Constellation Quality Health

UnitedHealthcare Community Plan – Mississippi

2023 External Quality Review

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Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies 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 2023 External Quality Review (EQR) conducted by Constellation Quality Health, formerly The Carolinas Center for Medical Excellence, 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 whether 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; a two-day virtual onsite visit; a compliance review, including validation of performance improvement projects (PIPs) and performance measures, validation 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)*
- Disenrollment *(§ 438.56)*
- Enrollee Rights *(§ 438.100)*
- Emergency and Post Stabilization Service *(§ 438.114)*

In 2022, DOM implemented a centralized credentialing process. Therefore, the Mississippi CCOs are not responsible for credentialing and recredentialing their providers, and an assessment of CCO compliance with Provider Selection *(§ 438.214, § 457.1233)* is not included in this report.

To assess United's compliance with quality, timeliness, and accessibility of services, Constellation Quality Health'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 established processes and guidelines for developing, reviewing, revising, and implementing policies, procedures, and standard operating procedures. Policies are reviewed at least annually, with revisions made as needed to maintain compliance with contractual requirements, laws, regulations, and accreditation standards. New and revised policies are reviewed by various committees, with final approval given by the Quality Management Committee. Staff can access policies on a SharePoint site and are routinely educated about new and revised policies.

Review of the Organizational Chart and onsite discussion confirmed staffing is sufficient to ensure all required activities can be conducted and all contractually required services are provided to members. All key positions are filled, and few vacancies are noted in other positions.

The Compliance Plan and the MS Fraud, Waste, and Abuse (FWA) Plan Addendum provide information about the roles and responsibilities of corporate and health plan Compliance Officers and the health plan's Compliance Oversight Committee. Information about processes and activities to prevent, detect, and address violations of laws and policies is found in the

UnitedHealthcare Compliance Program. The UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 and the related Mississippi addendum address processes and activities for preventing, detecting, and responding to actual or suspected fraud, waste, and abuse. Related policies provide additional detailed information about compliance and fraud, waste, and abuse processes. In addition, the Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) addresses expectations for behavior, accountability, and maintaining the privacy and security of information, among other topics. Initial and ongoing compliance and fraud, waste, and abuse training are provided to all employees, vendors, subcontractors, and others who conduct activities on behalf of United.

United provided appropriate documentation to demonstrate that its systems and processes are capable of meeting both the contractual and information system requirements defined by DOM. The infrastructure systems and processes are managed in accordance with policies and procedures that prioritize system security and resilience while adhering to the industry standard. United performs routine risk assessment protocols to identify and aid in risk identification and in implementation of preventative measures. Policy revisions are clearly marked, which demonstrates regular revisions and updates are being made. Policies, the Compliance Plan, the Code of Conduct, and related materials address processes for ensuring the confidentiality of protected information. Compliance training includes expectations for maintaining the confidentiality of applicable information.

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

CAN and CHIP geographic access standards and appointment access standards for providers are documented in policy and are compliant with contractual requirements. United runs quarterly geographic access reports to assess the network against the defined geographic standards. The most recent results indicate goals were met for rural and urban access to PCPs for CAN and CHIP. Quarterly appointment access studies are conducted to assess provider compliance with appointment access standards. The most recent results submitted showed low successful answer rates for several provider categories. Additionally, compliance with required appointment access standards was low for several categories across PCPs, obstetrics and gynecology, and behavioral health providers. The Service Quality Improvement Subcommittee monitors, tracks, and trends the results of geographic access assessments and appointment access studies to identify opportunities for improvement. In addition, United routinely assesses member and practitioner race, ethnicity, and languages and conducts ongoing monitoring of member satisfaction with the network.

United uses a provider data management system and conducts various activities to verify provider information, such as using automated systems, roster processing, leveraging provider

verification outreach campaigns, exchanging internal demographic data with CAQH, and requesting providers review and respond when variances are identified. United plans to employ additional, enhanced tools such as Synaptic Health Alliance, Google API, and Trust Evaluator to validate provider information. The printed CAN and CHIP Provider Directories and online "Doctor Lookup" tools include all required elements.

United conducts provider orientation following the Provider Orientation Plan within the first 30 days of the contract effective date for new providers. Ongoing provider education is conducted to keep providers informed of any changes that would impact them as providers within United's network. The CAN and CHIP Care Provider Manuals are comprehensive resources of information for providers. However, minor issues were noted in documentation of member benefit restrictions, exclusions, and prior authorization requirements in the Care Provider Manuals. Other minor documentation issues were also noted. Providers are educated about medical record documentation standards and are evaluated for compliance with those standards annually. For 2022, all providers from whom records were received met the threshold score of 85% or more.

United adopts and educates providers about clinical practice and preventive health guidelines. Information about expected use of the guidelines is communicated through the Care Provider Manuals. Provider compliance is assessed primarily through the medical record review process.

The provider satisfaction survey was administered by an independent research company on United's behalf. The response rate was 1.0%, a decrease from the previous year's rate of 1.2%. This response rate may not reflect the population of providers and results should be interpreted with caution. The percentage of providers rating the overall satisfaction with United as a "10" on a scale from 0 to 10 increased from 2021 to 2022. Service experience was scored as excellent or good by 63% of providers; ease of the appeals process was scored as excellent or good by 55%; and the credentialing process was scored as good/excellent for 75%.

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 specified in a health plan policy, in the CAN and CHIP Member Handbooks, and in the Care Provider Manuals. Members may also view member rights and responsibilities on the website and can contact the health plan to request the information.

Processes are in place for providing new members with education about the health plan, benefits, services, etc. New member education is provided through an information packet that includes an introduction letter, a Member Handbook, and instructions for accessing or requesting a copy of the Provider Directory.

The CAN and CHIP Member Handbooks are comprehensive resources for members to understand the health plan's processes, services, and requirements. However, the review revealed several issues related to documentation of member benefits in the CAN and CHIP Member Handbooks. The handbooks include information about member notification of changes in services and benefits. The CAN Member Handbook also includes information about notification of a provider's termination. The CHIP Member Handbook, however, does not include the timeframe for member notification of a provider's departure from the network.

United has processes for ensuring member materials are developed in a manner to ensure they are easily understood by members by not exceeding a 6th-grade reading comprehension level and using appropriate fonts for regular and large-print materials. Materials can also be provided in alternate languages and formats, and free translation and interpreter services are also offered.

Targets for call center performance/call metrics are defined by DOM. United monitors call center performance by collecting and analyzing call data to identify opportunities for improvement and developing action plans when needed. The Service Quality Improvement Subcommittee monitors trends related to member and provider call center activities. Results of performance throughout 2022 indicated all performance metrics were met in 2022.

The CAN and CHIP Member Handbooks include brief information about preventive health services and wellness programs. Members are instructed to contact Member Services with any questions or to get more information. United also educates members about population health activities and recommendations through member newsletters, mailings, automated and live calls, e-mails, text messages, and events such as health fairs and other health promotion events. Members that are engaged with care managers are informed of services that are offered through the program in which they are enrolled.

No policy was identified that addresses processes and requirements for member disenrollment. However, the CAN and CHIP Member Handbooks address member disenrollment processes and requirements and instruct members to contact DOM in writing or by telephone to request disenrollment and/or a change in health plan.

United's processes for processing member grievances are described in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. This document, along with the CAN and CHIP Member Handbooks, Provider Manuals, and the CCO's website define

grievances and describe the options for filing a grievance and timelines for resolving or extending grievances. A sample of United's CAN and CHIP grievance files was reviewed. All reviewed files were processed timely with appropriate resolution notifications noted. One CHIP file was not compliant with the grievance acknowledgement timeframe.

Quality Improvement

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

United has developed a Quality Improvement (QI) program that includes all aspects of health care quality. United's 2023 Quality Improvement and Population Health Management Program Descriptions for CAN and CHIP details the program's structure, objectives, scope, and methodology. The QI program operates in conjunction with Untied's Utilization Management program to improve the health and health care services provide to members.

The reduction of health disparities is addressed through United's Health Equity program. The goal of this program is to reduce health disparity and improve culturally and linguistically appropriate services. United has selected specific measures for the CAN and CHIP populations. For CAN, those measures include improving the HEDIS rates for Cervical Cancer Screening and Immunizations for Adolescents and improving the CAHPS score for Rating of Personal Doctor. For CHIP, the measures were to improve the HEDIS rates for Immunizations for Adolescents (Combo 2) in targeted counties and improve the CAHPS score for the Rating of Specialist.

Annually, United develops a QI work plan to identify the planned activities related to program priorities that are intended to improve the provisions of population health, quality, safety of clinical care, and services. For CAN and CHIP there were five specific goals outlined in the 2023 QI work plan. Those goals include improving specific HEDIS measures, CAHPS measures, Provider satisfaction, EPSDT rates, and HEDIS measures associated with the Performance Improvement Projects.

United's Quality Management Committee continues to be the decision-making body ultimately responsible for the QI Program. The Provider Advisory Committee is responsible for evaluating and monitoring the quality, continuity, accessibility, and availability of care rendered within the network. United's Chief Medical Officer chairs this committee and network providers specializing in OB/GYN, Internal Medicine, Psychiatry, Dentistry, Pediatrics, and Family Medicine are included as voting members. The Provider Advisory Committee meets and reports to the Quality Management Committee at least four times per year.

An annual review of the overall effectiveness of the QI Program is conducted to assess how well resources have been deployed to meet the objectives of the program. The 2022 Quality Improvement & Population Health Management Annual Evaluation Report (CHIP and CAN) was

detailed and contained a review and results of all aspects of the program. For goals that were not met, a root cause or barrier analysis was conducted and opportunities for improvements identified.

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, 2022, through December 31, 2022.

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) 2022.

All relevant HEDIS performance measures for the CAN and CHIP populations were compared for the current review year (2022) to the previous year (2021) and the changes from 2021 to 2022 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 2021 to 2022. A substantial increase or decrease is a change in rate greater than 10%.

Table 1: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	19.28%	30.14%	10.86%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days (Total)	18.53%	29.72%	11.19%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	0.0%	28.30%	28.30%
7-Day Follow-Up: 13-17 Years	0.0%	24.53%	24.53%
30-Day Follow-Up: 18+ Years	6.17%	26.52%	20.35%
7-Day Follow-Up: 18+ Years	3.29%	15.65%	12.36%

Measure/Data Element	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
30-Day Follow-Up: Total	5.43%	26.78%	21.35%
7-Day Follow-Up: Total	2.90%	16.94%	14.04%
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.67%	52.94%	-23.73%

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 2021 to 2022.

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	36.52%	49.83%	13.31%
Continuation and Maintenance (C&M) Phase	51.79%	69.44%	17.65%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	60.71%	72.97%	12.26%
6-17 years - 7-Day Follow-Up	32.14%	45.95%	13.81%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1-11)	32.00%	44.30%	12.30%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	61.29%	74.16%	12.87%
Substantial Decrease in Rate (>10% decrease)			
Antidepressant Medication Management (amm)			
Effective Continuation Phase Treatment	35.00%	24.32%	-10.68%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	57.50%	41.03%	-16.47%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for 2022 and the previous year (2021). The changes from 2021 to 2022 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	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 65+	0.00	230.41	230.41
Total	44.25	54.94	10.69
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	29.25%	40.15%	10.90%
Total Screening	36.43%	46.47%	10.04%
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	29.25%	50.73%	21.48%
Numerator 2 All Four Molars Sealed	17.32%	35.24%	17.92%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Ages 1-2	4.22%	22.28%	18.06%
Ages 3-5	11.52%	59.05%	47.53%
Ages 6-7	12.44%	64.66%	52.22%
Ages 8-9	12.46%	65.46%	53.00%
Ages 10-11	12.14%	63.66%	51.52%
Ages 12-14	10.98%	58.42%	47.44%
Ages 15-18	8.89%	48.36%	39.47%
Ages 19-20	5.02%	28.58%	23.56%
Total Ages <1-20	9.87%	50.98%	41.11%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 3-5	2.47%	25.44%	22.97%
Ages 6-7	2.75%	30.94%	28.19%
Ages 8-9	2.62%	31.27%	28.65%
Ages 10-11	2.00%	30.41%	28.41%
Ages 12-14	2.06%	26.32%	24.26%
Ages 15-18	1.54%	18.85%	17.31%
Total Ages 1-20	2.00%	23.21%	21.21%
Substantial Decrease in Rate (>10% decrease)			
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 65+	381.68	0	-381.68

Table 4: CHIP Non-HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	28.63%	47.09%	18.46%
Numerator 2 All Four Molars Sealed	17.88%	32.89%	15.01%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Ages 1-2	6.66%	32.91%	26.25%
Ages 3-5	11.26%	61.65%	50.39%
Ages 6-7	12.97%	69.39%	56.42%
Ages 8-9	13.62%	72.30%	58.68%
Ages 10-11	12.59%	69.90%	57.31%
Ages 12-14	11.96%	64.70%	52.74%
Ages 15-18	9.71%	54.04%	44.33%
Ages 19-20	5.48%	43.51%	38.03%
Total Ages <1-20	11.21%	61.17%	49.96%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 3-5	2.77%	30.51%	27.74%
Ages 6-7	2.88%	37.75%	34.87%
Ages 8-9	3.03%	39.15%	36.12%
Ages 10-11	2.22%	36.92%	34.70%
Ages 12-14	2.46%	31.32%	28.86%
Ages 15-18	1.98%	21.63%	19.65%
Ages 19-20	0.82%	14.22%	13.40%
Total Ages 1-20	2.40%	30.27%	27.87%
Substantial Decrease in Rate (>10% decrease)			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	29.83	0.00	-29.83
Total	29.83	0.00	-29.83

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. 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, United submitted four CAN PIPs. Topics for those PIPs included Reducing 30-Day Psychiatric Inpatient Readmission Rates, Improving Pregnancy Outcomes, Respiratory Illness Management, and Sickle Cell Disease Management Decreasing ER Utilization. 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 5: Reducing 30-Day Psychiatric Inpatient Readmission Rates PIP

Reducing 30-Day Psychiatric Inpatient Readmission Rates	
The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest rate from 21.4% in 2021 to 18.7% with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2022 to 19% in 2022. Individual facility rates were reported as well for each of the five facilities.	
Previous Validation Score	Current Validation Score
74/75=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 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 discharged 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 6: Improving Pregnancy Outcomes PIP

Improving 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. This PIP has a DOM goal rate of 94.92% for the HEDIS Timeliness of Prenatal care rate. The baseline rate was 92.21% and the remeasurement number three rate was 96.84%. This rate reflects an improvement in the visit rate and exceeds the goal rate.	
Previous Validation Score	Current Validation Score

Improving Pregnancy Outcomes	
80/80=100% 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 7: Respiratory Illness Management PIP

Respiratory Illness Management	
Respiratory Illness examines the appropriate medications (bronchodilators or systemic corticosteroids) for members with COPD exacerbations based on HEDIS measures, as well as the asthma medication ratio HEDIS measures. For bronchodilators, the baseline was 74.96%, 76.36% in 2021, and the 2022 rate was 78.40%, which demonstrates improvement. Corticosteroids improved from 42.24% at baseline, to 49.89% in 2021, and improving again in 2022 to 50.76%. The AMR baseline was 70.7% and increased to 75.79% for 2022.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Clinical practice consultants visit high-volume practices to discuss Clinical Practice Guidelines and evidence-based Quality Performance Guidelines and assist with interpreting patient care opportunity reports. • Pharmacy outreach to ensure members have educational materials, prescriptions are filled and assist with overrides or claims issues related to prescribed inhalers. • Communication with clinics regarding non-compliant members, patient care opportunity reports, and provider education.	

Table 8: Sickle Cell Disease Management Decreasing ER Utilization PIP

Sickle Cell Disease Management Decreasing ER Utilization
The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28%,

Sickle Cell Disease Management Decreasing ER Utilization	
decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%. Thus, the most recent rate did not show improvement in year over year trending.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Outreach to providers encouraging the use of hydroxyurea for patients who do not have a pharmacy claim for hydroxyurea. • Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients. • Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments. • Telehealth campaigns and after-hour care newsletters. • Weekly interdisciplinary rounds for Case Management. • Provider education with the After Hour Care newsletter.	

This year, United submitted the same four CHIP PIPs 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 9: 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 declined from 40.16% to 39.96%. This is below the goal rate of 41.36%. The rate for 18 - 21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%.	
Previous Validation Score	Current Validation Score
80/80 = 100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)
• 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 members to receive educational materials regarding wellness visits and immunizations.

Table 10: 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. The PIP report showed that the 30-day follow up rate improved from 65.8% in 2021 to 67.48% in 2022, exceeding the goal rate of 59.42%. The 7-day follow up rate improved from 35.11% in 2021 to 41.1% in 2022. The goal rate for United is 38.95%.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay. • Continue demographic workflow to improve capture of current contact numbers for enrollees. • Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCP to communicate relevant treatment information involving member care. • Network notes and Optum news and updates for UBH clinicians and facilities. • Case management initiates calls to schedule follow-up appointments.	

