The *CAN Contract, Section 6 (E)* states, "The Contractor must also utilize a web-based provider directory, which must be updated within 5 business days upon changes to the provider network." However, Policy NQM-052, Web-Based Directory Usability Testing, page 2, item D, states, "The Web-based practitioner and hospital directory information is updated within 30 calendar days of when new information is received." Onsite discussion confirmed updates are made to the online Provider Directory within 24 hours. *Corrective Action: Revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.*
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					The Provider website (www.uhcprovider.com) includes news and updates for providers, including policy updates, trainings, etc. In addition, various educational sessions and meetings are held throughout the state and ongoing provider education is provided through

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the website, provider office visits, newsletters, bulletins, and Provider Manual updates.
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					A policy titled, "Review of Clinical and Preventive Guidelines" states evidence-based clinical and preventive guidelines from nationally recognized sources are used to guide quality and health management programs. The Medical Technology Assessment Committee (MTAC) reviews the guidelines and reports the guidelines to the National Medical Care Management Committee (NMCMC) for oversight.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					The preventive guidelines are available to clinical personnel, network practitioners, and members on the website. Providers are notified annually by mail, fax, or e-mail of the availability of the guidelines on the website. The CAN Care Provider Manual includes information about the PHGs and links to access the information on the website.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
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					A policy titled, "Review of Clinical and Preventive Guidelines" states evidence-based clinical and preventive guidelines from nationally recognized sources are used to guide quality and health management programs. The Medical Technology Assessment Committee (MTAC) reviews the guidelines and reports the guidelines to the National Medical Care Management Committee (NMCMC) for oversight.
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					Clinical guidelines are available to clinical personnel, network practitioners, and members on the website. Providers are notified annually by mail, fax, or e-mail of the availability of the guidelines on the website. The CAN Care Provider Manual includes information about the clinical guidelines and links to access the information on the website.
II F. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					As noted in the 2021 Quality Improvement Program Description, United conducts Medical Record Review (MRR) of high volume providers for compliance with documentation standards. Trained reviewers collect data using Medical Record Review tools. Results and areas for improvement are disseminated to physicians as needed, with overall results and opportunities for improvement reported to the Provider Advisory Committee and Quality Management Committee. United requires providers to maintain member medical records in compliance with documentation guidelines and appliable regulations. Medical record documentation requirements are included in the CAN Care Provider Manual. The performance goal is 85%. Practitioners are notified of failing scores, failure to comply with record request, and identified deficiencies. Education and support are provided, and a follow-up review is conducted. If the follow-up review is not successfully passed, the Medical Director and/or quality committee reviews the documentation and determines an appropriate corrective action. Re-audits are conducted the in the next year after. Final MRR results are presented to health plan committee(s). This process is documented in Policy NQM-025, Ambulatory Medical Record Review Process.
2. The CCO monitors compliance with medical record documentation standards through periodic medical	X					Detailed results of the 2021 MRR were included in the Quality Improvement & Population Health

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
record audits and addresses any deficiencies with providers.						Management Annual Evaluation Report for 2021. For the 2021 Primary Care Physician audit, all audited providers achieved passing scores. Re-survey was conducted for three providers who did not pass the 2020 audit, and all passed. For the EPSDT/Well Child/Baby Audit, nine of 19 providers passed, three will be re-audited in 2022, and seven were cancelled due to having copy service. Re-survey was conducted for two providers who did not pass the previous audit. One of the two did not pass, and education was provided.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					A 50 item Likert scale self-report survey was administered by Escalent, an independent research company, on behalf of United. Of the 2730 sample providers, only 33 responded, creating a response rate of 1.3%. This is a decrease from last year's rate of 1.9%. Although similar to the national rate, this is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution. The 2021 results indicate that overall satisfaction has decreased directionally since 2020, with more providers rating United unfavorably. High performing areas include Specialty Support, Care Coordination, Medical Records, Communication with Practice, and Credentialing and Contracting.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Opportunities for improvement include the areas of Member Support, Prior Authorization, Appeals, Reimbursement, Customer Service, and First Call Resolution. *Recommendation: Continued efforts should be made to gather a better representation of the providers. Additional reminders may be appropriate, as well as other interventions that incentivize providers to respond to the survey.*
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 in June 2022 and to the Provider Advisory Committee in May 2022.

III. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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, lists member rights and responsibilities. Member rights are included in the Member Handbook provided to members at enrollment. Network

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers are also supplied with a Member Handbook.
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately documented across all sources reviewed, including Policy MBR4a, Notification of Rights, the CAN Member Handbook, and the CAN Care Provider Manual.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 appropriately documented across all sources reviewed, including Policy MBR4a, Notification of Rights, the CAN Member Handbook, and the CAN Care Provider Manual.
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		X				Policy MBR2a, Information Packets to members (prior to the 1st day of the month of their enrollment), states United provides new members an information packet indicating the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
which enrollment starts, of all benefits to which they are entitled, including:						member's first effective date of enrollment. This packet is provided via mail prior to the first day of the month in which their enrollment starts and no more than 14 days after the receipt of notification of the member's enrollment. According to the policy, the new member packet includes an introduction letter, ID card, Member Handbook, and Provider Directory. Disenrollment information is included in the Member Handbooks. Identified issues are addressed in the standards below.
1.1 Full disclosure of benefits and services included and excluded in coverage;						A listing of covered and excluded benefits is found in the CAN Member Handbook. Issues noted with documentation of benefits included: •The benefits information on page 38 of the CAN Member Handbook indicates well child care is not covered. This is an issue identified during the previous EQR. •The behavioral health benefits grid on page 39 of the Member Handbook lists peer support services but does not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. This is an issue identified during the previous EQR. *Corrective Action: Revise the CAN Member Handbook to correct the issues identified with documentation of benefits for well child care and peer support services.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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;						
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The CAN Member Handbook provides information on emergent and urgent care, including examples of symptoms or conditions for which each is appropriate, and processes for obtaining urgent and emergent services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 A description of the member's identification card and how to use the card;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						
1.13 A description of EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						Information about grievances, appeals, and State Fair Hearings, as well as a copy of the grievance and appeal form, are included in CAN Member Handbook.
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;						The CAN Member Handbook includes information that members may use an online directory or call Member Services to locate a provider. It provides an overview of the Provider Directory and instructs to contact Member Services to obtain a printed copy of the Provider Directory.
1.17 Instructions for reporting suspected cases of fraud and abuse;						Telephone numbers for reporting suspected fraud and abuse are included in the CAN Member Handbook.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						Page 54 of the CAN Member Handbook provides information about advance directives. The last