Table 11: 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. The BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93% with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66% with a goal rate of 68.61%.	
Previous Validation Score	Current Validation Score
100/100=100% High Confidence in Reported Results	94/95=100% Hight Confidence in Reported Results

Reducing Adolescent and Childhood Obesity
Interventions
• Member and provider education. • Phone calls to noncompliant members. • After-hours and weekend clinic days. • 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 12: 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. The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%.	
Previous Validation Score	Current Validation Score
100/100=100% High Confidence in Reported Results	94/95=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)

Constellation Quality Health's review of United's Utilization Management (UM) Program included program descriptions, relevant policies, medical necessity determination processes, the Member Handbook, the Provider Manual, and a sample of approval, denial, appeal, and care management files.

The 2023 CAN and CHIP Utilization Management (UM) Program Description, CAN and CHIP Pharmacy Program Description, CAN and CHIP Optum Behavioral Health Utilization Management Program Description and Work Plan outline United's UM objectives, scope of activities, and program structure for medical, behavioral health, and pharmacy services.

United's Chief Medical Officer provides clinical oversight of all clinical activities of the UM Program. The Behavioral Health Medical Director and Pharmacy Director provide clinical

oversight of their respective programs. Clinical reviews are conducted by actively licensed professionals that hold current licensure within their clinical specialties and utilize external and internal clinical guidelines to perform UM determinations. Nonclinical staff provide administrative support to the clinical staff. Constellation Quality Health's review of the sample approval and denial files reflected files were performed according to contractual regulations.

United conducts monthly case audits for UM Reviewers and annual Inter-Rater Reliability (IRR) tests are conducted for physicians and non-physician clinical reviewers to measure consistency in application of clinical criteria. Based upon the results, the UM Reviewers and Medical Directors exceeded the target goal.

During the previous EQR, Constellation Quality Health noted that the notice sent to members, CAN and CHIP UM Program Descriptions, policy, the CAN and CHIP Provider Manuals, and in the CAN and CHIP Member Handbooks did not mention the member's right to file a grievance when the health plan requested an extension. It is noted that in this EQR that United corrected the previously identified issue and informed the members of their right to file a grievance when an extension is requested in the previously stated materials.

OptumRx is the pharmacy benefit manager and is responsible for implementing pharmaceutical services. The CAN and CHIP Member Handbook, Provider Manual and Pharmacy Program Description provide an overview of the Preferred Drug List (PDL). During the previous EQR, Constellation Quality Health identified that the links provided in the CAN Member Handbook to access the PDL and a listing of over the counter (OTC) medicines resulted in an error message indicating "page not found." It was noted during this EQR that the embedded links in the CAN Member Handbook worked appropriately.

Various Program Descriptions and policies provide a descriptive overview of the program's scope, case management process, and care management programs for members. Members are referred for care management services through various referral sources and the health plan shared that IPro is a predictive modeling system that is utilized to aid in identifying potential members for care management. Also, providers are provided awareness of the case management program and referral process through various methods. New members are screened for appropriateness of case management services by completion of a health risk assessment (HRA and an individualized care plan is developed based upon the identified needs.

Processes for handling appeals are outlined in United's Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, in the CAN and CHIP Member Handbook, the Provider Manual, and website. Appeals are defined as an adverse benefit determination and indicate that appeals may be filed at any time by the member, legal guardian, authorized representative, or service provider. The timelines for the appeals acknowledgment, resolution, and extension if needed are consistently outlined in United's

materials specific to the Contract guidelines. However, inconsistencies regarding the right to appeal verbally without written follow-up was discussed onsite with references to three documents.

A sample of CAN and CHIP appeals files were reviewed and found that there were issues with language in acknowledgment and resolution letters that did not appear to match the filer. For example, some appeals filed by a provider contained member-specific wording. The Written Consent or Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf for CAN and CHIP appeals files. The sample files reviewed for both CAN and CHIP found that timely resolution was consistent overall.

Transitional case management is also offered to members to provide transitions of care for members across healthcare settings. The Interdisciplinary Team of physicians, care managers, nurses work collaboratively to ensure proper care coordination. A sample of United's CAN and CHIP care management files was submitted for review. The files indicate that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and submitted additional information post onsite, there were identified issues in reference to the transitional care management activities provided CHIP members regarding documentation of notes that entail a follow-up schedule of the member's progress and case closure.

Delegation

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

For this review, United reported six delegation agreements. Those delegated entities included Optum Behavioral Health, Dental Benefit Providers, Medical Transportation Management, eviCore National, MARCH Vision Care, and OptumRX. All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process.

Each subcontractor's performance is subject to a formal review at least once a year. For the 2022 EQR, Constellation found this annual review was not conducted for some of the delegated entities. For this EQR, United provided the annual evaluation for all entities.

Corrective Action Plans and Recommendations from Previous EQR

During the 2022 EQR for CAN, 11 standards were scored as "Partially Met" and no standards were scored as "Not Met." For CHIP, 12 standards were scored as "Partially Met" and no standards were scored as "Not Met." The following provides a high-level summary of those deficiencies:

- The benefits grid in the CAN Provider Manual indicated well child care is not covered. This was an issue previously identified during the 2021 EQR.
- The behavioral health benefits grids in the CAN and CHIP Provider Manuals listed peer support services but did not indicate whether these services are covered or not. This issue was also noted in the CHIP Member Handbook. These issues were previously identified during the 2021 EQR.
- The CHIP Provider Manual did not include the 7-day timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge. This was a repeated finding from the 2021 EQR.
- 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."
- The benefits information on page 38 of the CAN Member Handbook indicates well child care is not covered. This was a repeated finding from the 2021 EQR.
- The behavioral health benefits grid on page 39 of the CAN Member Handbook and on page 32 of the CHIP Member Handbook list peer support services but do not indicate whether these are covered or not. Onsite discussion confirmed these services are covered. These issues were previously identified during the 2021 EQR.
- The CAN and CHIP Member Handbooks offer 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 or on United's website.
- The notice sent to CAN and CHIP members regarding the need for an extension of the grievance resolution timeframe does not offer the member the right to file a grievance related to the extension.
- The notices sent to CAN and CHIP members when United requests an extension for completing a UM decision did not include 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, policies, the CAN and CHIP Provider Manuals, or the CAN and CHIP Member Handbooks.
- Links provided in the CAN Member Handbook to access the listing of OTC medicines and the PDL resulted in an error message indicating "Page Not Found." This issue was identified during a previous EQR and CCME recommended the link be corrected.

- United's website, the CAN and CHIP Member Handbook, and the CAN and CHIP Provider Manual incorrectly required members to follow a verbal appeal with a written appeal.
- The notices sent to CAN and CHIP members of an extension of the appeal resolution timeframe, the CAN and CHIP Member Handbooks, the CAN and CHIP Provider Manuals, and United's website did not inform members of their right to file a grievance if they disagree with the extension, as required by the *CAN* and *CHIP Contracts, Section 6*, and *42 CFR § 438.408 (c)*.
- The "Your Additional Rights" enclosure did not include the requirement that CHIP 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. This was a repeated finding from the 2021 EQR.
- The following issues were identified in the sample of CAN and CHIP appeal files reviewed:
    - The rationales in resolution notices in five CAN files and four CHIP files were not written in language clear and understandable to members and did not clearly indicate the physician who made the appeal decision.
    - The acknowledgement letter for one CAN file was not sent within the 10-calendar day requirement.
    - None of the CHIP resolution notices informing the member that the denial was upheld included the information that members have a right to request and receive benefits while the Independent External Review is pending.
- CAN and CHIP delegate oversight 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. Issues noted with documentation of delegation oversight include:
    - Optum Behavioral Health (CAN and CHIP) — There was no documentation of a formal annual evaluation for case management, utilization management, and quality management activities.
    - Medical Transportation Management (MTM) (CAN only)—There was no documentation of a formal annual evaluation of delegated services.
    - eviCore National (CAN and CHIP) — There was no documentation of a formal annual evaluation for delegated services.
    - MARCH Vision Care (CAN and CHIP) — There was no documentation of a formal annual evaluation for call center services, network adequacy, credentialing, and recredentialing.

- Optum RX (CAN and CHIP) — There was no documentation of a formal annual evaluation of delegated services.

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 13: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of United's compliance scores relative to each of the 13 Subpart D and QAPI standards above that were reviewed for United.

Table 13: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	30	30	100%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	28	28	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	24	24	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	36	90%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	4	4	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. C	16	16	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	8	8	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	38	38	100%
• Disenrollment Requirements and Limitations (§ 438.56)	Member Services, Section III. D	2	2	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Enrollee Rights Requirements (§ 438.100)	Member Services, Section III. A	6	6	100%
• Emergency and Post Stabilization Service (§ 42 C.F.R. 438.114)	Utilization Management, Section V. B	2	2	100%

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

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

- For Grievance and Appeal Systems, issues were noted related to appeal filing requirements in policies and on the CCO's website, appeal acknowledgement and resolution letters not addressed to members, and lack of written consent or appointment of representative when providers filed appeals on members' behalf.

Table 14, Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2022 review. For 2023, 184 of 188 standards received a score of "Met." Four standards were scored as "Partially Met."

Table 14: Scoring Overview - CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	31	0	0	0	0	31	100%
2023	31	0	0	0	0	31	100%
Provider Services							
2022	82	2	0	0	0	84	97.6%
2023	47	2	0	0	0	49	95.9%
Member Services							
2022	30	3	0	0	0	33	90.9%
2023	33	0	0	0	0	33	100%
Quality Improvement							
2022	19	0	0	0	0	19	100%
2023	19	0	0	0	0	19	100%
Utilization							
2022	49	5	0	0	0	54	90.7%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2023	52	2	0	0	0	54	96.3%
Delegation							
2022	1	1	0	0	0	2	50%
2023	2	0	0	0	0	2	100%
Totals							
2022	212	11	0	0	0	223	95.1%
2023	184	4	0	0	0	188	97.9%

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

Table 15, Scoring Overview—CHIP, provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2022 review. For 2023, 182 (97.8%) out of 186 standards received a score of "Met." Four standards were scored as "Partially Met."

Table 15: Scoring Overview - CHIP

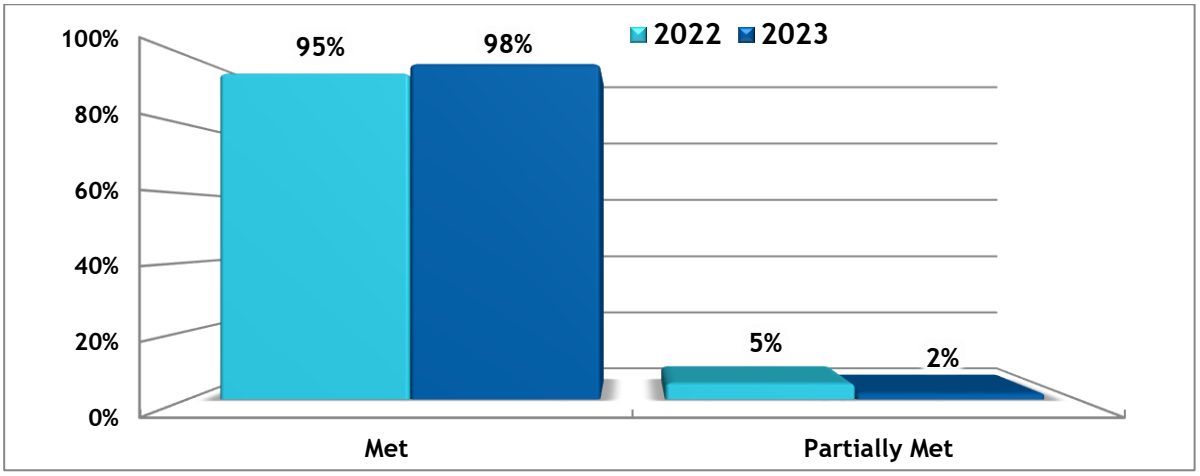
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	31	0	0	0	0	31	100%
2023	31	0	0	0	0	31	100%
Provider Services							
2022	80	3	0	0	0	83	96.4%
2023	47	1	0	0	0	48	97.9%
Member Services							
2022	29	3	0	0	0	32	90.6%
2023	32	0	0	0	0	32	100%
Quality Improvement							
2022	19	0	0	0	0	19	100%
2023	19	0	0	0	0	19	100%
Utilization							
2022	49	5	0	0	0	54	90.7%
2023	51	3	0	0	0	54	94.4%
Delegation							

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2022	1	1	0	0	0	2	50%
2023	2	0	0	0	0	2	100%
Totals							
2022	209	12	0	0	0	221	94.6%
2023	182	4	0	0	0	186	97.8%

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

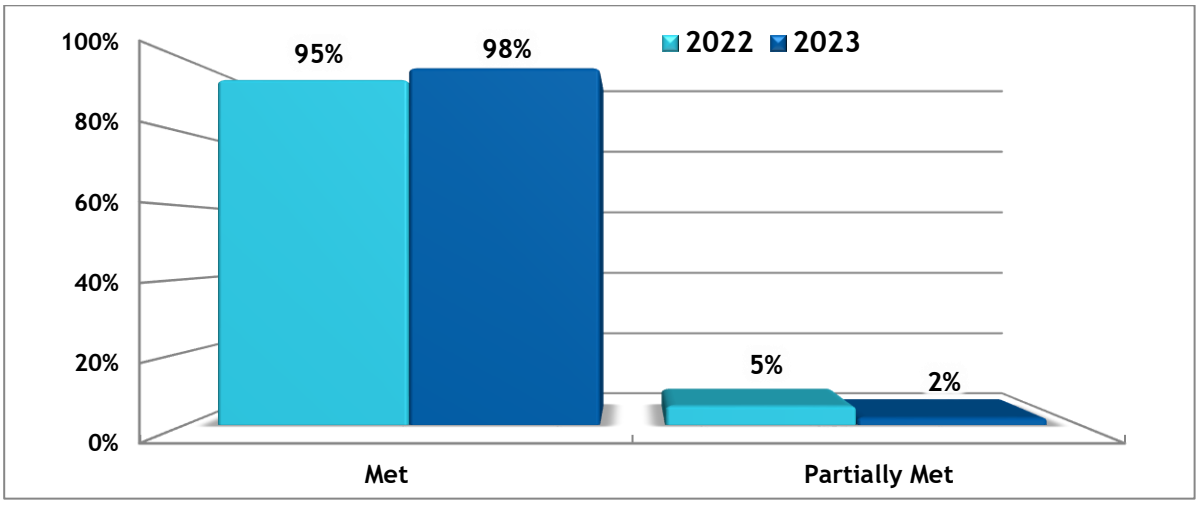
The 2023 Annual EQR for CAN shows that United achieved "Met" scores for 97.9% of the standards reviewed, and 2.1% of the standards were scored as "Partially Met." For CHIP, 97.8% of the standards were scored as "Met" and 2.2% were scored as "Partially Met."

Figure 1: Annual EQR Comparative Results – CAN



Scores were rounded to the nearest whole number.

Figure 2: Annual EQR Comparative Results – CHIP



Scores were rounded to the nearest whole number.

Recommendations and Opportunities for Improvements

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 16: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for policy development and ongoing review. Policies are housed in locations that are readily accessible by staff.	✓		
All key positions are filled, and overall staffing is sufficient.	✓		
United processes claims within timeframes that exceed DOM requirements.	✓		
Policies and procedures are well outlined and adhere to HITRUST standards for review and testing	✓		
Processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse are thoroughly documented in the UnitedHealthcare Compliance Program document, the UnitedHealthcare Anti-Fraud, Waste and Abuse Program, the UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program, and related policies and procedures.	✓		
The Code of Conduct: Our Principles of Ethics & Integrity provides comprehensive information to guide staff about expectations for appropriate business conduct.	✓		
Mandatory new hire and ongoing compliance training is provided to all employees, vendors, subcontractors, and employees of related business units who conduct activities on behalf of United.	✓		
Provider Services			
United appropriately documents geographic and appointment access standards for its provider network and conducts appropriate activities to evaluate the adequacy of the network.			✓
The Multicultural Health Care Program is in place to reduce health disparity and improve culturally and linguistically appropriate services for United's membership. United routinely evaluates the cultural competence of the network by assessing member and practitioner race, ethnicity, and languages at least every three years, addressing any gaps identified, and monitoring member satisfaction with the network.			✓
The printed CAN and CHIP Provider Directories and online "Doctor Lookup" tools include all required elements.			✓
The CCO conducts appropriate activities to validate Provider Directory information.			✓
Processes are in place for comprehensive initial and ongoing provider education.	✓		
United adopts preventive health and clinical practice guidelines, educates providers about the guidelines, and assesses provider compliance with the guidelines.	✓		
Provider Access Study successful contact rate increased from the previous year's rate.			✓
Member Services			

Strengths	Quality	Timeliness	Access to Care
Members are educated about their rights and responsibilities in multiple ways, and rights and responsibilities are consistently documented across policies, Member Handbooks, Provider Manuals, and the CCO's website.	✓		
New members are educated about the health plan, programs, benefits, and various processes and requirements through the Member Handbooks, websites, the new member packet, welcome calls, newsletters, etc.			✓
Appropriate processes are in place for notifying members of changes in benefits, services, and the provider network.			✓
United ensures member materials are written at an appropriate reading level and are available in alternate formats. Translation and interpretation services are also provided.			✓
Call Center staff use approved scripts that are reviewed at least annually, revised as needed, and presented to DOM for review and approval. Call center staff receive routine education about the Medicaid program, the CAN and CHIP programs, crisis calls, etc. during quarterly and ad hoc staff meetings and periodic updates.	✓		
Call center performance is monitored to identify opportunities for improvement with action taken to address any identified opportunities. All call center performance metrics were met in 2022.	✓		
Member satisfaction results for Child and Adult are examined internally and presented and addressed in QMC meetings	✓		
All CAN and CHIP grievance files reviewed for the 2023 EQR were resolved timely with the appropriate notifications to the filer.		✓	
Quality Improvement			
The 2022 Quality Improvement & Population Health Management Annual Evaluation Report (CHIP and CAN) was detailed and contained a review and results of all aspects of the program.	✓		
The CAN and CHIP PIPs met the validation requirements and received scores within the High Confidence range.	✓		
United's HEDIS auditor found that the CCO was fully compliant with all information systems Standards and determined that United submitted valid and reportable rates for all HEDIS measures in 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. Aqurate determined that United followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.	✓		
The following HEDIS MY 2022 measure rates had a greater than 10 percentage point improvement: • Follow-up After High -Intensity Care for Substance Use Disorder (FUI) (CAN), 7 days (18-64) and 7 days total indicators improved by over 10 percentage points. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) (CAN), all 6 indicators improved by over 12 percentage points. • Follow-up care for children prescribed ADHD Medication (ADD) (CHIP), both Initiation Phase and Continuation and Maintenance (C&M) Phase indicators improved by over 13 percentage points. • Follow-Up After Emergency Department Visit for Mental Illness (FUM) (CHIP), the 6-17 years 30-day and 7-day follow-up indicators improved by over 12 percentage points.	✓		

Strengths	Quality	Timeliness	Access to Care
• Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) (CHIP), the Blood Glucose testing for 1-11 indicator improved by over 12 percentage points. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) (CHIP), for the 12-17 age group indicator improved by over 12 percentage points. • Chronic Obstructive Pulmonary Disease (COPD) or Asthma in older adults' admission rate (PQI-05) (CAN). Age 65+ and Total indicators improved by over 10 percentage points. • Developmental Screening in the first 3 years of life (DEV-CH), Age 1 screening improved by over 10 percentage points for the CAN and CHIP population and Total screening indicator improved by over 10 percentage points for the CAN population. • Sealant Receipt on Permanent First Molars (SFM-CH) (CAN) (CHIP), all indicators improved by over 15 percentage points. • Topical Fluoride for Children (TLF-CH) all indicators besides the Ages 1-2 and Ages 19-20 indictors for Rate 2 improved by over 17 percentage points for the CAN population. All indicators besides the Ages 1-2 indictor for Rate 2 improved by over 13 percentage points for the CHIP population. • Oral Evaluation, Dental Services (OEV_CH), all indicators besides the Age <1 indicator improved by over 10 percentage points for the CAN and CHIP population.			
Utilization Management			
Approval files were completed in a timely manner according to contractual standards.		✓	
Denial files provided a clear understanding of the reasoning of the Adverse Benefit Decision and the appeals process.	✓		
Inter Rater Reliability scores results were 99% for Clinicians and Medical Directors and 96% for Behavioral Health UM Reviewers, exceeding the targeted goal of 90%.	✓		
The 2023 EQR found that appeals files were processed in a timely manner overall.		✓	
Delegation			
United measures compliance and performance of all delegated vendors. No issues were identified.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Provider Services				
For Non-Contracted Providers, page 10 of the CAN Care Provider Manual, there is no information that prior authorization is needed.	Recommendation: Revise the CAN Care Provider Manual, page 10, to indicate prior authorization may be required for visits with non-contracted providers.			✓
For Dental Services, page 7 of the CHIP Care Provider Manual includes exclusions for members over 21 years old. However, eligibility for	Recommendation: Remove exclusion information for members over 21 for dental service on page 7 of the CHIP Care Provider Manual. Revise the CHIP Care Provider			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
CHIP does not include those over 21 years old. Page 10 of the Care Provider Manual does not indicate prior authorization is required for visits to non-contracted providers.	Manual, page 10, to indicate prior authorization may be required for visits with non-contracted providers.			
Page 53-54 of the CHIP Care Provider Manual addresses the PCP to follow up "with members who are not compliant with the well-child and well-baby screening requirement and well-child and well-baby services." The manual instructs the reader to "See well-child section in this manual for more information." However, no "well-child" section was identified in the Provider Manual.	Recommendation: Revise the CHIP Care Provider Manual to include the referenced "well child" section or revise the information on pages 53-54 to remove the reference to the section.			✓
The CAN Care Provider Manual lists medical record documentation requirements and states the provider must have a policy for medical record retention but does not indicate the requirement for medical record retention.	Corrective Action: Revise the CAN Care Provider Manual to include the required timeframe for medical record retention.	✓		
Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the CAN Care Provider Manual or CHIP Care Provider Manual. Refer to the *CAN Contract, Section 7 (H) 2 (r)* and to the *CHIP Contract, Section 7 (H) 2 (r)*.	Corrective Action: Revise the CAN Care Provider Manual and CHIP Care Provider Manual to include information about requirements for a PCP to request reassignment of a member to another PCP.			✓
Response rates for provider satisfaction surveys remain low (1%) and may affect generalizability of the results.	Recommendation: Continued efforts should be made to gather a better representation of the providers.	✓		
Member Services				
For Non-Contracted Providers on page 38 of the CAN Member Handbook, there is no information that prior authorization is needed. There was a discrepancy between the CAN Member Handbook and CAN Care Provider Manual regarding Prescribed Pediatric Extended Care. The CAN Member Handbook, page 39, does not include the restriction found in the	Recommendation: Revise the CAN Member Handbook, page 38, to indicate prior authorization may be required for visits with non-contracted providers. On page 39 of the CAN Member Handbook, include the restriction for Prescribed Pediatric Extended Care that is noted in the CAN Care Provider Manual that the benefit is limited to those under 21.			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Provider Manual, page 11, that this benefit is limited to those under 21.				
For Dental Services, page 32 of the CHIP Member Handbook includes exclusions for members over 21 years old. However, eligibility for CHIP does not include those over 21 years old. Page 38 of the CHIP Member Handbook does not indicate prior authorization is required for visits to non-contracted providers.	Recommendation: Remove exclusion information for members over 21 for dental service on page 32 of the CHIP Member Handbook. Revise the CHIP Member Handbook, page 38, to indicate prior authorization may be required for visits with non-contracted providers.			✓
Information about coverage for family planning services is noted in the CHIP Member Handbook, page 13. However, no information was noted in the CHIP Member Handbook indicating benefits include direct access for female members to a women's health specialist in addition to a PCP.	Recommendation: Revise the CHIP Member Handbook to include information that benefits include direct access for female members to a women's health specialist in addition to a PCP.			✓
Information was not identified in the CHIP Member Handbook regarding the timeframe for member notification of a provider's departure from the network.	Recommendation: Revise the CHIP Member Handbook to include information that members will be notified within 14 days of receiving notice that a provider is leaving the network.		✓	
As noted during the previous EQR, the CAN Member Handbook, page 56, and the CHIP Member Handbook, page 49, state, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." However, the language from the *CAN Contract, Section 5 (K)* lists the agency as the "State Survey and Certification Division of the State Department of Health."	Recommendation: Revise the agency name indicated above on page 56 of the CAN Member Handbook and on page 49 of the CHIP Member Handbook.	✓		
The CAN Member Handbook and the CHIP Member Handbook indicate a Mental Health Crisis Line is available but do not indicate the hours of operation. Onsite discussion confirmed the Mental Health Crisis Line is available 24 hours a day.	Recommendation: Add the hours of operation for the Mental Health Crisis Line to the CAN Member Handbook and to the CHIP Member Handbook.			✓
For both CAN and CHIP, no policy was identified that addresses processes and requirements for member disenrollment.	Recommendation: Develop a policy to address processes and requirements related to member disenrollment.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Response rates for member satisfaction surveys remain low and may affect generalizability of the results	Recommendation: Continued efforts should be made to gather a better representation of the members for the member satisfaction surveys.	✓		
Quality Management				
In the CAN and CHIP Work Plans there was a typo regarding which QI Program Description was presented to the Quality Management Committee for approval.	Recommendation: Correct the information regarding the QI Program Descriptions that was presented to the Quality Management Committee for approval.	✓		
Several of the CAN and CHIP PIPs showed a decline in some of the rates being measured.	Recommendation: Assess the current interventions and consider any sub-analysis of reports to determine if specific subsets of the population are impacting improvements in the rates.	✓		
The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for United since their rates had a greater than 10% decline: • Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) (CAN) had a greater than 20 percentage point decline. This can be attributed to the small eligible population. • Antidepressant Medication Management (AMM) (CHIP), the Effective Continuation Phase Treatment indicator had a greater than 10 percentage point decline. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) (CHIP), 1-11 Years indicator had more than a 16 percentage point decline. • Hearth Failure Admission Rate (PQI-08) (CAN), the Age 65+ indicator declined by over 10 percentage points. • Diabetes Short-Term Complications Admission Rate (PQI01-AD) (CHIP), all indicators declined by over 10 percentage points.	Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.	✓		
During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-	Recommendation: Improve processes around oversight of the software vendor and ensure they are following specifications	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and United's vendor corrected the source code. United confirmed that the corrected source code was used to calculate the final rates.	when calculating the DOM required performance measures.			
Utilization Management				
The 2023 Care Management Model Program Description and Addendum and Policy NCM 002 Case Management Process provide an overview of the Health Risk Assessment. Policy NCM 002 Case Management Process is applicable to CAN and CHIP members as shared during onsite discussion. However, the policy does not reference CHIP Line of Business.	Recommendation: Please add CHIP reference to Policy NCM 002 Case Management Process as this is applicable to CHIP Contract, Section 8 (A) (1).	✓		
A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, there were three CHIP transitional care management files that did not have ongoing documentation of notes that entail a follow up schedule of the members' progress and process of case closure.	Corrective Action: Please ensure to obtain and accurately document a follow up schedule of the members' process receiving transitional care management services.	✓		

METHODOLOGY

The process Constellation Quality Health 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 four federally mandated EQR activities of compliance determination, validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On July 5, 2023, Constellation Quality Health 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 Constellation Quality Health 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 Constellation Quality Health requested.

The review consisted of two segments. The first was a desk review of materials and documents received from United on August 4, 2023, for review at the Constellation Quality Health offices (see *Attachment 1*).

The second segment was a virtual onsite review conducted on October 4, 2023, and October 5, 2023. 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 spreadsheets included in each of the following sections.

A. Administration

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

Constellation Quality Health's review of the Administration section includes policy management processes, health plan staffing, information management systems capabilities, compliance, program integrity, and processes to ensure confidentiality of health information.

United has established processes and guidelines for developing, reviewing, revising, and implementing policies, procedures, and standard operating procedures. Whenever possible, United adopts national policies for local health plan use. To ensure staff are aware of state-specific requirements, riders or addenda are attached to the corporate policies. All policies are reviewed at least annually, with revisions made as needed to maintain compliance with contractual requirements, laws, regulations, and accreditation standards. New policies and policy revisions are initially reviewed by the Policy and Review Steering Committee and then reviewed by other committees, as applicable, including the Health Quality Utilization Management (HQUM) Committee and Service Quality Improvement Subcommittee (SQIS). Final approval of all policies is given by the Quality Management Committee (QMC). Policies and procedures are housed on a SharePoint site for employee access, and staff are routinely educated about new and revised policies in a variety of ways.

Review of the Organizational Chart and onsite discussion confirmed staffing is sufficient to ensure all required activities can be conducted and all contractually required services are provided to members. All key positions are filled, and few vacancies are noted in other positions.

The UnitedHealthcare Compliance Program (Compliance Plan) and the UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2022-2023 (MS FWA Plan Addendum) identify the CCO's Compliance Officer and provide information about the roles and responsibilities of corporate and health plan Compliance Officers. The MS FWA Plan Addendum provides information about the health plan's Compliance Oversight Committee, its membership, quorum requirements, roles, and responsibilities.

Information about processes and activities to prevent, detect, and address violations of laws and policies is found in the UnitedHealthcare Compliance Program (Compliance Plan). The UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 (FWA Plan) and its related Mississippi addendum address processes and activities for preventing, detecting, and responding to actual or suspected FWA by employees, members, providers, suppliers, and contractors. Additional detailed information about all these processes is found in related policies.

The Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) covers five values related to business practice and conduct, including integrity, compassion, relationships, innovation, and performance. The Code of Conduct provides detailed information about who staff may contact when they have questions or concerns; expectations for behavior, accountability, and maintaining the privacy and security of information; appropriate use of assets and resources; communication; and maintaining a safe and inclusive work environment.

United maintains a core compliance training curriculum. Employee orientation includes mandatory compliance training encompassing the Code of Conduct, Privacy, Security Awareness, Conflicts of Interest, Fraud, Waste, and Abuse Prevention, etc. All employees, as well as vendors, subcontractors, and others who conduct activities on behalf of United are required to complete annual compliance training.

United encourages reporting of compliance and/or FWA issues through internal resources such as managers, senior management, Compliance Officers, the compliance hotline, and the Compliance and Ethics Help Center. Avenues are available for anonymous reporting, and a "no retaliation" policy is in force.

Health Information Systems

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

United provided appropriate documentation to demonstrate that it has the systems and processes capable of meeting both the contractual and information system requirements defined by DOM. The infrastructure systems and processes are managed in accordance with policies and procedures that prioritize system security and resilience while adhering to the industry standard. United performs routine risk assessment protocols to identify and aid in risk identification and in the implementation of preventative measures. Policy revisions are clearly marked which demonstrate regular revisions and updates to organization documentation.

Confidentiality

§ 438.224

Policies, the Compliance Plan, the Code of Conduct, and related materials address processes for ensuring the confidentiality of protected information. Compliance training includes expectations for maintaining the confidentiality of applicable information.