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sentence states, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." The *CAN Contract, Section 5 (J)* refers to the agency as the "State Survey and Certification Division of the State Department of Health." *Recommendation: Revise the CAN Member Handbook, page 54, to reference the correct state agency name in the information about members with complaints 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					Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, indicates that if there are changes to covered services, benefits, or the process that the member should use to access benefits, members will be informed at least 14 days prior to the implementation of the change. The policy also states that if a provider is terminated the member will be given 15 days written notice of termination of a provider where they may have been receiving services from or were seen on a regular basis by the terminated provider. Policy MBR8b, 15 day Written Notices of Termed Provider, states the timeframe for member notification of a provider's termination is 15 days.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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, states United ensures all written member materials are written in language that does not exceed a 6th grade reading comprehension level. Reading level of member materials is confirmed by using the Flesch-Kincaid Readability Scale. Also, member materials are written in at least 12 point font, and large print materials are written in 18 point font.
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					All written member materials are made available in prevalent non-English languages in the State of Mississippi. United notifies members of the availability of oral interpretation services, interpretation services for the hearing/vision impaired, and how to access those services. The Member Handbook outlines translation/interpreter services which are free for members. Language Line services are available 24-hour a day, seven days a week. Hearing impaired services are available by contacting Member Services by dialing 711. Member materials are available in alternate languages, Braille, audio, and large print. Information for TDD/TTY is located on the back of the member ID card, and language/cultural assistance information is included in the Member Handbooks. Translated versions of all member materials can be requested by calling Member Services. These processes are addressed in Policy MBR1a, DOM's Limited English Proficiency Policy, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MBR1b2, Notification of Oral Interpretation Services (Free of Charge).
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					As noted in the CAN Member Handbook, the Member Services Call Center is available by toll free telephone. The hours of operation are listed in the handbook. The NurseLine is available 24 hours/day, 7 days/week via toll free telephone and TTY 711. A Mental Health Crisis Line is available by toll-free telephone and TTY 711. Hours of operation are not included. During onsite discussion, staff were unable to state the hours of operation for the Mental Health Crisis Line. *Recommendation: Revise the CAN Member Handbook to list the hours of operation for the Mental Health Crisis Line.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call Center performance is monitored and reported quarterly to the SQIS. SQIS minutes from 5/17/22 include discussion of call center performance, including Q1 2022 performance metrics, analysis of repeat callers, top call drivers, etc. The 2021 CAN QI Program Evaluation (page 70) includes an overview of performance throughout 2021 using data from monthly call statistics, including: All Calls Offered, All Calls Handled, Abandonment Rate (ABN) percentage, Average Speed of Answer (ASA), and the Service Level rate. Per the Program Evaluation, all performance metrics were met in 2021.
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					United encourages new members to voluntarily select a PCP at enrollment and informs members they may change PCPs at any time. Members who do not select a PCP within 30 days of enrollment are auto assigned to a PCP based on age, sex, family history, and zip code. Members are informed that Member Services staff can assist with PCP selection and changes.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Members are informed of preventive health services and available disease management programs through the CAN Member Handbook, mailings, newsletters, etc.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					The CAN QI Program Description addresses the Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) and Well-Child Programs. United conducts outreach to members and practitioners regarding the programs and monitors/evaluates quality indicators for preventive care services. Member incentives (gift cards) are offered to motivate members to schedule appointments and close gaps in care.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					United sends member newsletters and other mailings to members to inform them of risk factors and encourage participation in wellness activities. Onsite discussion confirmed United also reminds members of wellness activities and recommended services through automated calls. The health plan partners with community organizations for educational events.
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 2022 Adult and Child CCC reports for the CAHPS survey were created by SPH Analytics and submitted to the desk materials.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						For the Adult survey, the generalizability of the survey results is difficult to discern due to low response rates. The response rate was 14.4% with 231 out of 1603 completed. This is a slight decrease from last year's response rate of 14.7%. The oversampling rate of 20% is still not impacting the response rate. For the Child CCC survey, the generalizability of the survey results is difficult to discern due to low response rates. The response rate was 10.3% with 203 out of 1968 completed. This is a slight decline from last year's rate of 10.8%. The oversampling rate of 20% is still not impacting the response rate. *Recommendation: Additional reminders for awareness and member Incentives may need to be considered to increase Member Satisfaction Survey response rates.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The Quality Improvement & Population Health Management Annual Evaluation Report July 2022 assessed the 2021 CAHPS surveys.
3. The CCO reports results of the member satisfaction survey to providers.	X					
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					Information was reported to the QMC in March 2022 and noted in the QMC Program Evaluation.
III G. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, describes the process used for responding to a member's complaint or a grievance.
1.1 Definition of a grievance and who may file a grievance;	X					A grievance is appropriately defined in United's policy, CAN Member Handbook, CAN Provider Manual, and on United's website.
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. However, the CAN Member Handbook, page 62, offers the member the option of filing an Expedited Grievance. This option is not mentioned in the grievance policy or on United's website. *Corrective Action: Update policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, and United's website to include the process followed for an expedited grievance.*
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;		X				Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, includes the steps United follows if an extension is needed to resolve the grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update the notice sent to members regarding the need for an extension and include the member's right to file a grievance if they disagree with the extension.
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					United provided a copy of the complaint and grievance logs. The log lacked detail regarding how the complaint or grievance was received, as required by the *CAN Contract, Section 11, Reporting Requirements, O. Contractor Member Complaints, Grievances, and Appeal Reporting.* Per onsite discussion, the column indicating how the grievance was received was not provided with the desk materials. The grievance log was provided after the onsite and contained all requirements.
2. The CCO applies the grievance policy and procedure as formulated.	X					CCME reviewed a sample of grievance files for CAN. All files demonstrated that grievances were processed timely and appropriate notifications were provided. The acknowledgement letter for one file was not sent within the 5-calendar day requirement. *Recommendation: Ensure the acknowledgement letters are sent within five calendar days of receipt of the grievances, as required by the CAN Contract, Section 6, K.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
opportunities, and reported to the appropriate Quality Committee.						
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					
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	Not Applicable	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					Annually, United develops and/or updates their Quality Improvement (QI) Program Description. For this EQR, United submitted the 2022 Quality Improvement and Population Health Management Program Description and Optum's 2022 Behavioral Health Quality Improvement Program Description. Optum Behavioral Health is a sister company that provides mental health and substance abuse services for members.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The QI Program Descriptions are detailed and include program goals, objectives, structure, and scope of work. Details regarding United's Population Health Management Program was added to the 2022 QI Program Description.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					Through the Health Equity Program, United addresses health care disparities and culturally and linguistically appropriate services (CLAS). United conducts an annual analysis to identify language, race and ethnicity disparities needing improvement. In 2021, areas targeted included eye exams for diabetics, breast cancer screenings, and the health care rating. Annually, an evaluation of the effectiveness of the program is conducted. For this EQR, United provided the CAN 2021 Health Equity Program Evaluation. The program evaluation included results for areas targeted in 2021. The results listed for the diabetic eye exams were incorrect. Also, the results for Jackson County were missing with no explanation regarding why this county was excluded. *Recommendation: Correct the errors identified in the CAN 2021 Health Equity Program Evaluation.*
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The QI Program Description includes data sources used to support the QI Program. Multiple data sources are used, including utilization data and analysis.
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	X					Per the QI Program Description, the QI Work Plan identifies planned activities related to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
implementation and completion, and the person(s) responsible for the project(s).						program priorities. The work plan is reviewed and updated at least quarterly. United submitted the 2021 and 2022 CAN Work Plans for review. The work plans clearly document planned activities, responsible parties, quarterly updates, and status of each activity. Under the HEDIS tab, United included barriers and interventions underway to address the barriers for each HEDIS measure. United tracks HEDIS measure results on a quarterly basis and the final rates are included when available. The objectives noted in the 2022 CAN Work Plan, under the Objectives tab, included improving specific health outcomes in the areas of pre-term births, reduction of hospital admissions, and the reduction of COVID-19 spread and hospitalizations. Neither the Work Plan nor the QI Program Description described any activities related to the reduction of hospital admissions. Onsite discussion revealed this was an error in the work plan. Also, the HEDIS rates had not been updated and were listed as pending in the 2021 CAN Work Plan. *Recommendation: Correct the objectives regarding hospital admissions in the 2022 Work Plan and update the HEDIS rates in the 2021 Work Plan.*
IV B. Quality Improvement Committee						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					United's Quality Management Committee is the decision-making body ultimately responsible for the QI Program. This committee reports to the Board of Directors and is chaired by the health plan's Chief Medical Officer. The Provider Advisory Committee is responsible for evaluating and monitoring the quality, continuity, accessibility and availability, utilization, and cost of the medial care rendered within the network. This committee is also chaired by the health plan's Chief Medical Officer and includes network primary care and subspecialty physicians participating as voting members.
2. The composition of the QI Committee reflects the membership required by the contract.	X					
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 reported CMS Adult and Child Core Set measures. Aqurate determined that United followed the measure specifications and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						produced reportable rates for all measures in the scope of the validation. *Recommendation: Improve processes around monitoring non-HEDIS rate trends to identify opportunities for improvement and verification of the rates reported.*
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					For this review, the same PIPs that were submitted for the 2021 EQR were submitted and validated. Topics for PIPs include Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All the CAN PIPs scored in the "High Confidence in Reported Results" range. The Behavioral Health Readmission, Respiratory Illness, and Sickle Cell Disease CAN 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. Determine if there are ways to identify the most impactful interventions and focus efforts on those methods and processes.*
IV E. Provider Participation in Quality Improvement Activities						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO requires its providers to actively participate in QI activities.	X					United's Provider Manual informs network providers about their expected participation in the QI Program. The Provider Manual indicates additional information regarding United's QI Program is available upon request.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					United's network providers receive feedback regarding their performance data through the Primary Care Provider Profile report and the Patient Care Opportunities report.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, provides the process used for monitoring provider compliance with the clinical practice and preventive health guidelines adopted by United. Last year, CCME recommended United include details regarding how the results are shared with the providers. The policy received for this EQR found the policy had been updated and included specific details regarding how results are shared with providers.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					United uses the Patient Care Opportunity Reports to track members with gaps in care, specifically members needing EPSDT Services. Members in need of an EPSDT screening are sent a physician-generated wellness reminder. Any problems identified during the EPSDT exam that require referrals are tracked on a quarterly basis through a supplemental report. Case Management staff are responsible for reaching

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						out to those members to offer assistance with the referral.
4.3 Diagnosis and/or treatment for children.	X					
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 evaluated the effectiveness of the 2021 QI Program and activities. The Quality Improvement & Population Health Management Annual Evaluation for CAN included results and interventions underway. Last year, CCME recommended United correct errors identified in the HEDIS rates and include a summary of the interventions planned. The 2021 program evaluation demonstrated the errors were corrected and interventions added.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					United has developed a Utilization Management (UM) program designed to provide medically necessary, cost-effective health care services in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the most appropriate setting. The CAN 2022 Utilization Management Program Description includes the program's objectives, scope, and the structure. Optum is responsible for the management of behavioral health services. Optum's Behavioral Health Utilization Management Program description included the scope, program structure, and processes used to make UM decisions. Both program descriptions outline the mechanisms for monitoring physical health, behavioral health, and pharmacy services for members.
1.1 Structure of the program;	X					Policy UCSMM 01.11-Document Oversight and Adherence, outlines operational policies and procedures according to state, federal, regulations and requirements. Additionally, the Utilization Management Program Description, Optum Behavioral Health Utilization Management Program Description and Work Plan, and Pharmacy Program Description define the structure of the program in conducting emergency admission review, pre-authorization review, case management, and urgent clinical appeal determination.
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				United's CAN UM Program Description defines the timeline for completing UM decisions. The program description contains a table on page 17 regarding notifications for a suspended review. However, the program description does not