Figure 3: Administration Findings

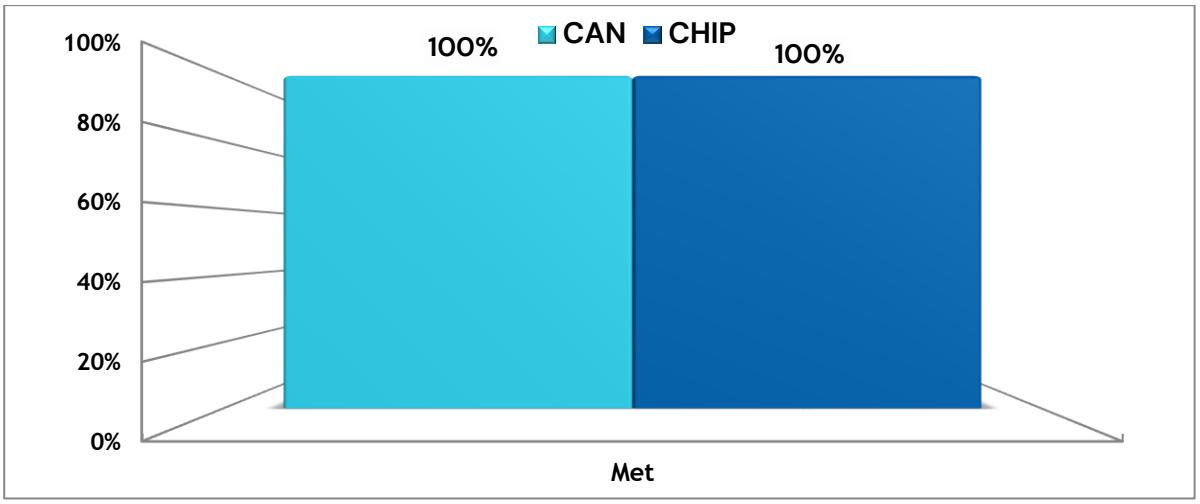


Table 17: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for policy development and ongoing review. Policies are housed in locations that are readily accessible by staff.	✓		
All key positions are filled, and overall staffing is sufficient.	✓		
United processes claims within timeframes that exceed DOM requirements.	✓		
Policies and procedures are well outlined and adhere to HITRUST standards for review and testing	✓		
Processes and activities to ensure compliance with laws and regulations and to prevent, detect, and respond to actual or suspected fraud, waste, and abuse are thoroughly documented in the UnitedHealthcare Compliance Program document, the UnitedHealthcare Anti-Fraud, Waste and Abuse Program, the UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program, and related policies and procedures.	✓		
The Code of Conduct: Our Principles of Ethics & Integrity provides comprehensive information to guide staff about expectations for appropriate business conduct.	✓		
Mandatory new hire and ongoing compliance training is provided to all employees, vendors, subcontractors, and employees of related business units who conduct activities on behalf of United.	✓		

ADMINISTRATION—CAN

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					Processes and guidelines for developing, reviewing, revising, and implementing policies, procedures, and standard operating procedures are found in Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures. National policies are adopted for local health plan use, with riders or addenda attached as needed to address State requirements. Policies are reviewed annually, with new policies and policy revisions presented to the Policy and Review Steering Committee and then reviewed by other committees, including the Health Quality Utilization Management (SQUM) Committee and Service Quality Improvement Subcommittee (SQIS). Final approval of all policies is given by the Quality Management Committee (QMC). Policies and procedures are housed on SharePoint for employee access and are also maintained in a shared file folder. Staff education about new and revised policies through team/staff meetings, ad hoc, and email.
I B. Organizational Chart / Staffing						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Michael Parnell is the Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Latrina McClenton is the Chief Operating Officer
1.3 Chief Financial Officer;	X					Chandler Ewing is the Chief Financial Officer.
1.4 Chief Information Officer;	X					The Chief Information Officer is Jim Solinsky.
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 serves as the Provider Services Manager. Onsite discussion confirmed she is in Alabama, but DOM has approved this deviation from the contract requirement for in-state location for this position.
1.6.1 *Provider contracting and education;	X					Staffing includes two teams who conduct provider education and network management activities. Of 17 staff across these teams, all but two are located within MS.
1.7 *Member Services Manager;	X					Kenisha Potter is the Member Services Manager.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					Alicia Fields is the Delegated Services and Appeals Manager, and Jennie Jenkins is the Appeals & Grievances Coordinator.
1.9 Utilization Management Coordinator;	X					Kim Bollman is the Health Services Director. Jennifer Brumfield is the Population Health Director, and Utilization Management Clinical Directors are Heather Ramos (inpatient) and Michelle Miller (outpatient).
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Senior Director of Clinical Quality.
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. She is an MS-licensed MD specializing in Pediatrics.
1.13 *Compliance Officer.	X					Charles Lechmaier is the Chief 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)*						
1. The CCO processes provider claims in an accurate and timely fashion.	X					United's percent paid claim average timeframe for 30 and 90 days exceeds Mississippi's timeliness requirements. United paid over 99% of clean claims

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						within 30 days and averaged almost 100% of clean claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United's ISCA documentation and onsite discussion confirms that the organization collects and stores enrollment and member demographic data using HIPAA compliant transaction formats and code sets. The enrollment data is processed and stored in the encounter data submission and reporting system, NEMIS. The system tests the data for accuracy, completeness, logic, and consistency via validation checks against state provided enrollment and provider information. United uses the system to submit encounter data to DOM 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 confirmed that United has the appropriate information system capability to perform required data collection and reporting functions. HEDIS and HEDIS-like reporting is performed by United using systems and industry standard software. In addition to verifying data with its systems, staff review performance measure reporting data for accuracy. United uses NCQA certified measure production software to produce HEDIS measure rates and other CMS adult and child core set measures rates. These rates are then reviewed and audited to ensure accuracy and completeness.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Business continuity and disaster recovery plans are in place to mitigate any incidents and restore service if an incident occurs. The disaster recovery 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. United updates its business continuity plans twice yearly. The Disaster Recovery and Business Continuity plans adhere to strict industry standards and ensure execution of protocols and policies in the event of a catastrophic event.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					The UnitedHealthcare Compliance Program (Compliance Plan) describes processes and activities to prevent, detect, and address violations of laws, policies, etc. The UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 (FWA Plan) addresses processes and activities related prevention, detection, and responses to FWA by providers, such as physicians, hospitals, pharmacies, treatment facilities, and other health care professionals or suppliers. It also addresses fraud and/or inappropriate or unethical conduct by employees, members, and contractors.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program 2022-2023 (MS FWA Plan Addendum) provides additional information about requirements and processes specific to Mississippi. A host of related documents and policies provide additional information.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) covers five values related to business practice and conduct, including integrity, compassion, relationships, innovation, and performance. Included in the Code of Conduct is information about: • Who to contact with questions or concerns. • Behavior and accountability expectations • Expectations for maintaining the privacy and security of information. • Appropriate use of assets and resources • Communication • Maintaining a safe and inclusive work environment Each individual section of the Code of Conduct specifies resources related to the topic addressed

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and references to specific policies from which more information can be obtained.
2.2 Identification of the Compliance Officer;						The Compliance Plan and the MS FWA Plan Addendum identify the CCO's Compliance Officer and provide information about the roles of the corporate and health plan Compliance Officers. The UnitedHealthcare Chief Compliance Officer is responsible for the implementation, strategy, and oversight of the corporate Compliance Program. Health plan Compliance Officers are responsible for oversight of health plan Compliance Programs and related activities. The CCO's Compliance Officer is accountable to the CCO's Chief Executive Officer.
2.3 Information about the Compliance Committee;						The MS FWA Plan Addendum provides information about the health plan's Compliance Oversight Committee, its membership, quorum requirements, roles, and responsibilities.
2.4 Compliance training and education;						As noted in Policy ID-6069, UnitedHealthcare Compliance Training & Education Policy, United maintains a core compliance training curriculum to ensure ongoing education for employees. New employee orientation includes mandatory compliance training encompassing the Code of Conduct, Privacy, Security Awareness, Conflicts of Interest, Fraud, Waste, and Abuse Prevention, etc. All employees, as well as vendors, subcontractors, and employees of related business units who conduct activities on behalf of United, are required to complete annual compliance training. Also, additional

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						role-focused or specialized compliance training may be required for certain staff based on business or job function. Electronic records of completion of required online training are maintained in United's online Learning Management System. In addition to online core compliance training, specialized training may be conducted through in-person sessions, web-based training, live or videotaped presentations, written training materials, etc. Records are maintained of completion of training through these additional forums. Network providers receive compliance training at initial provider orientation and through monthly Provider Advocate calls.
2.5 Lines of communication;						As noted in the Compliance Plan, the Compliance Program ensures that a communication and awareness strategy is in place to ensure effective communication to all employees, contractors, suppliers, and all other appropriate parties of compliance resources, initiatives, expectations, and other projects. United supports open and effective communication between the Compliance Officer and all employees, committee members, contractors, suppliers, and regulators by encouraging reporting of compliance and/or FWA issues through internal resources such as managers, senior management, Compliance Officers, the compliance hotline, and the Compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Ethics Help Center. Employees, contractors, etc. are required to report actual or suspected compliance and FWA issues and are subject to disciplinary action for failure to report. Avenues are available for anonymous reporting and a "no retaliation" policy is enforced.
2.6 Enforcement and accessibility;						The Compliance Plan and Code of Conduct include information about disciplinary actions that may be implemented when compliance issues are identified. The disciplinary guidelines are also included in the Employee Handbook, and published through training courses, intranet sites, newsletters, etc. All compliance violations, as well as violations of the law, the Code of Conduct, policies, and/or contractual obligations are taken seriously, and consistent disciplinary action is taken, and may include verbal and written warnings, suspension, and/or termination. Individuals may face legal action for criminal or illegal activities.
2.7 Internal monitoring and auditing;						The Compliance Plan addresses auditing and monitoring activities. Auditing activities are conducted to determine compliance with regulatory requirements including state and federal regulations. Monitoring activities are conducted to identify, prevent, and address organizational risk. Detailed information is included in Policy ID-6070, UnitedHealthcare Compliance Auditing & Monitoring Policy. Activities include:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• External regulatory audits and market conduct exams • Internal compliance audits to assess compliance with state/federal regulations, applicable laws, regulatory guidelines, contractual obligations, policies, and procedures. Business processes are also evaluated to identify opportunities to improve efficiency and to improve quality. • Internal compliance monitoring and risk mitigation activities to identify and prevent noncompliance with business regulatory requirements and to address any issues with effective corrective actions. • Business Monitoring to measure effectiveness is conducted within business, functional, and operational areas, including quality monitoring, performance measurement, and operational compliance monitoring, using established protocols for documentation, tracking, trending, and reporting.
2.8 Response to offenses and corrective action;						United's Compliance Plan states the health plan supports coordination across the organization to "promptly respond to suspected misconduct, ensure appropriate corrective action, and government agency reporting if required, for identified non-compliance." United reviews all credible concerns for further action, including inquiries, investigations, implementation of corrective or disciplinary actions, and reporting as required/applicable to regulatory authorities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Exclusion status monitoring.						The FWA Plan states United regularly queries and reviews federal and state sources for information about exclusions and/or sanctions. Policy ID-5881, New Hire and Periodic Employee Sanction Review, states United monitors employees, contractors, and suppliers by conducting background checks, sanctions checks, monthly CMS Precluded Provider List checks, and other specific database checks. For employees, monthly checks include the Office of Inspector General/General Services Administration (OIG/GSA), System for Award Management (SAM), United States Treasury non-SDN OFAC Sanction, Center for Medicare and Medicaid Precluded Provider List, and applicable State Medicaid sanction lists. The MS FWA Plan Addendum describes processes for monitoring network providers for sanctions and exclusions. As noted, the CCO monitors the Mississippi Sanctioned Provider List, as well as the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and the List of Excluded Individuals/Entities (LEIE) at enrollment and reenrollment as well as monthly. UHC notifies Optum Program Integrity (PI) of any providers that will be terminated within 48 hours, including the reason(s) for and date of termination, and any termination notification sent to the provider. The CCO must also notify PI of any providers who

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						have voluntarily terminated to avoid an audit and/or investigation.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					United provided a copy of the Community and State Health Plan Compliance Oversight Committee Charter. The charter describes the purpose and primary objective of the committee as assisting the CCO and Compliance Officer in developing and implementing the Compliance Program. The charter includes a listing of additional roles and responsibilities of the committee. Committee membership includes senior executive leadership and the Compliance Officer. The committee meets at least twice yearly, is co-chaired by the Compliance Officer and Chief Executive Officer, and a quorum is established with the presence of at least 51% of the voting members.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Processes for preventing, detecting, and responding to potential or suspected fraud, waste, and abuse are found in the Compliance Plan, FWA Plan, and related policies and documents.
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					The MS FWA Plan Addendum describes processes for payment suspensions and recoupments by the CCO and its subcontractors.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					The MS FWA Plan Addendum and the UnitedHealthcare Community & State Pharmacy

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Description include an overview of the Pharmacy Lock-in Program. Detailed information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program.
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					Policies, the Compliance Plan, the Code of Conduct, and related materials address processes for ensuring the confidentiality of protected information. Compliance training includes expectations for maintaining the confidentiality of applicable information.

ADMINISTRATION—CHIP

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					Processes and guidelines for developing, reviewing, revising, and implementing policies, procedures, and standard operating procedures are found in Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures. National policies are adopted for local health plan use, with riders or addenda attached as needed to address State requirements. Policies are reviewed annually, with new policies and policy revisions presented to the Policy and Review Steering Committee and then reviewed by other committees, including the Health Quality Utilization Management (SQUM) Committee and Service Quality Improvement Subcommittee (SQIS). Final approval of all policies is given by the Quality Management Committee (QMC). Policies and procedures are housed on SharePoint for employee access and are also maintained in a shared file folder. Staff education about new and revised policies through team/staff meetings, ad hoc, and email.
I B. Organizational Chart / Staffing						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Chief Executive Officer;	X					Michael Parnell is the Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Latrina McClenton is the Chief Operating Officer
1.3 Chief Financial Officer;	X					Chandler Ewing is the Chief Financial Officer.
1.4 Chief Information Officer;	X					The Chief Information Officer is Jim Solinsky.
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 serves as the Provider Services Manager. Onsite discussion confirmed she is in Alabama, but DOM has approved this deviation from the contract requirement for in-state location for this position.
1.6.1 *Provider contracting and education;	X					Staffing includes two teams that conduct provider education and network management activities. Of 17 staff across these teams, all but two are located within MS.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Member Services Manager;	X					Kenisha Potter 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 and Appeals Manager, and Jennie Jenkins is the Appeals & Grievances Coordinator.
1.9 Utilization Management Coordinator;	X					Kim Bollman is the Health Services Director. Jennifer Brumfield as the Population Health Director, and Utilization Management Clinical Directors are Heather Ramos (inpatient) and Michelle Miller (outpatient).
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Senior Director of Clinical Quality.
1.11 *Marketing and/or Public Relations;	X					
1.12 *Medical Director;	X					Dr. Dana Carbo Bryant is the Chief Medical Officer. She is an MS-licensed MD specializing in Pediatrics.
1.13 *Compliance Officer.	X					Charles Lechmaier is the Chief 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 claim average timeframe for 30 and 90 days exceeds Mississippi's timeliness requirements. United paid 99% or more clean claims within 30 days and averaged almost 100% of clean claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					ISCA documentation and onsite discussion confirms that the organization collects and stores enrollment and member demographic data using HIPAA-compliant transaction formats and code sets. The enrollment data is processed and stored in the encounter data submission and reporting system, NEMIS. The system tests the data for accuracy, completeness, logic, and consistency via validation checks against state provided enrollment and provider information. United uses the system to submit encounter data to DOM 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 confirmed that United has the appropriate information system capability to perform required data collection and reporting functions. HEDIS and HEDIS-like reporting is performed using systems and industry standard software. In addition to verifying data with its systems, staff review performance measure reporting data for accuracy. United uses NCQA certified measure production software to produce HEDIS measure rates and other CMS adult and child core set measures rates. These rates are then

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviewed and audited to ensure accuracy and completeness.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					Business continuity and disaster recovery plans are in place to mitigate any incidents and restore service if an incident occurs. The disaster recovery 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. United updates its business continuity plans twice yearly. The Disaster Recovery and Business Continuity plans adhere to strict industry standards and ensure execution of protocols and policies in the event of a catastrophic event.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					The UnitedHealthcare Compliance Program (Compliance Plan) describes processes and activities to prevent, detect, and address violations of laws, policies, etc. The UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 (FWA Plan) addresses processes and activities related prevention, detection, and responses to FWA by providers, such as physicians, hospitals, pharmacies, treatment facilities, and other health care professionals or suppliers.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						It also addresses fraud and inappropriate/unethical conduct by employees, members, and contractors. The UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program 2022–2023 (MS FWA Plan Addendum) provides additional information about requirements and processes specific to Mississippi. A host of related documents and policies provide additional information.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) covers five values related to business practice and conduct, including integrity, compassion, relationships, innovation, and performance. Included in the Code of Conduct is information about: • Who to contact with questions or concerns. • Behavior and accountability expectations • Expectations for maintaining the privacy and security of information. • Appropriate use of assets and resources • Communication • Maintaining a safe and inclusive work environment. Each individual section of the Code of Conduct specifies resources related to the topic addressed

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and references to specific policies from which more information can be obtained.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The Compliance Plan and the MS FWA Plan Addendum identify the CCO's Compliance Officer and provide information about the roles of the corporate and health plan Compliance Officers. The UnitedHealthcare Chief Compliance Officer is responsible for the implementation, strategy, and oversight of the corporate Compliance Program. Health plan Compliance Officers are responsible for oversight of health plan Compliance Programs and related activities. The CCO's Compliance Officer is accountable to the CCO's Chief Executive Officer.
2.3 Information about the Compliance Committee;						The MS FWA Plan Addendum provides information about the health plan's Compliance Oversight Committee, its membership, quorum requirements, roles, and responsibilities.
2.4 Compliance training and education;						As noted in Policy ID-6069, UnitedHealthcare Compliance Training & Education Policy, United maintains a core compliance training curriculum to ensure ongoing education for employees. New employee orientation includes mandatory compliance training encompassing the Code of Conduct, Privacy, Security Awareness, Conflicts of Interest, Fraud, Waste, and Abuse Prevention, etc. All employees, as well as vendors, subcontractors, and employees of related business units who conduct activities on behalf of United, are required to complete annual compliance training. Also,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						additional role-focused or specialized compliance training may be required for certain staff based on business or job function. Electronic records of completion of required online training are maintained in United's online Learning Management System. In addition to online core compliance training, specialized training may be conducted through in-person sessions, web-based training, live or videotaped presentations, written training materials, etc. Records are maintained of completion of training through these additional forums. Network providers receive compliance training at initial provider orientation and through monthly Provider Advocate calls.
2.5 Lines of communication;						As noted in the Compliance Plan, the Compliance Program ensures that a communication and awareness strategy is in place to ensure effective communication to all employees, contractors, suppliers, and all other appropriate parties of compliance resources, initiatives, expectations, and other projects. United supports open and effective communication between the Compliance Officer and all employees, committee members, contractors, suppliers, and regulators by encouraging reporting of compliance and/or FWA issues through internal resources such as managers, senior management, Compliance Officers, the compliance hotline, and the Compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Ethics Help Center. Employees, contractors, etc. are required to report actual or suspected compliance and FWA issues and are subject to disciplinary action for failure to report. Avenues are available for anonymous reporting and a "no retaliation" policy is in force.
2.6 Enforcement and accessibility;						The Compliance Plan and Code of Conduct include information about disciplinary actions that may be taken for compliance issues. The disciplinary guidelines are also included in the Employee Handbook, and published through training courses, intranet sites, newsletters, etc. All compliance violations, as well as violations of the law, the Code of Conduct, policies, and/or contractual obligations are taken seriously, and consistent disciplinary action is taken, and may include verbal and written warnings, suspension, and/or termination. Individuals may face legal action for criminal or illegal activities.
2.7 Internal monitoring and auditing;						The Compliance Plan addresses auditing and monitoring activities. Auditing activities are conducted to determine compliance with regulatory requirements including state and federal regulations. Monitoring activities are conducted to identify, prevent, and address organizational risk. Detailed information is included in Policy ID-6070, UnitedHealthcare Compliance Auditing & Monitoring Policy. Activities include: • External regulatory audits and market conduct exams

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Internal compliance audits to assess compliance with state/federal regulations, applicable laws, regulatory guidelines, contractual obligations, policies, and procedures. Business processes are also evaluated to identify opportunities to improve efficiency and to improve quality. • Internal compliance monitoring and risk mitigation activities to identify and prevent noncompliance with business regulatory requirements and to address any issues with effective corrective actions. Business Monitoring to measure effectiveness is conducted within business, functional, and operational areas, including quality monitoring, performance measurement, and operational compliance monitoring, using established protocols for documentation, tracking, trending, and reporting.
2.8 Response to offenses and corrective action;						United's Compliance Plan states the health plan supports coordination across the organization to "promptly respond to suspected misconduct, ensure appropriate corrective action, and government agency reporting if required, for identified non-compliance." United reviews all credible concerns for further action, including inquiries, investigations, implementation of corrective or disciplinary actions, and reporting as required/applicable to regulatory authorities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Exclusion status monitoring.						The FWA Plan states United regularly queries and reviews federal and state sources for information about exclusions and/or sanctions. Policy ID-5881, New Hire and Periodic Employee Sanction Review, states United monitors employees, contractors, and suppliers by conducting background checks, sanctions checks, monthly CMS Precluded Provider List checks, and other specific database checks. For employees, monthly checks include the Office of Inspector General/General Services Administration (OIG/GSA), System for Award Management (SAM), United States Treasury non-SDN OFAC Sanction, Center for Medicare and Medicaid Precluded Provider List, and applicable State Medicaid sanction lists. The MS FWA Plan Addendum describes processes for monitoring network providers for sanctions and exclusions. As noted, the CCO monitors the Mississippi Sanctioned Provider List, as well as the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and the List of Excluded Individuals/Entities (LEIE) at enrollment and reenrollment as well as monthly. UHC notifies Optum Program Integrity (PI) of any providers that will be terminated within 48 hours, including the reason(s) for and date of termination, and any termination notification sent to the provider. The CCO must also notify PI of any

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers who have voluntarily terminated to avoid an audit and/or investigation.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					United provided a copy of the Community and State Health Plan Compliance Oversight Committee Charter. The charter describes the purpose and primary objective of the committee as assisting the CCO and Compliance Officer in developing and implementing the Compliance Program. The charter includes a listing of additional roles and responsibilities of the committee. Committee membership includes senior executive leadership and the Compliance Officer. The committee meets at least twice yearly, is co-chaired by the Compliance Officer and Chief Executive Officer, and a quorum is established with the presence of at least 51% of the voting members.
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Processes for preventing, detecting, and responding to potential or suspected fraud, waste, and abuse are found in the Compliance Plan, FWA Plan, and related policies and documents.
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					The MS FWA Plan Addendum describes processes for payment suspensions and recoupments by the CCO and its subcontractors.
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					The MS FWA Plan Addendum and the UnitedHealthcare Community & State Pharmacy

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Description include an overview of the Pharmacy Lock-in Program. Detailed information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program.
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					Policies, the Compliance Plan, the Code of Conduct, and related materials address processes for ensuring the confidentiality of protected information. Compliance training includes expectations for maintaining the confidentiality of applicable information.

B. Provider Services

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

The review for Provider Services includes adequacy of the provider network, provider education about health plan processes and requirements, development of and education about clinical practice and preventive health guidelines, provider medical record documentation standards and medical record audits, and the provider satisfaction survey.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Policy PS14, Provider Orientation Plan, describes United's processes for new provider orientation, which is conducted within the first 30 days of the contract effective date. 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. Ongoing provider education is conducted to keep providers informed of any changes that would impact them as providers within United's network.

In addition to formal provider education processes, the CAN and CHIP Care Provider Manuals are comprehensive resources of information for providers. Minor issues were noted with documentation in the Care Provider Manuals, including:

- In the benefits grid on page 10 of the CAN Care Provider Manual and on page 10 of the CHIP Care Provider Manual, there is no information that prior authorization is needed for visits with non-contracted providers.
- For Dental Services, page seven of the CHIP Care Provider Manual includes exclusions for members over 21 years old; however, eligibility for CHIP does not include those over 21 years old.
- Page 53 of the CHIP Care Provider Manual refers the reader to the "well-child section" of the manual; however, no well-child section was identified in the Provider Care Manual.
- The CAN Care Provider Manual states the provider must have a policy for medical record retention but does not specify the required timeframe for medical record retention.
- Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the CAN Care Provider Manual or in the CHIP Care Provider Manual. Refer to the *CAN Contract, Section 7 (H) 2 (r)* and the *CHIP Contract, Section 7 (H) 2 (r)*.

United defines requirements for provider medical record documentation in health plan policy and educates providers about the standards in the CAN and CHIP Care Provider Manuals. An annual medical record audit is conducted to assess provider compliance with the medical record documentation standards. For the 2022 Medical Record Audit of PCPs, 20 clinics were included in the sample. Of the 20, 14 met the scoring threshold of 85% or more. One clinic did not submit records, and five of the 20 clinic record chases were cancelled due to the provider using a copy service. For the EPSDT/Well Child/Well Baby Audit, 19 providers were included in the random sample. 15 of the 19 scored 85% or more. Four of the 19 clinic record chases were canceled due to the provider using a copy service.

For provider education, deficiencies noted during the previous (2022) EQR and the current status of the deficiencies are noted in the following table.

Table 18: 2022 Provider Education CAP Items

Standard	2022 EQR Findings	2023 EQR Findings
CAN		
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	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.	The issues identified during the previous EQR related to documentation of well child care and peer support services were corrected.
United's 2022 Response: The CAN Provider Manual (pages 11-12) has been revised to indicate well child care and peer support services are covered. SUPPORTING DOCUMENTATION: 01, 06, 08, 09 2022.12.15 CAN-Care Provider-Manual RED DRAFT.docx		
3. The CCO regularly maintains and makes available a Provider Directory that includes 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	The review confirmed that United addressed a corrective action from the 2022 EQR to revise Policy NQM-052 to include the correct timeframe for

Standard	2022 EQR Findings	2023 EQR Findings
	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.*	updating the online Provider Directory.
United's 2022 Response: Policy NQM-052, Web-Based Directory Usability Testing (V.C on page 2), has been revised to include the correct timeframe for updating the online Provider Directory SUPPORTING DOCUMENTATION: 02,14 2022.12.14 Policy NQM-052, Web-Based Directory Usability Testing.docx		
CHIP		
2. Initial provider education includes: 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;	A listing of covered and excluded benefits is found in the CHIP Provider Manual. 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.	The issues identified during the previous EQR related to documentation of peer support services were corrected.
United's 2022 Response: The CHIP Care Provider Manual (page 10) and CHIP Member Handbook (page 35) have been revised to indicate peer support services are covered. SUPPORTING DOCUMENTATION: 12, 13, 18-20 2022.12.20 CHIP Care Provider Manual REDDRAFT.docx and 12, 15, 18-20 2022.12.22 CHIP Member handbook.pdf.		
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	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.*	The issue identified during the previous EQR related to documentation of timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge was corrected.
United's 2022 Response: The CHIP Care Provider Manual (page 57) has been revised to include the 7-day timeframe from appointments post discharge from an acute psychiatric hospital when CCO is aware of the discharge.		

Standard	2022 EQR Findings	2023 EQR Findings
SUPPORTING DOCUMENTATION: 12, 13, 18-20 2022.12.20 CHIP Care Provider Manual REDDRAFT.docx		

Practice Guidelines

§ 438.236, § 457.1233

United adopts clinical practice and preventive health guidelines from nationally recognized sources to guide quality and health management programs. The preventive and clinical practice 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. The CAN and CHIP Care Provider Manuals include information about the PHGs and links to access the information on the website. Provider compliance with use of the guidelines is assessed primarily through the medical record audit process.

Provider Satisfaction Survey Validation

The provider satisfaction survey was administered by Escalent, an independent research company, on behalf of United. Of the 3,334 providers included in the provider sample, only 33 responded, yielding a response rate of 1.0%. This is a decrease from the previous year's rate of 1.2%. This very low response rate may not reflect the population of providers. Thus, results should be interpreted with caution.

The percentage of providers rating the overall satisfaction with United as a "10" on a scale from 0 to 10 increased from 2021 to 2022. The service experience was scored as excellent or good by 63% of providers; the ease of the appeals process was scored as excellent or good by 55%; and the credentialing process was scored as good/excellent for 75%.

Table 19 offers the section of the worksheet that needs improvement, along with the reason and recommendation.

Table 19: 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 3,334 sample providers, only 33 responded, creating a response rate of 1.0%. This is a decrease from last year's rate of 1.2%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution.	Continued efforts should be made to gather a better representation of the providers.

Network Adequacy Validation

42 CFR § 438.68 (a), 42 CFR § 438.14(b)(1) 42 CFR § 457.1218. 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Constellation Quality Health conducted a validation review of United's provider network following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the CCO is meeting network standards defined by the State. To validate United's network, Constellation Quality Health requested and reviewed:

- Member demographics, including total enrollment and distribution by age ranges, sex, and county of residence.
- Geographic access assessments, network development plans, enrollee demographic studies, population needs assessments, provider-to-enrollee ratios, in-network and out-of-network utilization data, provider panel size limitations.
- A complete list of network providers.
- The total numbers of unique primary care and specialty providers in the network.
- A completed Provider Network File Questionnaire.
- Provider Appointment Standards and health plan policies.
- Provider Manual and Member Handbook.
- Sample of a provider contract.

A desk review of these documents was conducted to assess network adequacy. In addition, the results of the most recent Telephone Access Study were considered.

Overall, United met the requirements of the Network Adequacy Validation. The results of the Telephone Access Study conducted by Constellation Quality Health in Q3 2023 identified weaknesses regarding the provider contact information and the availability of routine and urgent appointments. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

The following is an overview of the results for each activity.

Provider Network File Questionnaire

Constellation reviewed the Provider Network File Questionnaire. United uses CSP Facets as the provider data management system, and verification is conducted through a portal update based on status information from the State. Automated systems that validate the provider directory include My Practice Profile, roster processing, leveraging provider verification outreach campaigns to improve demographic data, internal demographic data exchange with CAQH monthly, and requesting that providers review variances in provider data and respond

to United. United plans to employ additional, enhanced tools such as Synaptic Health Alliance, Google API, and Trust Evaluator. The member facing Provider Directory is updated bi-weekly, and the online directory is updated daily except Sunday and Tuesday. The printed CAN and CHIP Provider Directories and online "Doctor Lookup" tools include all required elements. This confirmed that United corrected the deficiency related to the CHIP Provider Directory that was noted during the previous EQR. See *Table 20*.

Table 20: 2022 Provider Directory CAP Items

Standard	2022 EQR Findings	2023 EQR Findings
CHIP		
3. The CCO regularly maintains and makes available a Provider Directory that includes 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.*	The issue identified during the previous EQR related to documentation of timeframe for appointments post-discharge from an acute psychiatric hospital when CCO is aware of the discharge was corrected.
United's Response: Policy NQM-052, Web-Based Directory Usability Testing (V.D on page 2), has been revised to include the correct timeframe for updating the online Provider Directory. SUPPORTING DOCUMENTATION: 02, 14 2022.12.14 Policy NQM-052, Web-Based Directory Usability Testing.docx.		

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

CAN and CHIP geographic access standards for primary care providers (PCP), specialists, and other provider types are found in Policy PS3, Geographic Access Standards. The time and distance standards documented in the policy are compliant with contractual requirements. United develops quarterly Geographic access reports to evaluate its network against the required time and distance standards. These reports are delivered each quarter to DOM, as well as to the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis purposes. For The Quarterly Report on Accessibility of MississippiCAN Members dated July 10, 2023, indicates 99.2% of member have access to at least two PCPs within the required urban access standard, and 100% of members have access to PCPs within the required rural access standard. The corresponding Quarterly Report on Accessibility of

MississippiCHIP Members dated July 10, 2023, indicates 99.3% of member have access to at least two PCPs within the required urban access standard, and 100% of members have access to PCPs within the required rural access standard.

Onsite discussion revealed that although United does not currently contract with Indian Health Care Providers, members may see these providers as if they were in network. No authorization is required, and claims systems are set to pay Indian Health Care Providers at an in-network rate. Onsite discussion also revealed that United routinely monitors network providers' panel status, and as of the most recent analysis, only about 0.01% of the network providers have closed panels.

United documents appointment access standards in Policy PS2, Access Standards – Appointment Availability Requirements. The appointment availability standards defined in the policy comply with contractual requirements. United contracts with DialAmerica to conduct quarterly assessments of provider compliance with appointment access standards. The Service Quality Improvement Subcommittee monitors, tracks, and trends the results and uses them to identify opportunities for improvement. The most recent results submitted showed low successful answer rates for several provider categories. Additionally, compliance with required appointment access standards was low for several categories across PCPs, obstetrics and gynecology, and behavioral health providers. Onsite discussion revealed that United routinely educates providers about appointment access standard compliance.

As noted in the Quality Improvement Program Description, United's Multicultural Health Care Program 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 and conducts ongoing monitoring of member satisfaction with the network.

Provider Access and Availability Study

Constellation Quality Health conducts Telephonic Provider Access Studies twice yearly for each CCO. Full details of these call studies are reported to DOM separately. For the most recent studies for CAN and CHIP conducted in Q3 2023, improvement was shown from the previous study that was conducted in Q4 2022. See *Table 21* and *Table 22*.

Table 21: CAN Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q4 2022	40 out of 99	40%	<.001

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q3 2023	61 out of 92	55%	

Table 22: CHIP Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q4 2022	40 out of 99	55%	<.0395
Q3 2023	61 out of 92	40%	

CAN: For Q3 2023, United submitted a total of 2,110 unique PCPs for the CAN population and a random sample of 97 was drawn for Phase 1. Of the 97 PCPs contacted, five calls were answered by voicemail and thereby omitted from the denominator in the success rate formula. After accounting for the voicemail answered calls, the Phase 1 success rate was 55% (51 out of 92). This is a statistically significant improvement in successful contacts from the previous cycle's rate of 40% (p<.001). The routine appointment compliance rate was 23% and the urgent appointment compliance rate was 15%. Provider directory validation had an attempted 51 PCP verifications, and the accuracy rate was 86% (44 out of 51).

CHIP: For Q3 2023, United CHIP submitted a total of 2,014 unique PCPs and a random sample of 94 was drawn for Phase 1. of the 94 PCPs contacted, 11 were answered by voicemail and thereby omitted from the denominator in the success rate formula. After accounting for voicemail answered calls, the Phase 1 success rate was 40% (33 of 83). This is a statistically significant decline in successful contacts from the previous cycle's rate of 40% (p = .0395). The routine appointment compliance rate was 59% (improvement over previous cycle) and the urgent appointment compliance rate was 22% (decline over previous cycle). Provider directory validation had an attempted 33 PCP verifications, and the accuracy rate was 82% (27 out of 33), which was a decline from the previous cycle's rate of 89%.