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include an explanation regarding what is considered a suspended review. *Recommendation: Update the UM Program Description and include an explanation of what is considered a suspended review.* The UM Program Description explains United may request an extension for completing authorization requests. The notice sent to members when United requests an extension for completing a UM decision is missing the information about the member's right to file a grievance regarding the extension, as required by *42 CFR 438.408 (c)*. This requirement is also not specifically mentioned in the CAN UM Program Descriptions, the policy, the Provider Manual, or in the CAN Member Handbook. *Corrective Action: Update the notice sent to members regarding a request for an extension to include the member's right to file a grievance as required by 42 CFR 438.408 (c). Also, update the CAN UM Program Description, the policy, the Provider Manual, and the CAN Member Handbook regarding the member's right to file a grievance.*
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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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					United's Chief Medical Officer is responsible for providing clinical consultation and oversight for all clinical activities. The UM Program Description provides an overview of the role and responsibilities of the Chief Medical Officer, such as clinical supervision, training, case review, oversight of clinical review criteria and implementation, clinical input in coverage determinations, etc. Additionally, the Chief Medical Officer chairs and serves on various committees, such as the Provider Advisor Committee, Service Quality Improvement Committee, and Utilization Management Program Committee. The Behavioral Health Regional Medical Director is responsible for the clinical oversight of the Behavioral Health Utilization Management Program. The Pharmacy Director works directly with the Chief Medical Officer, other medical directors, and clinical staff to promote appropriate utilization and cost-effective use of drugs.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					
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. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					External and internal clinical review criteria, such as InterQual and Milliman Care Guidelines, are used to determine medical necessity. The CAN UM Program Description, page 11, states United uses external and internal clinical review criteria that the quality oversight committee evaluates annually, and the medical director or equivalent designee approves. During the previous EQR (2021), United mentioned the health plan was transitioning from Milliman to InterQual review criteria. Policy UCSMM.06.10, Clinical Review Criteria (UCSMM 06.10 Rider 1), was not updated to reflect the review criteria currently being used by United. This policy still references Milliman as the review criteria. *Recommendation: Update policy UCSMM.06.10, Clinical Review Criteria (UCSMM 06.10 Rider 1), to address the current criteria used by United for making utilization management decisions.*
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					CCME reviewed a sample of CAN approval files and found decisions were made utilizing InterQual criteria or United's clinical coverage policies.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Per the 2021 CAN UM Program Evaluation, starting September 1, 2021, the InterQual IRR process began to evaluate staff using InterQual criteria. Clinical staff, including medical directors, participated in an online InterQual Interrater Reliability (IRR) assessment, for which the goal is for each staff person to score 90% or better. The overall InterQual IRR totals were 99.85%, exceeding the goal of 90%. Accomplishments included high pass rates achieved among participants for all three IRRs and adherence to published launch schedule, meeting all deadlines. Results reflected processes are on-target for consistency and adherence to established guidelines. A policy was not provided with the desk materials that outlines the IRR process used by United. Following the onsite, United provided their Standard Operating Procedure which outlines the InterQual IRR Assessment processes.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.		X				The Provider Manual and Pharmacy Program Description provide an overview of the Preferred Drug List (PDL). The CAN Member Handbook provides a telephone number for members to request a copy of the complete list and identifies that over the counter (OTC) medications are available at no cost to the member. 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.” This issue was

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified during a previous EQR and CCME recommended the link be corrected. *Corrective Action: Ensure the embedded links for the PDL and OTC medications list in the CAN Member Handbook are functional.*
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					The Pharmacy Program Description and policies such as Policy KB0033844, OptumRX Medical Prior Authorization Policy and Procedure, and Policy ID 31407, Emergency Medication Supply, describe United's processes and procedures for prior authorization of medications.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Per Policy UCSMM 06.13, Non clinical Intake and Initial Screening, non-clinical staff or licensed health professionals may conduct nonclinical initial screening. Per onsite discussion, the non-clinical staff responsibilities include conducting intake, case routing, and information requests from providers. Clinical reviews are conducted by actively licensed health care professionals that hold current licensure as a Registered Nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), or an appropriate licensed health professional as referenced in Policy UCSMM 06.14, Initial Clinical Review. The licensed health care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						professionals have access to licensed clinical medical director if a Level II medical necessity review is needed, as identified in Policy 06.16, Peer Clinical Review. Review of the denial and approval files reflects decisions are made by appropriate clinical staff, such as nurses or behavioral health specialists.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the CAN approval files reflects that physical health and behavioral health utilization decisions are made within the required timeframes and are consistent with Policy UCSMM.06.16, Initial Review Timeframes, and the UM Program Description.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Denial files reflected attempts to obtain additional clinical information when needed to render a determination of medical necessity.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					As reflected in the sample of denial files, final adverse determinations were made by an appropriate physician when requests did not meet medical necessity. Additionally, denials of pharmacy requests were initially made by a pharmacist and subsequently, a health plan medical director provided final determination. A description of peer-to-peer availability by telephone was also communicated appropriately to providers when notified of an adverse decision.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis	X					In accordance with Policies USMM.06.18, Initial Adverse Determinations, and CAN MS

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
for the denial of service and the procedure for appeal.						Rider.06.18, Initial Adverse Determination Notices, denial decisions were communicated timely to members and providers. The adverse benefit determination notices mailed to the provider and member described the reasoning for the denial and procedures for filing an appeal. However, most of the adverse benefit determination notices (2022 decisions) in the sample of denial files and the adverse benefit determination notice letter templates titled "CAN UHCCP NABD DENIAL" and "CAN UHCCP NABD REDUCTION IN SERVICE" incorrectly stated the member is required to submit a verbal appeal in writing. Updated adverse benefit determination notices were provided and include the correct information regarding the submission of an appeal. *Recommendation: Remove the information in the Adverse Benefit Determination Notices requiring a member to submit their verbal appeal request in writing.*
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					United addresses the process for handling member appeals in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. Information is also provided on United's website, in the Member Handbook, and in the Provider Manual. United also has a process outlined in Policy POL2018-01, MS Provider Grievance, Appeal, State

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Administrative Hearing and Independent External Review Policy.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The Member Handbook, Care Provider Manual, and POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, provide a descriptive definition of an adverse benefit determination and identify that an appeal can be filed by a member, legal guardian, authorized representative, or service provider.
1.2 The procedure for filing an appeal;		X				The process and timeframe for filing appeals are documented in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. The process and timeframe are also found in the CAN Member Handbook, Provider Manual, and on United's website. However, the website, CAN Member Handbook (page 63), and the Provider Manual incorrectly require the member to follow a verbal appeal with a written appeal. *Corrective Action: Correct the appeal information found on United's website, CAN Member Handbook, and Provider Manual to remove the requirement that a verbal appeal must be followed with a written appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Appeal resolution timeframes are documented in policy, the CAN Member Handbook, Provider Manual, and on United's website. The information indicates United may extend the timeframe for appeal resolution and will provide written notice to the member of the delay. United provided a copy of the notice sent to members if an extension is needed. This notice, the CAN Member Handbook, Provider Manual, and United's website do not inform members of their right to file a grievance if they disagree with the extension, as required by the *CAN Contract, Section 6, and 42 CFR § 438.408 (c).* *Corrective Action: Include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal in the member notice, the CAN Member Handbook, Provider Manual, and United's website.*
1.6 Written notice of the appeal resolution as required by the contract;	X					The written notice of appeal resolution provides directives on the process to request a State Fair Hearing according to Policy POL 2015-01, MS Member Appeal, State Fair Hearing External Appeal and Grievance, the Care Provider Manual, Member Handbook and United's letter template examples.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				A sample of CAN appeal files was reviewed. The following issues were identified: •The rationale in the resolution notices in five files was not written in language clear and understandable to members. The rationale was confusing regarding the physician who made the appeal decision. For example, the verbiage in one of the notices mentions the reviewing physician specializes in Plastic Surgery. The next paragraph indicates the decision was made by a physician board certified in Internal Medicine. •The acknowledgement letter for one file was not sent within the 10-calendar day requirement. United acknowledged during the onsite that the resolution letters were confusing, and that they are working on a solution to improve the notifications. *Corrective Action: Continue working on a solution to improve the appeal resolution notifications. Develop a plan to monitor and edit the notifications before sending the notices to members.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United Healthcare maintains an analysis of trends of appeals for medical and behavioral health services. An appeal analysis is included in the UM Program Evaluation, Quality Improvement Evaluation, and Behavioral Health

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Management and Improvement Program Evaluation. Trends are reported to the Healthcare Quality and Utilization Management Committee and Provider Advisory Committee. As reported in the UM Program Evaluation, the number of Clinical Member appeals increased from 137 in 2020 to 144 in 2021.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					The 2022 Care Management Model Program Description and Addendum (CAN) provides an overview of the program, including the program's scope, purpose, and goals. Optum's Behavioral Health Complex Case Management Program Description provides this information specific to behavioral health care management. Care Management policies and procedures provide additional detail about care management processes and requirements.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Processes and methods for identifying members who may benefit from case management services are detailed in Policy NCM 001, Identification of High Risk Members for Case Management. Methods of member identification include self-reported information, new enrollee health risk screenings, claims/encounter data, hospital admission and discharge data, pharmacy and laboratory data, and other data collected through UM processes. Members may

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						also be referred for CM services by internal health plan departments and programs, information from DOM, self-referrals, and provider referrals.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Policy NCM 002, Case Management Process, and Policy MS 002 Rider, Case Management Process describe processes for conducting health risk assessments (HRAs). The initial HRA is conducted no later than 30 calendar days from member identification or as quickly as the member's condition requires. Prior to conducting the HRA, staff review the referral source and risk stratification data, as well as any information provided by a previous health plan. At least 3 attempts are made to contact the member. If ultimately unsuccessful, a letter outlining the CM Program and how to contact the CM is sent to the member.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					Policy NCM 002, Case Management Process states the HRA includes the member's health status, including condition specific issues, the event or diagnosis that identified member for complex case management, clinical history, comorbidities, and the member's self-reported health status.
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					Policy NCM 002, Case Management Process, states the HRA includes an evaluation of living

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						arrangements, identification of environmental needs, caregiver resources and involvement, and social determinants.
4.4 Member's current treatment provider and treatment plan, if available.	X					Policy NCM 002, Case Management Process, states the HRA includes documentation of current medications, evaluation of current treatment, including preventive care, medications, treating physicians, self-care, and understanding of self-management of condition.
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					
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					As noted in Policy NCM 002, Case Management Process, Care Managers, along with members, re-evaluate and modify the plan of care based on the member's accomplishments and progress. The interdisciplinary care team (ICT) is updated about revisions to the plan of care as appropriate, and the Care Manager works with the ICT, as needed, to address and coordinate care needs. Reassessments are completed at least annually and with significant condition changes.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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 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 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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy MS 002 Rider, Case Management Process, addresses this requirement for CAN members.
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					Policy MS 002 Rider, Case Management Process, addresses this requirement for CAN members.
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, addresses requirements and processes for continuity of care when the member disenrolls from the CCO. In this case, the care manager facilitates the transition to the new health plan by sharing the members care plan, historical utilization data, etc. upon request with the new health plan. Additionally, if the member's eligibility ends and for children/adolescents that experience a change in benefits or coverage, the care manager educates the member about community-based organizations and alternate resources for care.
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					The CAN Member Handbook and Provider Manual describe Disease and Care Management programs and inform members how they may access these programs.
V E. Transitional Care Management						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Policy MS 021, Transitional Care Management, includes processes for coordinating and managing transitions of care across healthcare settings and providers. Activities include tracking and analyzing care transitions and sharing results with the Interdisciplinary Care Team (ICT). The Quality Improvement Department monitors and evaluates practitioner performance in coordinating care and ensuring continuity of care by monitoring complaints and appeals, practitioner medical records, member and provider satisfaction surveys, and reviewing service utilization with practitioners.
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					
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					
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					Annually, United evaluates and updates the UM Program as necessary. This includes evaluating the program's structure, scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of senior-level physicians and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						designated behavioral healthcare practitioners in the UM program. Member and practitioner experience data are also considered in the UM Evaluation. The 2021 MSCAN UM Program Evaluation was provided for review.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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 specify functions to be delegated, reporting responsibilities, performance expectations, and consequences that may result from substandard performance. Processes for delegation activities and oversight requirements are found in: •The UnitedHealthcare Credentialing Plan 2021–2023 •Policy ID-5714, Pharmacy Delegated Entity Oversight •Optum® Behavioral Health's Delegated Credentialing policy

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The United Behavioral Health Credentialing Plan 2022 – 2023
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				Oversight documentation submitted for review confirmed each delegate submits routine reports and United holds routine meetings with the delegates to discuss performance and any needs. The documentation confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated are subjected to an annual evaluation process. As noted in the 2022 MS DOM EQRO AUDIT NARRATIVE #18 document submitted after the onsite, "The oversight for all non-credentialing delegated entities occurs through routine established reports to facilitate performance monitoring on a monthly and annual basis. This oversight measures the operational component of these delegated entities and their performance measures. Evaluations pertaining to utilization, clinical, and quality are measured separately." Issues noted with documentation of delegation oversight include: •Optum Behavioral Health — routine monitoring was provided in a file labeled "35_MSCAN_DVOC_Scorecard_OBH_MS 2021-2022," but there was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities. Annual evaluation

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation was provided for credentialing and recredentialing activities. •Medical Transportation Management (MTM) – routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents. However, there was no documentation of a formal annual evaluation of delegated services. •eviCore National – routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for delegated services. •MARCH Vision Care – routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing. •Optum RX – routine monitoring was provided as noted on the DVOC Scorecard document, but there was no documentation of a formal annual evaluation of delegated services. *Corrective Action: Ensure each entity delegated to conduct any service or activity that is ultimately a health plan responsibility is subjected to a formal evaluation at least once a year, and that the formal annual evaluation includes all activities delegated to the entity. Refer to the CAN Contract, Section 15 (B).*

CCME CHIP Data Collection Tool

Plan Name:	**UnitedHealthcare CHIP**
Review Performed:	2022

I. ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, addresses United's guidelines for developing, reviewing, revising, and implementing policies, procedures, and standard operating procedures. Department Managers are responsible for adopting national policies. Riders or addenda are developed and added to the national policy when needed to address state-specific requirements. Standard Operating Procedures are created, when possible, to outline processes and provide detailed instructions. New and revised policies are reviewed by the Policy and Review Steering Committee before being presented to other committees such as the Health Quality Utilization Management (SQUM) Committee and Service Quality Improvement

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Subcommittee (SQIS). All policies are ultimately presented to the Quality Management Committee (QMC) for final review and approval. Policies are reviewed annually and are accessible to all employees via SharePoint and a shared file folder. Staff are informed of new and revised policies during routine team meetings and as needed during ad hoc meetings and/or email.
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					Michael Parnell is United's Chief Executive Officer.
1.2 *Chief Operating Officer;	X					United's Chief Operating Officer is Latrina McClenton.
1.3 Chief Financial Officer;	X					Chandler Ewing is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Glennis Johnson is United's Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Jason Bell is the Claims Administrator.
1.6 *Provider Services Manager;	X					Rhona Waldrep, Provider Services Director, oversees the Provider Relations, Provider Services, and Network Management Teams.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					Randy Knoll is the Member Outreach Director and oversees the Member Services and Marketing Teams. Dawn Jewell is the Member Services Manager.
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					Alicia Fields is the Delegated Services & Appeals Manager. Jennie Jenkins is the Complaint/Grievance/Appeal Coordinator.
1.9 Utilization Management Coordinator;	X					Kim Bollman, Health Services Director, oversees the Prior Authorization, Utilization Management, and Case Management Teams. Kristi Plotner is the Behavioral Health Director and Heather Odem is the Pharmacy Director. Jennifer Brumfield, Population Health Director, oversees Housing & Employment Navigators.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson, Quality Management Director, oversees the Quality Management, Accreditation, and Wellness Teams.
1.11 *Marketing and/or Public Relations;	X					
1.12 *Medical Director;	X					Dr. Dana Carbo-Bryant is the Chief Medical Officer. Medical Directors include Dr. Yolanda Wilson, Dr. Kia Tillis, and Dr. Jack Sariego.
1.13 *Compliance Officer.	X					Eric Sandkuhl is the Interim Compliance Officer.
2. Operational relationships of CCO staff are clearly delineated.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I C. Information Management 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 averages for 30 and 90 days exceed Mississippi's claims payment 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					Information Systems Capability Assessment (ISCA) documentation and onsite discussion confirmed United collects enrollment and member demographics using HIPAA compliant transaction formats and code sets. The data is processed and stored by United's encounter data submission and reporting system. The system tests the data for accuracy, completeness, logic, and consistency. 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					ISCA documentation and onsite discussion confirmed United appropriate capabilities to perform required data collection and reporting functions.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United has business continuity and disaster recovery plans in place to mitigate potential incidents and restore service in the event of an incident. These 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. The business continuity plans are updated twice a year.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2021-2022 (FWA Plan) describes processes to prevent, detect, correct, and report instances of Fraud, Waste, and Abuse (FWA) "to protect the ethical and fiscal integrity of its health care plans and programs." Information specific to Mississippi is found in the UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2021-2022 (FWA Plan Addendum).
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The UnitedHealth Group Code of Conduct (Code of Conduct) provides employees with information about the company's principles of ethics and integrity, and consequences of violating the Code of Conduct. It includes information about whom employees may contact for questions or concerns, and contact information for reporting instances of compliance, ethics, safety, and FWA violations. Each section of the Code of Conduct includes a reference to related policies that provide additional information.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The FWA Plan Addendum includes information about the CCO's Compliance Officer and states the Compliance Officer serves as the primary point of contact for the State.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Information about the Compliance Committee;						The corporate FWA Plan includes information about the corporate UHC Compliance Program Integrity Oversight Committee. However, the FWA Plan Addendum (for Mississippi) does not include information about the local health plan Compliance Oversight Committee (Compliance Oversight Committee). Information about the local committee was noted in the QI Program Description. *Recommendation: Revise the Mississippi FWA Plan Addendum to include information about the health plan's C&S Mississippi Compliance Oversight Committee.*
2.4 Compliance training and education;						Policy ID-6069, UnitedHealthcare Compliance Training & Education Policy, addresses compliance training requirements. Compliance training is required at the time of employment and annually for all employees and applicable delegated vendors/subcontractors. Compliance training topics include the Code of Conduct, Privacy and Security Awareness, Intellectual Property, Conflicts of Interest, Anti-Corruption, Harassment Prevention, and FWA Prevention. Additional role-focused or specialized compliance training may be required based on areas of business functions/operations or on individual job function. The company uses an online Learning Management System and specialized interactive training may be conducted by web-based tools, live or videotaped presentations, written

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						materials, or a combination of these to provide training. Compliance training records are maintained.
2.5 Lines of communication;						Lines of communication include designated web portals, call centers, databases, and anonymous hotlines, tip lines and portals. Specific communication channels include, but are not limited to: •UnitedHealth Group Compliance & Ethics Help Center •UnitedHealthcare Fraud Tip Line •UnitedHealthcare External Fraud Hotline •UnitedHealthOne Fraud Tip Line •Member Call Center(s) •Provider Call Center(s) •Optum Fraud, Waste and Abuse Hotline
2.6 Enforcement and accessibility;						The Code of Conduct informs employees that violations of the Code of Conduct, policies, laws, regulations, and contractual obligations may have legal and regulatory consequences. It states that all violations are taken seriously and may 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 FWA Plan describes routine monitoring and auditing activities, which include pre- and post-payment data analytics and data mining; analysis of aberrant billing patterns, payment errors, and industry trends; review of provider quality care complaints and provider audits; exclusion and sanction monitoring and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						verification; monitoring and oversight of delegated entities; and FWA Program compliance and performance audits.
2.8 Response to offenses and corrective action;						Mechanisms for prompt response to detected offenses and corrective action include provider notification, education and recovery efforts, termination from the network; and referral to law enforcement, regulatory, and administrative agencies pursuant to state and federal laws and regulatory requirements When investigative activity indicates credible evidence of fraudulent, wasteful, and/or abusive activity, retrospective affirmative recovery actions against paid claims are taken in in accordance with applicable contract, regulatory and legal requirements.
2.9 Exclusion status monitoring.						Policy ID-5881, New Hire and Periodic Employee Sanction Review, and Policy PDM-1, Provider Disclosures/National Disclosure Program, describe processes followed for exclusion status monitoring for employees, contractors, and suppliers. United conducts initial sanctions checks and background checks on new employees prior to the first day of work. Monthly checks are conducted of the CMS Precluded Provider List, OIG/GSA List of Excluded Individuals/Entitles (LEIE), General Services Administration's System for Award Management (SAM), Social Security Administration's Death Master File, National Plan & Provider Enumeration System (NPPES) Registry, etc., as applicable.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Optum's Provider Sanctions Monitoring Policy and Procedure states the Optum Sanctions team conducts monthly review of sanction sources for changes or updates to sanction records monthly. Sanction sources monitored are specified in the policy.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Oversight Committee assists the Compliance Officer and CEO in developing and implementing the Compliance Program. The committee is chaired by the Compliance Officer and CEO and meets quarterly and as needed. Committee membership includes the Compliance Officer, CEO, and senior executive leaders. A minimum of 51% of the committee membership constitutes a quorum. Members may designate surrogate attendees with voting privileges. The Community and State Health Plan Compliance Oversight Committee Charter defines the purpose and primary objective of the committee, committee composition and membership, roles and responsibilities, and structure and operation. The charter was most recently adopted on May 24, 2022.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes for payment suspensions, recoupments, etc. are included in the FWA Plan.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					The 2021-2022 UnitedHealthcare Community and State Pharmacy Program Description (Pharmacy Program Description), provides information about the High Prescription Utilization Program (Lock-In Program) that has been implemented to minimize drug abuse and diversion by identifying and managing members who have a potential for misuse or abuse of certain drugs. The information includes methods of member identification for inclusion in the program, members who would be excluded, processes for member notification of inclusion and the contents of the notification, member monitoring processes. Of note, the documentation indicates United has noted an improvement in utilization during member lock-in that continues after the lock-in period has expired. Additional information about the program is included in Policy ID-31884, C&S High Prescription Utilization Program. Brief information is also included in the Care Provider Manual and Member Handbook.
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					United's processes for maintaining confidentiality of protected information are documented throughout the materials reviewed. Employees are trained on principles and expectations for maintaining the confidentiality of applicable information. External committee members sign confidentiality agreements.

II. PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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 provider credentialing and recredentialing are found in the UnitedHealthcare Credentialing Plan 2021-2023 (Credentialing Plan). Additional state-specific requirements are listed in the State and Federal Regulatory Addendum Attachment E to the UnitedHealthcare Credentialing Plan (Credentialing Plan Addendum). The Credentialing Plan, Section 4.2 (B) (6) addresses conducting queries for sanctions and exclusions and lists the queries conducted. The Credentialing Plan did not address querying the Social Security Administration's Death Master File (SSDMF). Onsite discussion confirmed the SSDMF is checked by another department within the organization prior to completing initial credentialing. *Recommendation: Update the Credentialing Plan to include information about querying the SSDMF at initial credentialing.*
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 Board of Directors delegates overall responsibility for credentialing and recredentialing to the National Credentialing Committee (NCC). The health plan's Medical Director administers the Credentialing Plan and credentialing activities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						United's Provider Advisory Committee (PAC) reviews and approves credentialing determinations made by the NCC. The Medical Director can approve initial credentialing and recredentialing files that meet all required criteria. The PAC is chaired by the Chief Medical Officer and membership includes practicing network providers with specialties of OB GYN, Internal Medicine, Psychiatry, Pediatrics, and Family Medicine. Additional voting members include a Dentist and a Nurse Practitioner specializing in Internal Medicine. Voting is restricted to network providers, and the Chair votes only in case of a tie vote. The PAC meets at least four times each year and reports to the QMC. Review of PAC meeting minutes confirmed the quorum was established for each meeting and attendance was satisfactory.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					A sample of initial credentialing files was reviewed for CHIP. All files were compliant with initial credentialing requirements.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical 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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 or providers billing laboratory services;	X					
3.1.15 Fingerprints, when applicable.	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. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					A sample of recredentialing files was reviewed for CHIP. All were compliant with recredentialing requirements.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Provider office site reassessment, when applicable.	X					None of the provider files required office site reassessment.
4.4 Review of practitioner profiling activities.	X					
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					As stated in the Credentialing Plan, Regional Peer Review Committees, comprised of practitioners, Medical Directors, and clinical staff, conduct peer reviews and investigate Quality of Care (QOC) complaints and referrals. This committee makes recommendations to the National Peer Review and Credentialing Policy Committee (NPRCPC) regarding any action that should be taken related to complaints or referrals. The NPRCPC has ultimate decision-making authority on all disciplinary actions that affect restriction, suspension, or termination of participation status of physicians or health care professionals. When provider participation is terminated, the provider receives written notification of the reason(s) and any appeal process that is available.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					A sample of initial credentialing and recredentialing files for organizational providers was reviewed for CHIP. All files were compliant with credentialing and recredentialing requirements.
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)*						
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.						Geographic access standards for CHIP providers are documented in Policy PS3, Geographic Access Standards, and are compliant with contractual requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As noted in Policy PS10, PCP Panel Notification, United notifies PCPs of assigned enrollees and other panel changes within five business days of receipt of the Member Listing Report from DOM. Participating providers may access panel information on the secure provider portal. Within five days of receiving the Member Listing Report from DOM, United identifies PCPs with panel changes and notifies the providers via a mailed postcard.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, indicates all providers, including non-participating providers, may call the toll-free telephone number listed on the member ID card to verify member enrollment. Participating providers may access member enrollment information via the secure, password-protected online provider portal.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Policy PS3, Geographic Access Standards, states United performs quarterly geographic access studies to evaluate network adequacy. The Quarterly Report on Accessibility of Mississippi CHIP Members dated 7/11/22 indicates 99.3% of members have appropriate access to adult PCPs and 99.2% of members have appropriate access to pediatric PCPs.
1.5 Members have access to specialty consultation from network providers located	X					The Quarterly Report on Accessibility of MississippiCHIP Members, dated 7/11/22, indicates goals were met for most specialties;