The next call study will take place in February 2024.

As displayed in *Figure 4: 2023 Provider Services Findings*, 96% of the Provider Services standards were scored as "Met" for CAN, and 98% were scored as "Met" for CHIP.

Figure 4: Provider Services Findings

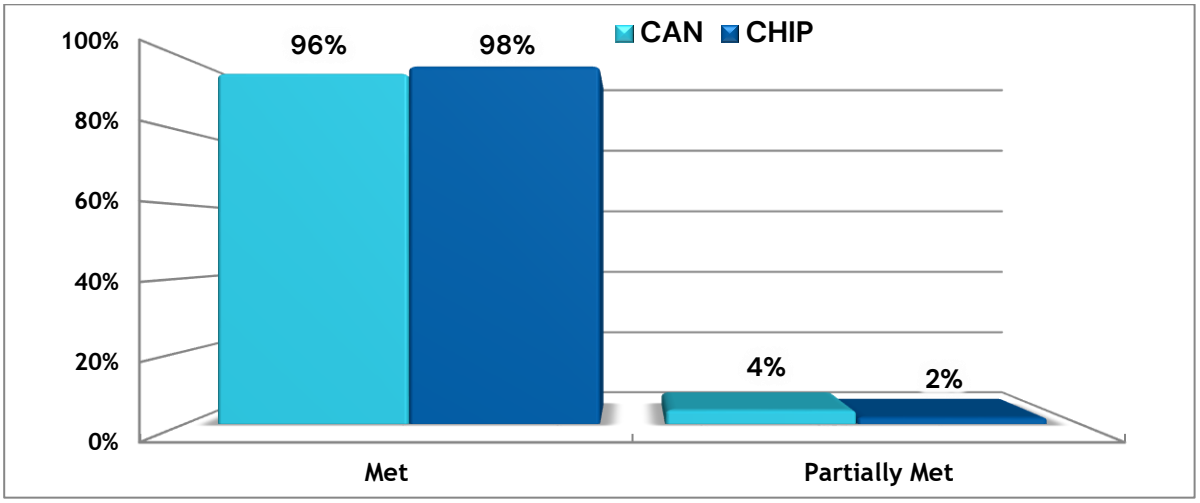


Table 23: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
United appropriately documents geographic and appointment access standards for its provider network and conducts appropriate activities to evaluate the adequacy of the network.			✓
The Multicultural Health Care Program is in place to reduce health disparity and improve culturally and linguistically appropriate services for United's membership. United routinely evaluates the cultural competence of the network by assessing member and practitioner race, ethnicity, and languages at least every three years, addressing any gaps identified, and monitoring member satisfaction with the network.			✓
The printed CAN and CHIP Provider Directories and online "Doctor Lookup" tools include all required elements.			✓
The CCO conducts appropriate activities to validate Provider Directory information.			✓
Processes are in place for comprehensive initial and ongoing provider education.	✓		
United adopts preventive health and clinical practice guidelines, educates providers about the guidelines, and assesses provider compliance with the guidelines.	✓		
Provider Access Study successful contact rate increased from the previous year's rate.			✓

Table 24: Provider Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
For Non-Contracted Providers, page 10 of the CAN Care Provider Manual, there is no information that prior authorization is needed.	Recommendation: Revise the CAN Care Provider Manual, page 10, to indicate prior authorization may be required for visits with non-contracted providers.			✓
For Dental Services, page 7 of the CHIP Care Provider Manual includes exclusions for members over 21 years old. However, eligibility for CHIP does not include those over 21 years old. Page 10 of the Care Provider Manual does not indicate prior authorization is required for visits to non-contracted providers.	Recommendation: Remove exclusion information for members over 21 for dental service on page 7 of the CHIP Care Provider Manual. Revise the CHIP Care Provider Manual, page 10, to indicate prior authorization may be required for visits with non-contracted providers.			✓
Page 53-54 of the CHIP Care Provider Manual addresses the PCP to follow up "with members who are not compliant with the well-child and well-baby screening requirement and well-child and well-baby services." The manual instructs the reader to "See well-child section in this manual for more information." However, no "well-child" section was identified in the Provider Manual.	Recommendation: Revise the CHIP Care Provider Manual to include the referenced "well child" section or revise the information on pages 53-54 to remove the reference to the section.			✓
The CAN Care Provider Manual lists medical record documentation requirements and states the provider must have a policy for medical record retention but does not indicate the requirement for medical record retention.	Corrective Action: Revise the CAN Care Provider Manual to include the required timeframe for medical record retention.	✓		
Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the CAN Care Provider Manual or CHIP Care Provider Manual. Refer to the *CAN Contract, Section 7 (H) 2 (r)* and to the *CHIP Contract, Section 7 (H) 2 (r)*.	Corrective Action: Revise the CAN Care Provider Manual and CHIP Care Provider Manual to include information about requirements for a PCP to request reassignment of a member to another PCP.			✓
Response rates for provider satisfaction surveys remain low (1%) and may affect generalizability of the results.	Recommendation: Continued efforts should be made to gather a better representation of the providers.	✓		

PROVIDER SERVICES—CAN

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Adequacy of the Provider Network *42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)*						
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Within 5 business days of receipt of the Member Listing Report from DOM, United notifies PCPs of enrollees assigned to them and of any changes to their panels through the secure provider portal and by mailing post card notifications. This process is described in Policy PS10, PCP Panel Notification.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					All providers (participating and non-participating) providers can verify member enrollment with United by using the secure provider portal. Member ID cards also provide a telephone number that may be used to verify enrollment. This information was identified in Policy PS4, Member Enrollment Verification.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Per onsite discussion, an element of routine monitoring of the provider network is providers' panel status. As of the most recent analysis, only 413 providers out of a total of 4258 providers have closed panels.
1.4 Members have two PCPs located within a 15-mile radius for urban	X					As noted in Policy PS3, Geographic Access Standards, United develops quarterly Geographic

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
counties or two PCPs within 30 miles for rural counties.						access reports to evaluate its network against contract requirements. These reports are delivered each quarter to DOM, as well as to the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis purposes. CAN geographic access standards for primary care providers (PCPs) are found in Policy PS3, Geographic Access Standards. As noted in the policy, the access standard for all PCPs is two within 15 miles (urban) and two within 30 miles (rural). The parameters are compliant with contractual requirements. The Quarterly Report on Accessibility of MississippiCAN Members dated July 10, 2023, indicates 99.2% of member have access to at least two PCPs within the required urban access standard, and 100% of members have access to PCPs within the required rural access standard. For CAN, 100% of members have access to an FQHC and 98.7% have access to an RHC. Onsite discussion revealed that although United does not currently contract with Indian Health Care Providers, members may see these providers as if they were in network. No authorization is required, and claims systems are set to pay Indian Health Care Providers at an in-network rate.

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					CAN geographic access standards are found in Policy PS3, Geographic Access Standards. The access standards noted in the policy correspond to those specified in the *CAN Contract, Section 7 (B)*.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Quarterly Geographic access reports are shared with the Service Quality Improvement Subcommittee (SQIS) for reporting, tracking, and trending. When issues of network noncompliance, gaps, or insufficiencies are identified, they are shared with Network Management for additional analysis, including the specific geographic area affected and any impact to the membership. This allows for identification of opportunities to address the issues. Network Management staff will engage with any identified provider targets; however, if there are no available providers within the geographic area, DOM is notified. Other internal departments, such as Case Management, work with affected members to ensure needs are met and care is continued. These processes are documented in Policy PS3, Geographic Access Standards.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical	X					As noted in the Quality Improvement Program Description, United's Multicultural Health Care Program (MHCP) is in place to reduce health disparity and improve culturally and linguistically

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
needs, and accessibility considerations.						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. • Evaluating for language and cultural gaps in the network every 3 years. • 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					
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					Constellation reviewed the Provider Network File Questionnaire (PNFQ). United uses CSP Facets as the data management system. Verification is conducted through a portal update based on status information from the State. The member-facing directory is updated bi-weekly for the paper-based directory; the online directory is updated daily except Sunday and Tuesday.
1.10 The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy PS13, Provider terminations, provides general guidelines for provider terminations, such as the timeline for notification of the provider and member notification.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Advisory Committee agenda (2/8/23) shows discussion of provider sanctions and terminations. Onsite discussion confirmed the Regional Peer Review Committee remains active. The Regional Peer Review 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.
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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					United contracts with Dial America to conduct quarterly appointment access and after-hours access call studies. The most recent results submitted showed low successful answer rates for several provider categories. Additionally, compliance with required appointment access standards was low for several categories across PCPs, obstetrics and gynecology, and behavioral health providers. Onsite discussion revealed that United routinely educates providers about appointment access standard compliance.
2.3 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 review confirmed that United addressed a corrective action from the 2022 EQR to 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	
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					The Narrative Provider Directory info document (in access availability folder 26) describes the use of automated systems that validate the provider directory, such as: • My Practice Profile • Roster processing • Leveraging Provider Verification Outreach campaigns to improve demographic data • Exchanging internal demographic data to CAQH monthly • Requesting that providers review variances and respond to United United plans to employ additional, enhanced tools such as "Synaptic Health Alliance, Google API, Trust Evaluator, My Practice Profile, and CAQH demographic maintenance. In addition, "UHC conducts internal quality reviews through the Provider Data Accuracy (PDA) Attestation Process. This process validates provider data through attestations, phone call campaigns to providers, and other methods. An attestation is a confirmation from a provider as to the accuracy of the provider's data that will display in our directories."
3. The CCO's provider network is adequate and is consistent with the requirements of	X					The State has established time/distance requirements for primary care, obstetrics and gynecology, and specialty providers. The methods

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the CMS protocol, "Validation of Network Adequacy."						used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated United and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.
II B. 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:						
2.1 A description of the Care Management system and protocols;	X					The CAN Provider Manual discusses Coordination of Care (for community–based health and preventive services) and Case Management services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					The CAN Care Provider Manual includes information about claims and billing processes, 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 grid that lists covered benefits is found in the CAN Care Provider Manual. For Non-Contracted Providers, page 10 of the CAN Care Provider Manual does not indicate that prior authorization is needed. *Recommendation: Revise the CAN Care Provider Manual, page 10, to indicate prior authorization may be required for visits with non-contracted providers.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					The Provider Manual, page 20, provides Referral Guidelines, including the responsibilities of Care providers for initiating and coordinating referrals, prior authorizations. Out of network PCP or specialists pre authorizations are handled on an individual bases.
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.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					Page 56 of the CAN Care Provider Manual lists services included under EPSDT. Page 57 states it is a provider's 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				The CAN Care Provider Manual lists medical record documentation requirements and states the provider must have a policy for medical record retention. However, the Care Provider Manual does not indicate the requirement for medical record retention. *Corrective Action Plan: Revise the CAN Care Provider Manual to include the required timeframe for medical record retention.*
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	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the emergency supply of medication until authorization is complete;						
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;		X				The CAN Care Provider Manual addresses the roles and responsibilities of PCPs. Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the CAN Care Provider Manual. Refer to the *CAN Contract, Section 7 (H) 2 (r).* *Corrective Action Plan: Revise the CAN Care Provider Manual to include information about requirements for a PCP to request reassignment of a member to another PCP.*
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	X					Information about the Quality Improvement Program and expectations for provider

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
utilization management criteria and processes;						participation in Quality Management are addressed in the CAN 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 provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, and that are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					The "Review of Clinical and Preventive Guidelines" policy 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. A policy titled, "Review of Clinical and Preventive Guidelines" states evidence-based clinical and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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 and clinical practice 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. 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.
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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II D. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy NQM-025, Ambulatory Medical Record Review Process, Attachment B, lists the provider medical record documentation standards. The standards are also documented in the CAN Care Provider Manual.
2. The CCO monitors compliance with medical record documentation standards	X					The 2022 Quality Program Evaluation documents results of the 2022 Medical Record Audit for PCPs.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
through periodic medical record audits and addresses any deficiencies with providers.						Out of 20 clinics evaluated, 14 scored 85% or more. One out of 20 providers did not submit records, and five out of 20 clinic record chases were cancelled due to the provider using a copy service. For the EPSDT/Well Child/Well Baby Audit, 19 providers were randomly selected, and 15 of the 19 scored 85% or more. Four of 19 clinic record chases were canceled due to the provider using a copy service.
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					The provider satisfaction survey was administered by Escalent, an independent research company, on behalf of United. Of the 3,334 providers included in the sample, only 33 responded, yielding a response rate of 1.0%. This is a decrease from last year's rate of 1.2%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. The percentage of providers rating the overall satisfaction with United as a "10" on a scale from 0 to 10 increased from 2021 to 2022. The service experience was scored as excellent or good by 63% of providers; the ease of the appeals process was scored as excellent or good by 55%; and the credentialing process was scored as good/excellent for 75%.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Continued efforts should be made to gather a better representation of the providers.
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					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. Results were presented to the QMC in June 2023 and to the Provider Advisory Committee in May 2023.

PROVIDER SERVICES—CHIP

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. 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), 42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The CCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						

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					Within five business days of receipt of the Member Listing Report from DOM, United notifies PCPs of enrollees assigned to them and of any changes to their panels through the secure provider portal and by mailing post card notifications. This process is described in Policy PS10, PCP Panel Notification.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					All providers (participating and non-participating) can verify member enrollment with United by using the secure provider portal. Member ID cards also provide a telephone number that may be used to verify enrollment. This information was identified in Policy PS4, Member Enrollment Verification.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Per onsite discussion, an element of routine monitoring of the provider network is the providers' panel status. As of the most recent analysis, only 413 providers out of a total of 4258 providers have closed panels.
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					As noted in Policy PS3, Geographic Access Standards, United develops quarterly Geographic access reports to evaluate its network against contract requirements. These reports are delivered each quarter to DOM, as well as to the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis purposes. CHIP geographic access standards for primary care providers (PCPs) are found in Policy PS3, Geographic Access Standards. As noted in the policy, the access standard for all PCPs is two

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						within 15 miles (urban) and two within 30 miles (rural). These parameters are compliance with contractual requirements. The Quarterly Report on Accessibility of MississippiCHIP Members dated July 10, 2023, indicates 99.3% of member have access to at least two PCPs within the required urban access standard, and 100% of members have access to PCPs within the required rural access standard. For CHIP, 100% of members have access to an FQHC and an RHC. Onsite discussion revealed that although United does not currently contract with Indian Health Care Providers, members may see these providers as if they were in network. No authorization is required, and claims systems are set to pay Indian Health Care Providers at an in-network rate.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.	X					CHIP geographic access standards are found in Policy PS3, Geographic Access Standards. The access standards noted in the policy correspond to those specified in the *CHIP Contract, Section 7 (B)*.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Quarterly Geographic access reports are shared with the Service Quality Improvement Subcommittee (SQIS) for reporting, tracking, and trending. When issues of network noncompliance, gaps, or insufficiencies are identified, they are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						shared with Network Management for additional analysis, including the specific geographic area affected and any impact to the membership. This allows for identification of opportunities to address the issues. Network Management staff will engage with any identified provider targets; however, if there are no available providers within the geographic area, DOM is notified. Other internal departments, such as Case Management, work with affected members to ensure needs are met and care is continued. These processes are documented in Policy PS3, Geographic Access Standards.
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 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. • Evaluating language and cultural gaps in the network every 3 years. • Monitoring member satisfaction, including experience with physicians and other providers. In addition, it was noted that "Effectiveness of Interventions on reduction of Health Care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Disparities based on the results of measurement of health care disparities the organization annually identifies and priorities opportunities to reduce health care disparities and improve Cultural Linguistic Appropriate Services."
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					Constellation reviewed the Provider Network File Questionnaire (PNFQ). United uses CSP Facets as the data management system. Verification is conducted through a portal update based on status information from the State. The member facing directory is updated bi-weekly for the paper-based directory; the online directory is updated daily except Sunday and Tuesday.
1.10 The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					Policy PS13, Provider terminations, provides general guidelines for provider terminations, such as the timeline for notification of the provider and member notification. The Provider Advisory Committee agenda (2/8/23) shows discussion of provider sanctions and terminations. Onsite discussion confirmed the Regional Peer Review Committee remains active. The Regional

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Peer Review 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.
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. 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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Improvement Subcommittee monitors, tracks, and trends the results and uses them to identify opportunities for improvement.
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					United contracts with Dial America to conduct quarterly appointment access and after-hours access call studies. The most recent results submitted showed low successful answer rates for several provider categories. Additionally, compliance with required appointment access standards was low for several categories across PCPs, obstetrics and gynecology, and behavioral health providers. Onsite discussion revealed that United routinely educates providers about appointment access standard compliance.
2.3 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 review confirmed that United addressed a corrective action from the 2022 EQR to revise Policy NQM-052 to include the correct timeframe for updating the online Provider Directory.
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					The Narrative Provider Directory info document (in access availability folder 26) describes the use of automated systems that validate the provider directory, such as: • My Practice Profile • Roster processing