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
within the contract specified geographic access standards.						however, there are a few gaps identified, including pediatric specialists and other specialties. Onsite discussion included United's ongoing efforts to mitigate the identified gaps.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Policy PS3, Geographic Access Standards, states United performs quarterly geographic access studies to evaluate network adequacy. If areas of noncompliance are discovered, resulting actions will include conducting further analysis to specify the geographic area and impacted membership; conducting research to identify opportunities for network development to engage identified provider targets and close gaps, and working with affected members to ensure necessary services are accessible and to maintain continuity of care.
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					As noted in the 2021 Quality Improvement Program Description, United's Multicultural Health Care Program (MHCP) is in place to reduce health disparity and improve culturally and linguistically appropriate services. United evaluates the effectiveness of services provided to members by: •Assessing member and practitioner race, ethnicity, and languages at least every three years. •Assessing for language and cultural gaps in the network every 3 years. •Monitoring member satisfaction, including experience with physicians and other providers.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy PS2, Access Standards – Appointment Availability Requirements, defines appointment availability requirements for providers in United network. The appointment availability standards defined in the policy comply with contractual requirements. United has contracted with DialAmerica to conduct quarterly assessments of PCPs, OBGYNs, and behavioral health providers to assess compliance with appointment access standards. Quarterly and annual assessments are conducted to assess the level of compliance for high-volume specialty providers. Failure to meet access requirements results in direct outreach to the provider. The Service Quality Improvement Subcommittee monitors, tracks, and trends the results and uses them to identify opportunities for improvement. Review of the CHIP_2022 2nd Quarter Appointment Availability Analysis document reflected low success rates for contacting providers. Onsite discussion revealed United continues efforts to determine barriers to successful contacts and implement interventions to improve the success rates.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy PS14, Provider Orientation Plan, describes United's processes for new provider. A Provider Advocate is assigned to each new provider and contacts the provider within the first 30 days of the contract effective date. During the welcome call, the advocate answers any immediate questions and schedules an orientation session. New provider orientation sessions are conducted according to the UnitedHealthcare Provider Orientation Plan, as documented in SOP-PS14, Standard Operating Procedure – Provider Orientation Plan Summary & Checklist.
2. Initial provider education includes:						Per the CHIP Provider Manual, the Provider Services Call Center hours of operation are Monday – Friday 7 a.m. to 5 p.m. However, during onsite discussion, United staff confirmed the Provider Services Call Center operates from 7:30 a.m. to 5:30 p.m. to comply with the *CHIP Contract, Section 7 (H) (1)*. *Recommendation: Revise the CHIP Provider Manual to include the correct hours of operation for the Provider Services Call Center.*
2.1 A description of the Care Management system and protocols, including transitional care management;	X					
2.2 Billing and reimbursement practices;	X					The CHIP Care Provider Manual includes information about claims and billing processes, including claims format, claim processing time, submission rules, electronic submission, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				A listing of covered and excluded benefits is found in the CHIP Provider Manual. Issues noted with documentation of benefits included: •The behavioral health benefits grid in the CHIP Provider Manual, page 10, lists peer support services but does not indicate whether these are covered or not. This is also the case in the CHIP Member Handbook, page 32. Onsite discussion confirmed these services are covered. This is an issue that was identified during the previous 2021 EQR. *Corrective Action: Revise the CHIP Care Provider Manual and CHIP Member Handbook to correct the issues identified with documentation of benefits for peer support services.*
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				The CHIP Care Provider Manual correctly documents most appointment access standards; however, page 56 does not include the 7 day timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge. This is a repeated finding from the 2021 EQR. *Corrective Action: Revise the CHIP Care Provider Manual to include complete information about the timeframe for appointments post-discharge from an acute psychiatric hospital.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Page 53 of the CHIP Care Provider Manual states it is a provider's responsibility to contact members who are non-compliant with EPSDT screenings and services. It does not reference Well-Baby and Well-Child screenings and services, which is the term used for the CHIP population. *Recommendation: Revise the CHIP Care Provider Manual, page 53, to reference Well-Baby and Well-Child screenings and services instead of EPSDT screenings and services.*
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The CHIP Care Provider Manual includes information about covered medications, prior authorization processes, the Preferred Drug List (PDL), and the availability of a 3-day emergency supply of medication.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Information about the Quality Improvement Program and expectations for provider participation in Quality Management are addressed in the CHIP Care Provider Manual.
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				The printed CHIP Provider Directory and the online "Doctor Lookup" tool include all required elements. The *CHIP Contract*, *Section 6 (E)* states, "The Contractor must also utilize a web-based provider directory, which must be updated within 5 business days upon changes to the provider network." However, Policy NQM-052, Web-Based Directory Usability Testing, page 2, item D, states, "The Web-based practitioner and hospital directory information is updated within 30 calendar days of when new information is received." Onsite discussion confirmed updates are made to the online Provider Directory within 24 hours. *Corrective Action: Revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					The Provider website (www.uhcprovider.com) includes news and updates for providers, including policy updates, trainings, etc. In addition, various educational sessions and meetings are held throughout the state and ongoing provider education is provided through the website, provider office visits, newsletters, bulletins, and Provider Manual updates.
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					A policy titled, "Review of Clinical and Preventive Guidelines" states evidence-based clinical and preventive guidelines from nationally recognized sources are used to guide quality and health management programs. The Medical Technology Assessment Committee (MTAC) reviews the guidelines and reports the guidelines to the National Medical Care Management Committee (NMCMC) for oversight.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					The preventive guidelines are available to clinical personnel, network practitioners, and members on the website. Providers are notified annually by mail, fax, or e-mail of the availability of the guidelines on the website. The CHIP Care Provider Manual includes information about the PHGs and links to access the information on the website.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					A policy titled, "Review of Clinical and Preventive Guidelines" states evidence-based clinical and preventive guidelines from nationally recognized sources are used to guide quality and health management programs. The Medical Technology Assessment Committee (MTAC) reviews the guidelines and reports the guidelines to the National Medical Care Management Committee (NMCMC) for oversight.
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					Clinical guidelines are available to clinical personnel, network practitioners, and members on the website. Providers are notified annually by mail, fax, or e-mail of the availability of the guidelines on the website. The CHIP Care Provider Manual includes information about the clinical guidelines and links to access the information on the website.
II F. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					As noted in the 2021 Quality Improvement Program Description, United conducts Medical Record Review (MRR) of high volume providers for compliance with documentation standards. Trained reviewers collect data using Medical Record Review tools. Results and areas for improvement are disseminated to physicians as needed, with overall results and opportunities for improvement reported to the Provider Advisory Committee and Quality Management Committee. United requires providers to maintain member medical records in compliance with documentation guidelines and appliable regulations. Medical record documentation requirements are included in the CHIP Care Provider Manual. The performance goal is 85%. Practitioners are notified of failing scores, failure to comply with record request, and identified deficiencies. Education and support are provided, and a follow-up review is conducted. If the follow-up review is not successfully passed, the Medical Director and/or quality committee reviews the documentation and determines an appropriate corrective action. Re-audits are conducted the in the next year after. Final MRR results are presented to health plan committee(s). This process is documented in Policy NQM-025, Ambulatory Medical Record Review Process.0
2. The CCO monitors compliance with medical record documentation standards through periodic medical	X					Detailed results of the 2021 MRR were included in the Quality Improvement & Population Health Management Annual Evaluation Report for 2021.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
record audits and addresses any deficiencies with the providers.						For the 2021 Primary Care Physician audit, all audited providers achieved passing scores. Re-survey was conducted for three providers who did not pass the 2020 audit, and all passed. For the EPSDT/Well Child/Baby Audit, nine of 19 providers passed, three will be re-audited in 2022, and seven were cancelled due to having copy service. Re-survey was conducted for two providers who did not pass the previous audit. One of the two did not pass, and education was provided.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					A 50 item Likert scale self-report survey was administered by Escalent, an independent research company, on behalf of United. Of the 2730 sample providers, only 33 responded, creating a response rate of 1.3%. This is a decrease from last year's rate of 1.9%. Although similar to the national rate, this is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution. The 2021 results indicate that overall satisfaction has decreased directionally since 2020, with more providers rating United unfavorably. High performing areas include Specialty Support, Care Coordination, Medical Records, Communication with Practice, and Credentialing and Contracting. Opportunities for improvement include the areas of Member Support, Prior Authorization,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Appeals, Reimbursement, Customer Service, and First Call Resolution. *Recommendation: Continued efforts should be made to gather a better representation of the providers. Additional reminders may be appropriate, as well as other interventions that incentivize providers to respond to the survey.*
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 in June 2022 and to the Provider Advisory Committee in May 2022.

III. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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, lists rights to which members are entitled and member responsibilities. Member rights are included in the Member Handbook provided to members at enrollment. Network providers are also supplied with a Member Handbook.
2. Member rights include, but are not limited to, the right:	X					Member rights are appropriately documented across all sources reviewed, including Policy

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						MBR4a, Notification of Rights, the CHIP Member Handbook, and the CHIP Care Provider Manual.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To 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.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Member responsibilities include the responsibility:	X					Member responsibilities are appropriately documented across all sources reviewed, including Policy MBR4a, Notification of Rights, the CHIP Member Handbook, and the CHIP Care Provider Manual.
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				Policy MBR2a, Information Packets to members (prior to the 1st day of the month of their enrollment), states United provides new members an information packet indicating the member's first effective date of enrollment. This packet is provided via mail prior to the first day of the month in which their enrollment starts and no more than 14 days after the receipt of notification of the member's enrollment. According to the policy, the new member packet includes an introduction letter,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ID card, Member Handbook, and Provider Directory. Disenrollment information is included in the Member Handbooks. Identified issues are addressed in the standards below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						A listing of covered and excluded benefits is found in the CHIP Member Handbook. Issues noted with documentation of benefits included: •The behavioral health benefits information in the grid in the CHIP Member Handbook, page 32, lists peer support services but does not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. This is an issue that was identified during the previous 2021 EQR. *Corrective Action: Revise the CHIP Member Handbook to correct the issues identified with documentation of benefits for peer support services.*
1.1.1 Benefits include family planning and 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; information regarding co-payments and out-of-pocket maximums;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						The CHIP Member Handbook provides information on emergent and urgent care, including examples of symptoms or conditions for which each is appropriate, and processes for obtaining urgent and emergent services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						
1.13 A description of the Well-Baby and Well-Child services which include:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						
1.13.7 Vision screening;						
1.13.8 Hearing screening;						
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
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	Not Applicable	Not Evaluated	
1.15 Procedures for filing complaints/grievances and appeals;						Information about grievances, appeals, and Independent External Reviews, as well as a copy of the grievance and appeal form, are included in the CHIP Member Handbook.
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						The CHIP Member Handbook includes information that members may use an online directory or call Member Services to locate a provider. It provides an overview of the Provider Directory and instructs to contact Member Services to obtain a printed copy of the Provider Directory.
1.17 Instructions on reporting suspected cases of fraud and abuse;						Telephone numbers for reporting suspected fraud and abuse are included in the CHIP Member Handbook.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						Page 44 of the CHIP Member Handbook provides information about advance directives. The last sentence states, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." The *CHIP Contract, Section 5 (l)* refers to the agency as the "State Survey and Certification Division of the State Department of Health." *Recommendation: Revise the CHIP Member Handbook, page 44, to reference the correct state agency name in the information about members with complaints about advance directives.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, indicates that if there are changes to covered services, benefits, or the process that the member should use to access benefits, members will be informed at least 14 days prior to the implementation of the change. The policy also states that if a provider is terminated the member will be given 15 days written notice of termination of a provider where they may have been receiving services from or were seen on a regular basis by the terminated provider. Policy MBR8b, 15-day written notices of termed provider, states the timeframe for member notification of a provider's termination is 15 days.
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, states United ensures all written member materials are written in language that does not exceed a 6th-grade reading comprehension level. Reading level of member materials is confirmed by using the Flesch-Kincaid Readability Scale. Also, member materials are written in at least 12 point font, and large print materials are written in 18 point font.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					All written member materials are made available in prevalent non-English languages in the State of Mississippi. United notifies members of the availability of oral interpretation services, interpretation services for the hearing/vision impaired, and how to access those services. The Member Handbook outlines translation/interpreter services which are free for members. Language Line services are available 24-hour a day, seven days a week. Hearing impaired services are available by contacting Member Services by dialing 711. Member materials are available in alternate languages, Braille, audio, and large print. Information for TDD/TTY is located on the back of the member ID card, and language/cultural assistance information is included in the Member Handbooks. Translated versions of all member materials can be requested by calling Member Services. These processes are addressed in Policy MBR1a, DOM's Limited English Proficiency Policy, and Policy MBR1b2, Notification of Oral Interpretation Services (Free of Charge).
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					As noted in the CHIP Member Handbook, the Member Services Call Center is available by toll