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Leveraging Provider Verification Outreach campaigns to improve demographic data • Exchanging internal demographic data to CAQH monthly • Requesting that providers review variances and respond to United United plans to employ additional, enhanced tools such as Synaptic Health Alliance, Google API, Trust Evaluator, My Practice Profile, and CAQH demographic maintenance. In addition, "UHC conducts internal quality reviews through the Provider Data Accuracy (PDA) Attestation Process. This process validates provider data through attestations, phone call campaigns to providers, and other methods. An attestation is a confirmation from a provider as to the accuracy of the provider's data that will display in our directories."
3. The CCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The State has established time/distance requirements for primary care, obstetrics and gynecology, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated United and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information security practices have been implemented.
II B. 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:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					The CHIP Provider Manual discusses Coordination of Care (for community-based health and preventive services) and Case Management services.
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.
2.3 Member benefits, including covered services, benefit	X					A grid that lists covered benefits is found in the CHIP Care Provider Manual.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						For Dental Services, page 7 of the CHIP Care Provider Manual includes exclusions for members over 21 years old. However, eligibility for CHIP does not include those over 21 years old. Page 10 of the Care Provider Manual does not indicate prior authorization is required for visits to non-contracted providers. *Recommendation: Remove exclusion information for members over 21 for dental service on page 7 of the CHIP Care Provider Manual. Revise the CHIP Care Provider Manual, page 10, to indicate prior authorization may be required for visits with non-contracted providers.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					The CHIP Provider Manual, page 18, provides Referral Guidelines, including the responsibilities of Care providers for initiating and coordinating referrals, prior authorizations. Out of network PCP or specialists pre authorizations are handled on an individual basis.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					The CHIP Care Provider Manual correctly documents appointment access standards.
2.6 Recommended standards of care including Well-Baby and	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Well-Child screenings and services;						
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					Page 53 of the CHIP Care Provider Manual notes that it is a PCP responsibility to follow up "with members who are not compliant with the well-child and well-baby screening requirement and well-child and well-baby services." The bottom of page 53 and page 54 list the services included. The Care Provider Manual instructs the provider to "See well-child section in this manual for more information." However, no "well-child" was identified in the Provider Manual. *Recommendation: Revise the CHIP Care Provider Manual to include the referenced "well child" section or revise the information on pages 53-54 to remove the reference to the section.*
2.8 Medical record handling, availability, retention, and confidentiality;	X					The CHIP Care Provider Manual lists medical record documentation requirements and states the provider must have a policy for medical record retention. The manual indicates providers must retain records for a period of not less than 10 years from the close of the CHIP program agreement.
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
informed prescription choices and the emergency supply of medication until authorization is complete;						
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;		X				The CHIP Care Provider Manual addresses the roles and responsibilities of PCPs. Information that addresses contacting the health plan regarding assigning a member to an alternate PCP was not noted in the CHIP Care Provider Manual. Refer to the *CHIP Contract, Section 7 (H) 2 (r).* *Corrective Action Plan: Revise the CHIP Care Provider Manual to include information about requirements for a PCP to request reassignment of a member to another PCP.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					
II C. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(c)*						
1. The CCO develops preventive health and clinical practice guidelines for the care of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					The "Review of Clinical and Preventive Guidelines" policy 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.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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 preventive health and clinical practice guidelines and the expectation that they will be followed for CCO members to providers.	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. 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.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to member high-risk groups;	X					
3.5 Behavioral health.	X					
II D. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy NQM-025, Ambulatory Medical Record Review Process, Attachment B, lists the provider medical record documentation standards. The standards are also documented in the CHIP Care Provider Manual.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	X					The 2022 Quality Program Evaluation documents results of the 2022 Medical Record Audit for the EPSDT/Well Child/Well Baby. A total of 19 providers were randomly selected, and 15 of the 19 clinics scored 85% or more. Four of the 19 clinic record chases were canceled due to the provider using a copy service.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					The provider satisfaction survey was administered by Escalent, an independent research company, on behalf of United. Of the 3,334 providers included in the sample, only 33 responded, yielding a response rate of 1.0%. This is a decrease from last year's rate of 1.2%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. The percentage of providers rating the overall satisfaction with United as a "10" on a scale from 0 to 10 increased from 2021 to 2022. The service experience was scored as excellent or good by 63% of providers; the ease of the appeals process was scored as excellent or good by 55%; and the credentialing process was scored as good/excellent for 75%. *Recommendation: Continued efforts should be made to gather a better representation of the providers.*
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	X					The CCO reports to the appropriate committee on the results of the provider satisfaction survey and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provider satisfaction survey and the impact of measures taken to address quality problems that were identified.						the impact of measures taken to address quality problems that were identified. Results were presented to the QMC in June 2023 and to the Provider Advisory Committee in May 2023.

C. 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

The review of Member Services encompasses member rights and responsibilities, member education processes, call center activities and monitoring, member enrollment and disenrollment, the member satisfaction survey, and member requests for practitioner changes.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

Member rights and responsibilities are specified in Policy MBR4a, Notification of Rights, the CAN and CHIP Member Handbooks, and the Care Provider Manuals. Members may also view member rights and responsibilities on the website and can contact the health plan to request the information.

Member CCO Program Education

42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)

United provides an information packet to new members that includes an introduction letter, a Member Handbook, and instructions for accessing or requesting a copy of the Provider Directory. The Member ID card is sent in a separate mailing. The Member Support section of the CAN and CHIP Member Handbooks include information about services and functions available through the Member Services call center and the NurseLine, through the member portal, and information that is available on the website. In addition, welcome calls are placed to newly enrolled members to allow them to ask questions and to assist in selecting a PCP when needed.

The CAN and CAN Member Handbooks list the hours of operation for the Member Services Call Center, which are compliant with contractual requirements, and informs that the NurseLine is available 24 hours a day, 7 days a week. Both handbooks indicate a Mental Health Crisis Line is also available but do not indicate the hours of operation. Onsite discussion confirmed the Mental Health Crisis Line is available 24 hours a day.

The CAN and CHIP Member Handbooks are comprehensive resources for members to understand the health plan's processes, services, and requirements. The CAN and CHIP include grids listing benefits that are covered and any associated limitations. Issues noted with the documentation of benefits include:

- For Non-Contracted Providers, page 38 of the CAN Member Handbook and page 38 of the CHIP Member Handbook do not indicate prior authorization is needed.
- There was a discrepancy between the CAN Member Handbook and CAN Care Provider Manual regarding Prescribed Pediatric Extended Care. The CAN Member Handbook, page

39, does not include the age restriction found in the Provider Manual, page 11, for Prescribed Pediatric Extended Care.

- For Dental Services, page 32 of the CHIP Member Handbook includes exclusions for members over 21 years old. However, eligibility for CHIP does not include those over 21 years old.
- No information was noted in the CHIP Member Handbook indicating benefits include direct access for female members to a women's health specialist in addition to a PCP.

Information about processes and requirements for prior authorizations, obtaining care from out of network providers, is found throughout the CAN and CHIP Member Handbook. The handbooks also provide information about emergent and urgent care, examples of conditions for which each is appropriate, and processes for obtaining these types of care. The handbooks also include information to guide members in obtaining prescriptions, use of the Preferred Drug List, over the counter and injectable medication coverage, and the Pharmacy Lock-In Program. It also informs members of the availability of a 3-day emergency supply of medication.

Members are informed in the CAN Member Handbook that they will be notified in writing within 14 days before a change in benefits and services, and within 14 days of receiving notice of a provider's withdrawal from the network. The CHIP Member Handbook also indicates members will be notified in writing within 14 days before a change in benefits and services. However, the CHIP Member Handbook does not include the timeframe for member notification of a provider's departure from the network.

An overview of advance directives is found in the CAN Member Handbook and includes the types of advance directives that may be enacted and definitions of terminology. However, the CAN Member Handbook, page 56, and the CHIP Member Handbook, page 49, state, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." The *CAN Contract, Section 5 (K)* lists the agency as the "State Survey and Certification Division of the State Department of Health."

United has processes for ensuring member materials are developed in a manner to ensure they are easily understood by members. Member materials do not exceed a 6th-grade reading comprehension level, as confirmed by using the Flesch-Kincaid Readability Scale and appropriate fonts are used for regular and large-print materials. United can provide member materials in alternate languages and formats. Free translation and interpreter services are also offered.

Targets for call center performance/call metrics are defined by DOM. As noted in the 2023 Quality Improvement and Population Health Management Program Description (CAN and CHIP), Member Services call data is collected, analyzed, and monitored to identify

opportunities for improvement, and action plans are developed based on identified opportunities. The Service Quality Improvement Subcommittee monitors trends related to member and provider call center activities. Results of performance throughout 2022 indicated all performance metrics were met in 2022.

Call Center staff use approved scripts when interacting with members. These scripts are reviewed at least annually, revised as needed, and presented to DOM for review and approval. The scripts are available to staff electronically. Onsite discussion confirmed Call Center staff receive routine education about various topics, including the Medicaid program, the CAN and CHIP programs, and crisis calls, during quarterly and ad hoc staff meetings and periodic updates.

Preventive Health and Chronic Disease Management Education

The CAN and CHIP Member Handbooks include brief information about preventive health services and wellness programs. Members are instructed to contact Member Services with any questions or to get more information. The CAN and CHIP 2023 Quality Improvement and Population Health Management Program Descriptions state members are educated about population health activities and recommendations through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, and events such as health fairs and other health promotion events. In addition, members that are engaged with care managers are informed of services that are offered through the program in which they are enrolled.

Member Enrollment and Disenrollment

42 CFR § 438.56

No policy was identified that addresses processes and requirements for member disenrollment. However, the CAN and CHIP Member Handbooks addresses member disenrollment processes and requirements and instruct that members must contact DOM in writing or by telephone to request disenrollment and/or a change in health plan. The handbook indicates members may request disenrollment and/or to change plans without cause during the initial 90 days of enrollment, defines circumstances under which a member may request "for cause" disenrollment at any time, and describes circumstances under which a member may be involuntarily disenrolled.

Table 25: 2022 Member CCO Program Education CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including: 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.*	The issues identified during the previous EQR related to documentation of well child care and peer support services were corrected.
United's 2022 Response: The CAN Member Handbook (page 39-40) has been revised to indicate well child care and peer support services are covered. SUPPORTING DOCUMENTATION: 03, 04, 06-09, 16 2022.12.20 CAN Member handbook.pdf		
CHIP		
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: 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.*	The issues identified during the previous EQR related to documentation of peer support services were corrected.
United's 2022 Response: The CHIP Member Handbook (page 35) has been revised to indicate well child care and peer support services are covered. SUPPORTING DOCUMENTATION: 12, 15, 18-20 2022.12.22 CHIP Member handbook.pdf		

Grievances

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

United's processes for handling member grievances are found in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. This document, along with the CAN and CHIP Member Handbooks, Provider Manuals, and the CCO's website define grievance terminology and describe the options for filing grievances verbally or in writing at any time. Timelines for resolving or extending grievances were outlined consistently throughout United's member and provider materials. The UHC CAN Notice of Extension Letter was corrected from the previous EQR to include the member's right to file a grievance if they disagree with the extension.

United's Standard Operating Procedures (SOP) provide instructions and training information on the steps for documenting grievances by the Customer Care Call Center staff. Grievances are logged according to the contractual guidelines and are analyzed internally to address potential patterns.

A sample of United's CAN and CHIP grievance files was reviewed for the current EQR. All CAN and CHIP grievance files reviewed were processed timely with appropriate resolution notifications noted. One CAN file included an acknowledgement letter that exceeded the acknowledgement timeframe outlined in Policy POL2015-01.

The following table details the 2022 EQR findings and CAP response items specific to grievance standards.

Table 26: 2022 Grievances CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
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: 1.2 The procedure for filing and	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.*	The issues identified during the previous EQR related to the offering of an expedited appeal process to members were corrected.

Standard	EQR Comments	2023 EQR Findings
handling a grievance;		
United's 2022 Response: UHC has reviewed the information within the policy, website, and member handbook. Per the CAN contract, the investigation and final Contractor resolution process for grievances shall be completed within (30) calendar days of the date the Grievance is received by the Contractor, or as expeditiously as the members health requires. As a result, the language within the CAN Member handbook (page 64) will reflect the following statement: "We will review your grievance and send notice of our decision within thirty (30) calendar days of receiving your grievance or as expeditiously as your health condition requires. SUPPORTING DOCUMENTATION: 03, 04, 06-09, 16 2022.12.20 CAN Member handbook		
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	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. *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 issues identified during the previous EQR related offering a member the right to file a grievance if they disagree with the decision to extend the resolution timeframe for a grievance.
United's 2022 Response: The member notice (page 3) has been revised to include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal. SUPPORTING DOCUMENTATION: 05, 06, 09, 17, 18, 20 2022.12.20 Member Notice of Extension.docx		
CHIP		
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: 1.2 The procedure for filing and handling a grievance;	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.*	The issues identified during the previous EQR related to the offering of an expedited appeal process to members were corrected.
United's 2022 Response: UHC has reviewed the information within the policy, website, and member handbook. Per the CAN contract, the investigation and final Contractor resolution process for grievances shall be completed within (30) calendar days of the date the Grievance is received by the Contractor, or as expeditiously as the members health requires. As a result, the language within the CAN Member handbook (page 64) will reflect the following statement: "We will review your grievance and send notice of our decision within thirty (30) calendar days of receiving your grievance or as expeditiously as your health condition requires.		

Standard	EQR Comments	2023 EQR Findings
SUPPORTING DOCUMENTATION: 03, 04, 06-09, 16 2022.12.20 CAN Member handbook		
1.3 Timeliness guidelines for resolution of the grievance;	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 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 issues identified during the previous EQR related offering the member the right to file a grievance if they disagree with the decision to extend the resolution timeframe for a grievance.
United's 2022 Response: The member notice (page 3) has been revised to include member's right to file a grievance if they disagree with an extension. SUPPORTING DOCUMENTATION: 05, 06, 09, 17, 18, 20 2022.12.20 Member Notice of Extension.docx		

Member Satisfaction Survey Validation

UnitedHealthcare contracts with Press Ganey vendor to conduct both the child and adult member satisfaction surveys. The surveys were fielded from February 2023 through May 2023.

For MY2022, the adult response rate was 16.1% (299 out of 1857), which is an improvement from the previous year's response rate of 14.4%. For year over year trending, the findings showed improvement in rating of health plan and rating of health care. The largest decline was the rate for customer service.

The Child CCC response rate was 10.8% for MY2022 (212 out of 1972), which is an improvement over the previous year's response rate of 10.3%. For the CCC population, improvement was demonstrated in ease of filling out forms, getting care quickly, and rating of specialist. The largest decline was rating of health care for general population respondents and customer service for CCC respondents.

Press Ganey summarizes and details all results from Adult and Child surveys. Documentation indicated the survey results and opportunities for improvement were discussed in the Quality Management Committee on 9/11/2023.

United informs providers of the survey results yearly. A draft copy of the letter to be sent to providers informing them of the CAHPS results with yearly trending was provided after the onsite.

As noted in *Figure 5: Member Services Findings*, 100% of the standards for CAN and CHIP for the Member Services review were scored as "Met."