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						free telephone. The hours of operation are listed in the handbook. The NurseLine is available 24 hours/day, 7 days/week via toll free telephone and TTY 711. A Mental Health Crisis Line is available by toll-free telephone at and TTY 711. Hours of operation are not included. During onsite discussion, staff were unable to state the hours of operation for the Mental Health Crisis Line. *Recommendation: Revise the CHIP Member Handbook to list the hours of operation for the Mental Health Crisis Line.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call Center performance is monitored and reported quarterly to the SQIS. SQIS minutes from 5/17/22 include discussion of call center performance, including Q1 2022 performance metrics, analysis of repeat callers, top call drivers, etc. The 2021 CHIP QI Program Evaluation (pages 60-61) includes an overview of performance throughout 2021 using data from monthly call statistics, including: All Calls Offered, All Calls Handled, Abandonment Rate (ABN) percentage, Average Speed of Answer (ASA), and the Service Level rate. Per the Program Evaluation, all performance metrics were met in 2021.
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					United encourages new members to voluntarily select a PCP at enrollment and informs members they may change PCPs at any time. Members who do not select a PCP within 30 days of enrollment are auto assigned to a PCP based on age, sex, family history, and zip code. Members are informed that Member Services staff can assist with PCP selection and changes.
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					Members are informed of preventive health services and available disease management programs through the CHIP Member Handbook, mailings, newsletters, etc.
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					
3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					The CHIP QI Program Description addresses the Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) and Well-Child Programs. United conducts outreach to members and practitioners regarding the programs and monitors/evaluates quality indicators for preventive care services. Member incentives (gift cards) are offered to motivate members to schedule appointments and close gaps in care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					United sends member newsletters and other mailings to members to inform them of risk factors and encourage participation in wellness activities. Onsite discussion confirmed United also reminds members of wellness activities and recommended services through automated calls. The health plan partners with community organizations for educational events.
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					A formal annual assessment of member satisfaction was conducted by a vendor, SPH Analytics. A report was submitted to United in 2022. The report met all CMS validation elements. For the Child CCC survey, the sample size for the general population was 1,962 with 255 completed surveys, for a response rate of 13.0%. This is a decline from the previous rate of 15.9%. The response rates are below the NCQA target rate of 40%, but higher than the average national response rate of 10.2%. *Recommendation: Additional reminders for awareness and member Incentives may need to be considered to increase Member Satisfaction Survey response rates.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Data for CHIP CAHPS survey was analyzed and compared to internal goals and last year's results.
3. The CCO reports the results of the member satisfaction survey to providers.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Discussion of CAHPS results relative to last year's results were discussed in the QMC in March 2022.
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					United follows Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, for processing CHIP complaints and grievances. This policy describes the process used for responding to a member's complaint or a grievance.
1.1 Definition of a grievance and who may file a grievance;	X					A grievance is appropriately defined in United's policy, the CHIP Member Handbook, the Provider Manual and on United's website.
1.2 The procedure for filing and handling a grievance;		X				The CAN Member Handbook, page 62, offers the member the option of filing an Expedited Grievance. This option is not mentioned in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, or on United's website. *Corrective Action: Update the CHIP Member Handbook, Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance and United's website to include the process followed for an expedited grievance.*
1.3 Timeliness guidelines for resolution of the grievance;		X				Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, includes the steps United follows if an extension or additional time is needed to resolve the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievance. However, the notice sent to the member regarding the need for the extension does not offer the member the right to file a grievance related to the extension. *Corrective Action: Update the notice sent to members regarding the need for an extension and include the member's right to file a grievance if they disagree with the extension.*
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					United provided a copy of the complaint and grievance logs. The log lacked detail regarding how the complaint or grievance was received as required by the *CHIP Contract, Section 10 (L), Reporting Requirements*. Per onsite discussion the column indicating how the grievance was received was not provided with the desk materials. The grievance log was provided after the onsite. This log contained all the requirements.
2. The CCO applies the grievance policy and procedure as formulated.	X					CCME reviewed a sample of grievance files for CHIP. All files demonstrated the grievances were process timely and appropriate notifications were provided.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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	Not Applicable	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					For CHIP, United develops a separate QI Program Description to address the activities conducted for the CHIP Population. The Program Description is updated annually and submitted to the Board of Directors, Quality Management Committee, and DOM for approval. Behavioral Health Services for CHIP members are provided by Optum.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					United addresses health disparities through their Health Equity Program. United conducts an annual analysis to identify language, race, and ethnicity disparities needing improvement. In 2021, areas targeted for CHIP included improving the rates for adolescent well-child exams and member satisfaction. Annually, an evaluation of the effectiveness of the program is conducted. For this EQR, United provided the CHIP 2021 Health Equity Program Evaluation.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The QI Program Description includes data sources United uses to support the QI Program. Multiple data sources are used, including utilization data and analysis.
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's QI Work Plan identifies planned activities related to program priorities. The work plan is reviewed and updated at least quarterly. United submitted the 2021 and 2022 CHIP Work Plans for review. The work plans clearly document planned activities, responsible parties, quarterly updates, and status of each activity. Under the HEDIS tab, United included barriers and interventions underway for each HEDIS measure. United tracks HEDIS measure results on a quarterly basis and the final rates are included when available. However, in the 2021 Work Plan the 2021 HEDIS performance rates had not been updated and were listed as pending.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the HEDIS rates in the 2021 Work Plan.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					United's Quality Management Committee is responsible for the oversight of the QI program for the CHIP population. This committee reports to the Board of Directors and is chaired by the health plan's Chief Medical Officer. United's Provider Advisory Committee is responsible for evaluating and monitoring the quality, continuity, accessibility, and availability, utilization, and cost of the medical care within the network. The health plan Chief Medical Officer and network primary care and subspecialty physicians participate as voting members.
2. The composition of the QI Committee reflects the membership required by the contract.	X					
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.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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. *Recommendation: Improve processes around monitoring non-HEDIS rate trends to identify opportunities for improvement and verification of the rates reported.*
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					All the CHIP PIPs scored in the "High Confidence" range. The Follow Up After Hospitalization CHIP PIP 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. Determine if there are ways to identify the most impactful interventions and focus efforts on those methods and processes.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 informs network providers about their expected participation in the QI Program. The Provider Manual indicates additional information regarding United's QI Program is available upon request.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					United's network providers receive feedback regarding their performance data through the Primary Care Provider Profile report and the Patient Care Opportunities report.
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 Well-Baby and Well-Child screenings and results;	X					Standard Operating Procedures mention any problems identified during Well-Baby or Well-Child exams that require referral are tracked on a quarterly basis. Case Management staff are responsible for reaching out to those members to offer assistance with any needed referrals.
4.3 Diagnosis and/or treatment for children.	X					
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 evaluated the effectiveness of the 2021 QI Program and activities. The Quality Improvement & Population Health Management Annual Evaluation for CHIP included the results and interventions underway.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to:	X					The CHIP 2022 Utilization Management Program Description includes the program's objectives, scope, and structure. Optum is responsible for the management of behavioral health care services. Optum's Behavioral Health Utilization Management Program Description included the scope, program structure, and processes used to make UM decisions. Both program descriptions outline the mechanisms for monitoring physical health, behavioral health, and pharmacy services for members.
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					The CHIP Utilization Program Description states United utilizes applicable state/federal laws, contract requirements, or InterQual, and for behavioral health members, BH Level of Care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Guidelines (LOCGs), are guidelines and standards utilized in making UM decisions.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				United's CHIP UM Program Description defines the timeline for completing UM decisions. The program description contains a table on page 17 regarding notifications for a suspended review. However, the program description does not include an explanation regarding what is considered a suspended review. *Recommendation: Update the UM Program Description and include an explanation of what is considered a suspended review.* The notice sent to members when United requests an extension for completing a UM determination is missing information regarding the member's right to file a grievance regarding the extension, as required by *42 CFR §438.408 (c)*. This requirement is also not specifically mentioned in UM Program Descriptions, policy, the Provider Manual, or the Member Handbook. *Corrective Action: Update the notice sent to members regarding a request for an extension to include the member's right to file a grievance as required by 42 CFR §438.408 (c). Also, update the CHIP UM Program Description, the policy, the Provider Manual, and the CHIP Member Handbook regarding the member's right to file a grievance.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					United indicates appeal resolution shall occur within thirty days from the date of the initial appeal for standard appeals and within 72 hours for expedited appeals, as described in Policy UCSMM 07.11, Appeals Timeframes, and Policy UCSMM 07.12, Appeals Process and Records Documentation. Additionally, the timeframe may be extended up to fourteen days at member request or if additional information is needed, 0and a written notice for the reason of delay provided.
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					United's Chief Medical Officer is responsible for providing clinical consultation and oversight for all clinical activities. The UM Program Description provides an overview of the role and responsibilities of the Chief Medical Officer, such as clinical supervision, training, case review, oversight of clinical review criteria and implementation, clinical input in coverage determinations, etc. Additionally, the Chief Medical Officer chairs and serves on various committees, such as the Provider Advisor Committee, Service Quality Improvement Committee, and Utilization Management Program Committee. The Behavioral Health Regional Medical Director is responsible for the clinical oversight

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of the Behavioral Health Utilization Management Program. The Pharmacy Director works directly with the Chief Medical Officer, other medical directors, and clinical staff to promote appropriate utilization and cost-effective use of drugs.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					
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. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					External and internal clinical review criteria, such as InterQual and Milliman Care Guidelines, are used to determine medical necessity. The CHIP UM Program Description, page 11, states United uses external and internal clinical review criteria that the quality oversight committee evaluates annually, and the medical director or equivalent designee approves. During the previous EQR (2021), United mentioned the health plan was transitioning from Milliman to InterQual review criteria. Policy UCSMM.06.10 Clinical Review Criteria (UCSMM 06.10 Rider 1), was not updated to reflect the review criteria currently being used by United. This policy still references Milliman as the review criteria. *Recommendation: Update policy UCSMM.06.10 Clinical Review Criteria (UCSMM 06.10 Rider 1) to address the current criteria used by United for making utilization management decisions.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					CCME reviewed a sample of CHIP approval files and found decisions were made utilizing InterQual criteria or United's clinical coverage policies.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Approval files reflect that UM nurses and behavioral health clinicians review pertinent medical records and consider individual member circumstances while making UM decisions. Consultation with Medical Directors was utilized appropriately.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					The 2021 CHIP UM Program Evaluation provided an overview of the IRR process and results. A policy regarding the IRR process was not provided with the desk materials. Following the onsite, United provided their Standard Operating Procedure, which outlines the InterQual IRR Assessment processes.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The Provider Manual and Pharmacy Program Description provide an overview of the Preferred Drug List (PDL). The CHIP Member Handbook provides a telephone number for members to request a copy of the complete list and identifies that over the counter (OTC) medications are available at no cost to the member. Links are provided in the CHIP Member Handbook to access the listing of OTC medicines and PDL.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Emergency care and post-stabilization requirements are outlined in Policy UCSMM.04.11, Consumer Safety, the Member Handbook, and the Utilization Management Program Description and Addendum.
7. Utilization management standards/criteria are available to providers.	X					United's Provider Manual provides an overview of clinical guidelines and processes for medical necessity determination and provides a website link for further information. United's Adverse Benefit Determination Notices provide information that providers can request a copy of clinical guidelines.
8. Utilization management decisions are made by appropriately trained reviewers.	X					
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of CHIP approval files reflects that physical health and behavioral health utilization decisions are made within the required timeframes and consistent with Policy UCSMM.06.16, Initial Review Timeframes, and the UM Program Description.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					In accordance with Policies USMM.06.18, Initial Adverse Determinations, and CAN MS Rider.06.18, Initial Adverse Determination Notices, denial decisions were communicated timely to providers and members. The adverse benefit determination notices mailed to the provider and member described the reasoning for denial and procedures for filing an appeal. However, most of the adverse benefit notices (2022 decisions) found in the sample of CHIP denial decisions reviewed by CCME, and the Adverse Benefit Notice letter templates titled "CHP UHCCP INITIAL REVIEW," and "CHP UHCCP TERM RED" incorrectly stated the member is required to submit a verbal appeal in writing. *Recommendation: Remove the information in the Adverse Benefit Determination Notices requiring a member to submit their verbal appeal request in writing.*
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					A descriptive overview of the appeals process is provided in the Member Handbook, Member Resources section on the website, CHIP BH UM Program Description, CHIP UM Program Description and Workplan, and Care Provider Manual. As outlined in Policy POL2015-01, a

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review of grievances and appeals occurs no less than annually to assess system processes and possible improvement measures.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The Member Handbook, Care Provider Manual, and POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, identify that an appeal can be filed by a member, legal guardian, authorized representative, or service provider. Policy POL2015-01, the Member Handbook, and Care Provider Manual provide a descriptive definition of the term "adverse benefit determination."
1.2 The procedure for filing an appeal;		X				The process and timeframe for filing appeals are documented in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. The process and timeframe are also found in the CHIP Member Handbook, Provider Manual, and on United's website. However, the website, CHIP Member Handbook (page 49), and the Provider Manual incorrectly require the member to follow a verbal appeal with a written appeal. *Corrective Action: Correct the appeal information found on United's website, CHIP Member Handbook, and the Provider Manual to remove the requirement that a verbal appeal must be followed with a written appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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				Appeal resolution timeframes are documented in policy, the CHIP Member Handbook, Provider Manual, and on United's website. The information indicates United may extend the timeframe for appeal resolution and will provide written notice to the member of the delay. United provided a copy of the notice sent to members if an extension is needed. This notice, the CHIP Member Handbook, Provider Manual, and United's website do not inform members of their right to file a grievance if they disagree with this extension, as required by the *CHIP Contract, Section 6, and 42 CFR § 438.408 (c)*. *Corrective Action: Include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal in the member notice, the CHIP Member Handbook, Provider Manual, and United's website.*
1.6 Written notice of the appeal resolution;		X				The CHIP Uphold and Overturned letter templates provided with the desk materials contain the required information. Additionally, the "Your Additional Rights" enclosure provides information and instructions for requesting an Independent External Review. However, it does

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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. This was an issue identified during the 2021 EQR and not corrected. *Corrective Action: 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 held liable for the cost, according to the CHIP Contract, Section E (14)(d).*
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				A sample of CHIP appeal files wase reviewed. The following issues were identified: •The rationale in the resolution notices for four CHIP files was not written in language clear and understandable to members. The rationale was confusing regarding the physician who made the appeal decision. For example, the notice indicated the decision was made by a physician specializing in Plastic Surgery. However, further verbiage states the decision was made by a medical director who specializes in Pediatrics and Neonatology. United acknowledged during the onsite that the resolution letters were confusing, and that they are working on a solution to improve the notifications. •Also, none of the resolution letters sent when the denial was upheld contained the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirement that members have a right to request and receive benefits while the Independent External Review is pending. *Corrective Action: Continue working on a solution to improve the appeal resolution notifications. Develop a plan to monitor and edit the notifications before sending the notices to members. Include information regarding the member's right to request and receive benefits while the Independent External Review is pending, and that the member can be held liable for the cost.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United Healthcare maintains an analysis of trends of appeals for medical and behavioral health services. An appeal analysis is reviewed in the UM Program Evaluation, Quality Improvement Evaluation, and the Behavioral Health Quality Management and Improvement Program Evaluation. Trends are reported to the Healthcare Quality and Utilization Management Committee and Provider Advisory Committee. As reported in the Behavioral Health Quality Improvement Program Evaluation, there were five member-initiated appeals due to medical necessity criteria and no barriers or opportunities for improvement were identified.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					The 2022 Care Management Model Program Description and Addendum (CHIP) provides an overview of the program, including the program's scope, purpose, and goals. Optum's Behavioral Health Complex Case Management Program Description provides this information specific to behavioral health care management. Care Management policies and procedures provide additional detail about care management processes and requirements.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Processes and methods for identifying members who may benefit from case management (CM) services are detailed in Policy NCM 001, Identification of High Risk Members for Case Management. Methods of member identification include self-reported information, health risk screenings, claims/encounter data, hospital admission and discharge data, pharmacy and laboratory data, and other data collected through UM processes. Members may also be referred for CM services by internal health plan departments and programs, information from DOM, self-referrals, and provider referrals.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Policy NCM 002, Case Management Process, and Policy MS 002 Rider, Case Management Process describe processes for conducting health risk assessments (HRAs). The initial HRA is conducted no later than 30 calendar days from member identification or as quickly as the member's condition requires. Prior to conducting the HRA, staff review the referral source and risk stratification data, as well as

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						any information provided by a previous health plan. At least 3 attempts are made to contact the member. If ultimately unsuccessful, a letter outlining the CM Program and how to contact the CM is sent to the member.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					Policy NCM 002, Case Management Process, states the HRA includes the member's health status, including condition specific issues, the event or diagnosis that identified member for complex case management, clinical history, comorbidities, and the member's self-reported health status.
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					Policy NCM 002, Case Management Process, states the HRA includes an evaluation of living arrangements, identification of environmental needs, caregiver resources and involvement, and social determinants.
4.4 Member's current treatment provider and treatment plan, if available.	X					Policy NCM 002, Case Management Process, states the HRA includes documentation of current medications, evaluation of current treatment, including preventive care, medications, treating physicians, self-care, and understanding of self-management of condition.
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
within 30 days of completion of the health risk assessment.						
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					As noted in Policy NCM 002, Case Management Process, Care Managers, along with members, re-evaluate and modify the plan of care based on the member's accomplishments and progress. The interdisciplinary care team (ICT) is updated about revisions to the plan of care as appropriate, and the Care Manager works with the ICT, as needed, to address and coordinate care needs. Reassessments are completed at least annually and with significant condition changes.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.						
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					Policy MS 002 Rider, Case Management Process, addresses this requirement for CHIP members.
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					Policy MS 002 Rider, Case Management Process, addresses this requirement for CHIP members.
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, addresses requirements and processes for continuity of care when the member disenrolls

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						from the CCO. In this case, the care manager facilitates the transition to the new health plan by sharing the members care plan, historical utilization data, etc. upon request with the new health plan. Additionally, if the member's eligibility ends and for children/adolescents that experience a change in benefits or coverage, the care manager educates the member about community-based organizations and alternate resources for care.
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					The CHIP Member Handbook and Provider Manual describe Disease and Care Management programs and inform members how they may access these programs.
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					Policy MS 021, Transitional Care Management, includes processes for coordinating and managing transitions of care across healthcare settings and providers. Activities include tracking and analyzing care transitions and sharing results with the Interdisciplinary Care Team (ICT). The Quality Improvement Department monitors and evaluates practitioner performance in coordinating care and ensuring continuity of care by monitoring complaints and appeals, practitioner medical records, member and provider satisfaction surveys, and reviewing service utilization with practitioners.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The 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 Quality Management Committee, and the Healthcare Quality and Utilization Management (HQUM) for approval.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The CHIP 2021 UM Program Evaluation and Program Description with Addendum were approved by the HQUM Committee on 5/15/22 and Quality Management Committee on 6/8/22.

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	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 specify functions to be delegated, reporting responsibilities, performance expectations, and consequences that may result from substandard performance. Processes for delegation activities and oversight requirements are found in: •The UnitedHealthcare Credentialing Plan 2021-2023 •Policy ID-5714, Pharmacy Delegated Entity Oversight •Optum® Behavioral Health's Delegated Credentialing policy •The United Behavioral Health Credentialing Plan 2022 - 2023
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				Oversight documentation submitted for review confirmed each delegate submits routine reports and United holds routine meetings with the delegates to discuss performance and any needs. The documentation confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated are subjected to an annual evaluation process. As noted in the 2022 MS DOM EQRO AUDIT NARRATIVE #18 document submitted after the onsite, "The oversight for all non-credentialing delegated entities occurs through routine established reports to facilitate performance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitoring on a monthly and annual basis. This oversight measures the operational component of these delegated entities and their performance measures. Evaluations pertaining to utilization, clinical, and quality are measured separately." Issues noted with documentation of delegation oversight include: •Optum Behavioral Health — routine monitoring was provided in a file labeled "35_MSCAN_DVOC_Scorecard_OBH_MS 2021-2022," but there was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities. Annual evaluation documentation was provided for credentialing and recredentialing activities. •eviCore National — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for delegated services. •MARCH Vision Care — routine monitoring was provided as noted on the DVOC Scorecard 2021 and 2022 documents, but there was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing. •Optum RX — routine monitoring was provided as noted on the DVOC Scorecard document, but there was no documentation of a formal annual evaluation of delegated services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Ensure each entity delegated to conduct any service or activity that is ultimately a health plan responsibility is subjected to a formal evaluation at least once a year, and that the formal annual evaluation includes all activities delegated to the entity. Refer to the CAN Contract, Section 15 (B).