Figure 5: Member Services Findings

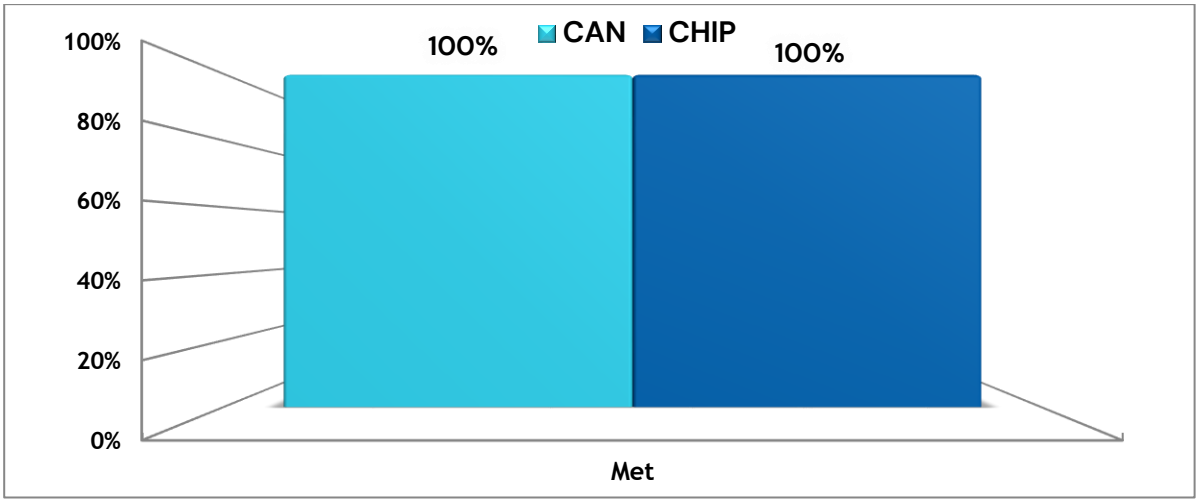


Table 27: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members are educated about their rights and responsibilities in multiple ways, and rights and responsibilities are consistently documented across policies, Member Handbooks, Provider Manuals, and the CCO's website.	✓		
New members are educated about the health plan, programs, benefits, and various processes and requirements through the Member Handbooks, websites, the new member packet, welcome calls, newsletters, etc.			✓
Appropriate processes are in place for notifying members of changes in benefits, services, and the provider network.			✓
United ensures member materials are written at an appropriate reading level and are available in alternate formats. Translation and interpretation services are also provided.			✓
Call Center staff use approved scripts that are reviewed at least annually, revised as needed, and presented to DOM for review and approval. Call center staff receive routine education about the Medicaid program, the CAN and CHIP programs, crisis calls, etc. during quarterly and ad hoc staff meetings and periodic updates.	✓		
Call center performance is monitored to identify opportunities for improvement with action taken to address any identified opportunities. All call center performance metrics were met in 2022.	✓		
Member satisfaction results for Child and Adult are examined internally and presented and addressed in QMC meetings	✓		
All CAN and CHIP grievance files reviewed for the 2023 EQR were resolved in a timely manner with the appropriate notifications to the filer.		✓	

Table 28: Member Services Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
For Non-Contracted Providers on page 38 of the CAN Member Handbook, there is no information that prior authorization is needed. There was a discrepancy between the CAN Member Handbook and CAN Care Provider Manual regarding Prescribed Pediatric Extended Care. The CAN Member Handbook, page 39, does not include the restriction found in the Provider Manual, page 11, that this benefit is limited to those under 21.	Recommendation: Revise the CAN Member Handbook, page 38, to indicate prior authorization may be required for visits with non-contracted providers. On page 39 of the CAN Member Handbook, include the restriction for Prescribed Pediatric Extended Care that is noted in the CAN Care Provider Manual that the benefit is limited to those under 21.			✓
For Dental Services, page 32 of the CHIP Member Handbook includes exclusions for members over 21 years old. However, eligibility for CHIP does not include those over 21 years old. Page 38 of the CHIP Member Handbook does not indicate prior authorization is required for visits to non-contracted providers.	Recommendation: Remove exclusion information for members over 21 for dental service on page 32 of the CHIP Member Handbook. Revise the CHIP Member Handbook, page 38, to indicate prior authorization may be required for visits with non-contracted providers.			✓
Information about coverage for family planning services is noted in the CHIP Member Handbook, page 13. However, no information was noted in the CHIP Member Handbook indicating benefits include direct access for female members to a women's health specialist in addition to a PCP.	Recommendation: Revise the CHIP Member Handbook to include information that benefits include direct access for female members to a women's health specialist in addition to a PCP.			✓
Information was not identified in the CHIP Member Handbook regarding the timeframe for member notification of a provider's departure from the network.	Recommendation: Revise the CHIP Member Handbook to include information that members will be notified within 14 days of receiving notice that a provider is leaving the network.		✓	
As noted during the previous EQR, the CAN Member Handbook, page 56, and the CHIP Member Handbook, page 49, state, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." However, the language from the *CAN Contract, Section 5 (K)* lists the agency as the "State Survey and Certification Division of the State Department of Health."	Recommendation: Revise the agency name indicated above on page 56 of the CAN Member Handbook and on page 49 of the CHIP Member Handbook.	✓		
The CAN Member Handbook and the CHIP Member Handbook indicate a Mental Health Crisis Line is available but do not indicate the	Recommendation: Add the hours of operation for the Mental Health Crisis Line			✓

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
hours of operation. Onsite discussion confirmed the Mental Health Crisis Line is available 24 hours a day.	to the CAN Member Handbook and to the CHIP Member Handbook.			
For both CAN and CHIP, no policy was identified that addresses processes and requirements for member disenrollment.	Recommendation: Develop a policy to address processes and requirements related to member disenrollment.	✓		
Response rates for member satisfaction surveys remain low and may affect generalizability of the results	Recommendation: Continued efforts should be made to gather a better representation of the members for the member satisfaction surveys.	✓		

MEMBER SERVICES—CAN

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					Member rights are specified in Policy MBR4a, Notification of Rights, and included in the CAN Member Handbook and CAN Care Provider Manual. As noted in Policy MBR4a, information about member rights and responsibilities is included in the information provided to new members, including the Member Handbook. Providers are also informed of member rights and responsibilities via the Care Provider Manuals.
2. Member rights include, but are not limited to, the right:	X					All required member rights are included in Policy MBR4a, 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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Member responsibilities include the responsibility:	X					All required member responsibilities are included in Policy MBR4a, 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 which	X					Processes for providing new member information are found in Policy MBR2a, Information Packets to members (prior to the 1st day of the month of their enrollment). As noted in the policy, United provides

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
enrollment starts, of all benefits to which they are entitled, including:						an information packet to new members before the first day of the month of enrollment and no more than 14 days after receiving notification of the member's enrollment. Onsite discussion confirmed the information packet includes an introduction letter and Member Handbook, along with information about how to access the Provider Directory. The Member ID card is sent in a separate mailing.
1.1 Full disclosure of benefits and services included and excluded in coverage;						A grid that lists covered benefits is found in the CAN Member Handbook. It was noted that issues identified during the previous EQR were corrected. For Non-Contracted Providers, page 38 of the CAN Member Handbook does not indicate that prior authorization is needed. There was a discrepancy between the CAN Member Handbook and CAN Care Provider Manual regarding Prescribed Pediatric Extended Care. The CAN Member Handbook, page 39, does not include the restriction found in the Provider Manual, page 11, that this benefit is limited to those under 21. *Recommendation: Revise the CAN Member Handbook, page 38, to indicate prior authorization may be required for visits with non-contracted providers. On page 39 of the CAN Member Handbook, include the restriction for Prescribed Pediatric Extended Care that is noted in the CAN*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Care Provider Manual that the benefit is limited to those under 21.
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;						Information about prior authorization requirements and processes is found throughout the CAN Member Handbook.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						Information about processes for and restrictions on obtaining care from out of network providers is included in the CAN Member Handbook.
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Information about emergent and urgent care, examples of conditions for which each is appropriate, and processes for obtaining these types of care are included in the CAN Member Handbook.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Policies and procedures for accessing specialty/referral care;						Page 24 of the CAN Member Handbook instructs members about obtaining specialty care and includes a list of provider types for which a referral is not required.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						The CAN Member Handbook addresses obtaining prescriptions, the Preferred Drug List, the need for prior authorization when applicable, over-the-counter medication coverage, injectable medications, and the Pharmacy Lock-In Program. It also informs members of the availability of a 3-day emergency supply of medication. The handbook also addresses coverage of durable medical equipment.
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;						Members are informed that they will be notified in writing within 14 days before a change in benefits and services, and within 14 days of receiving notice of a provider's withdrawal from the network.
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;						The role of the PCP, provider types that may serve as a PCP, and information about processes for choosing and changing the PCP are included.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						The Member Support section of the CAN Member Handbook includes information about services and functions available through the member portal and the Member Services call center. Additionally, information about the NurseLine and communication assistance is included.
1.13 A description of EPSDT services;						Members are given an overview of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) well child program as well as the schedule for EPSDT visits with the PCP.
1.14 Procedures for disenrolling from the CCO;						Members are instructed that to request disenrollment or change health plans, they must contact DOM in writing or by telephone. Also provided is an explanation of for-cause disenrollment requests and circumstances that are appropriate for a for-cause disenrollment request. Information about other reasons a member may be disenrolled is included.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						The CAN Member Handbook provides information about grievances, appeals, and State Fair Hearings. A copy of the grievance and appeal form is included.
1.16 Procedure for obtaining the names, qualifications, and titles of						The CAN Member Handbook informs members that the following information is available on United's

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						website or by contacting Member Services: a complete list of network providers including provider names, addresses, telephone numbers, professional qualifications, specialties, medical schools, residency programs, board certifications, and languages. An overview of the Provider Directory is also included, and members are instructed to contact Member Services to get a printed copy of the directory.
1.17 Instructions for reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						An overview of advance directives is found in the CAN Member Handbook and includes the types of advance directives that may be enacted and definitions of terminology. As noted during the previous EQR, the CAN Member Handbook, page 56, states, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." However, the language from the *CAN Contract, Section 5 (K)* lists the agency as the "State Survey and Certification Division of the State

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Department of Health." This was a recommendation from the previous EQR. *Recommendation: Revise the agency name indicated above on page 56 of the CAN Member Handbook.*
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					Per the process outlined in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, members are informed at least 14 days prior to implementation of any changes to covered services, benefits, or the process that the member should use to access benefits. The policy also states that members are provided with 15 days' written notice of termination of a provider from whom they have been receiving services or who they saw on a regular basis. 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 as required by the contract.	X					As noted in Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension, United's member materials are written so that they do not exceed a 6th-grade reading comprehension level, as confirmed by using the Flesch-Kincaid Readability Scale. Member materials are written in

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						at least 12-point font, and large print materials are written in 18-point font. Member materials are submitted to DOM for approval prior to disseminating to members.
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Policy MBR1a, DOM's Limited English Proficiency Policy, states United ensures all member enrollment notices and informational/instructional materials are available in any prevalent non-English languages in the State of Mississippi. Policy MBR1b2, Notification of Oral Interpretation Services (Free of Charge), states members are notified via the Member Handbook of the availability of cost-free translation and interpreter services. Interpreter services are available around the clock through the Language Line, and interpreters/relay services are available for members with visual or hearing impairments. Member materials are available in alternate formats, such as large font, Braille, audio tapes, etc.
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					The Director of Member Services and Outreach Community works with the Marketing Services team to draft materials, which are then reviewed by the Compliance Officer to ensure compliance with

Standard	Score					Comments
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						contractual requirements. The materials are then submitted to DOM for review and approval. Any feedback or changes requested by DOM will be incorporated into the materials for final approval by DOM. United keeps a log of any marketing complaints received and any resulting action. These are reviewed with the Plan President and Compliance Officer routinely. These processes are documented in Policy MBR11a, Marketing Material, and Policy MBR12, Submission of Marketing Materials.
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					The CAN Member Handbook lists the hours of operation for the Member Services Call Center as 7:30 am to 5:30 pm Monday, Tuesday, Thursday, and Friday. Wednesday hours are 7:30 a.m. to 8:00 p.m. The first Saturday and Sunday of each month, the call center is available from 8:00 a.m. to 5:00 p.m. The NurseLine is available 24 hours a day, 7 days a week. The CAN Member Handbook indicates a Mental Health Crisis Line is also available but does not indicate the hours of operation. This is a repeat finding from the previous EQR, for which a recommendation was offered.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion confirmed the Mental Health Crisis Line is available 24 hours a day. *Recommendation: Add the hours of operation for the Mental Health Crisis Line to the CAN Member Handbook.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Call Center staff use approved scripts when interacting with members. These scripts are reviewed at least annually, revised as needed, and presented to DOM for review and approval. The scripts are available to staff electronically. Onsite discussion confirmed call center staff receive routine education about the Medicaid program, the CAN and CHIP programs, crisis calls, etc. during quarterly and ad hoc staff meetings and periodic updates.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					As noted in the 2023 Quality Improvement and Population Health Management Program Description (CAN), Member services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities. The Service Quality Improvement Subcommittee monitors trends related to member and provider call center activities. The CAN 2022 Quality Improvement & Population Health Management Annual Evaluation Report,

Standard	Score					Comments
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						pages 82 – 83, states accessibility of telephonic customer services is reviewed annually. Targets for call center performance/call metrics are defined by DOM. Results of performance throughout 2022 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 2022. SQIS minutes reflect reporting of call center metrics and performance at each meeting.
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					Policy MBR3b, Communication – Encouraging voluntary PCP selections, states the new member enrollment packet provides information about PCPs, including how to find a PCP, and instructs members to contact Member Services with any questions. Welcome calls are placed to newly enrolled members and they are encouraged to ask questions about their PCP. Policy MBR3a, Assignment of Primary Care Provider (PCP), states members who are not assigned to a PCP in the enrollment file received from DOM are assigned to a PCP based on various factors such as age, gender, zip code, etc. within 24 hours of receipt

Standard	Score					Comments
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						of the enrollment file. Members may request to change their PCP at any time. The PCP assigned to the member is indicated on Member ID cards.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					No policy was identified that addresses processes and requirements for member disenrollment. The CAN Member Handbook, page 58, addresses member disenrollment processes and requirements for mandatory and optional enrollees, and instructs that members must contact DOM in writing or by telephone to request disenrollment or to request a change in health plan. The handbook indicates members may request disenrollment without cause during the initial 90 days of enrollment, defines circumstances under which a member may request "for cause" disenrollment at any time, and describes circumstances under which a member may be disenrolled without requesting disenrollment. *Recommendation: Develop a policy to address processes and requirements related to member disenrollment.*
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them	X					The CAN 2023 Quality Improvement and Population Health Management Program Description states members are educated about population health

Standard	Score					Comments
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and encourages members to utilize these benefits.						activities and recommendations through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, and events such as health fairs and other health promotion events. Members that are engaged with care managers are informed of services that are offered through the program in which they are enrolled. The CAN Member Handbook includes brief information about preventive health services and wellness programs. Members are instructed to contact Member Services with any questions or to get more information.
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					All members are provided with prenatal education, pregnancy-specific health risk assessments, referrals, support to engage in care, and ongoing surveillance for emerging/worsening risks. The Healthy First Steps Program is in place to encourage high risk and rising risk pregnant members to engage in care and to support improved birth outcomes through care management services through the clinical Care Management team.
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					UnitedHealthcare contracts with Press Ganey vendor to do both the child and adult surveys. The surveys were fielded from Feb 2023 through May 2023. For MY2022, adult response rate was 16.1% (299 out of 1857) which is an improvement from last year's response rate of 14.4%. For year over year trending, the findings showed improvement in rating of health plan and rating of health care. The largest decline was the rate for customer service. The Child CCC response rate was 10.8% for MY2022 (212 out of 1972) which is an improvement over the previous year's response rate of 10.3%. Improvement was shown for the general population for coordination of care and ease of filling out forms. For the CCC population, improvement was demonstrated in ease of filling out forms, getting care quickly, and rating of specialist. The largest decline was rating of health care for general population respondents and customer service for CCC respondents.

Standard	Score					Comments
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2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from Adult and Child surveys.
3. The CCO reports results of the member satisfaction survey to providers.	X					A draft copy of the letter to be sent to providers informing them of the CAHPS results with yearly trending was provided after the onsite.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The survey results and opportunities for improvement were discussed in the Quality Management Committee on 9/11/2023.
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					Processes for handling member grievances are detailed in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance.
1.1 Definition of a grievance and who may file a grievance;	X					A grievance is defined in the CAN Member Handbook, CAN Provider Manual, and on United's website as "…an expression of dissatisfaction about any matter other than an adverse benefit determination."
1.2 The procedure for filing and handling a grievance;	X					Information on the verbal or written filing of grievances and for options for assistance is

Standard	Score					Comments
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						outlined in policy POL2015-01, Member Appeal, State Fair Hearing, the CAN Member Handbook, the Provider Manual, and website.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					The timelines for the acknowledgement, extension if needed, and resolution of grievances are clearly outlined in United's policy, the CAN Member Handbook, Provider Manual, and website.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					Constellation Quality Health reviewed a sample of CAN grievance files and found that all were resolved in a timely manner with the appropriate notifications to the filer. The acknowledgment letter for one CAN grievance file exceeded the 5-day timeframe indicated in policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance.
3. Grievances are tallied, categorized, analyzed for patterns and potential	X					

Standard	Score					Comments
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quality improvement 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					

MEMBER SERVICES—CHIP

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					Member rights are specified in Policy MBR4a, Notification of Rights, and included in the CHIP Member Handbook and CHIP Care Provider Manual. As noted in Policy MBR4a, information about member rights and responsibilities is included in the information provided to new members, including the Member Handbook. Providers are also informed of member rights and responsibilities via the Care Provider Manuals.
2. Member rights include, but are not limited to, the right:	X					All required member rights are included in Policy MBR4a, 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;						

Standard	Score					Comments
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2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					All required member responsibilities are included in Policy MBR4a, the CHIP Member Handbook, and the CHIP Care Provider Manual.

Standard	Score					Comments
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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					Processes for providing new member information are found in Policy MBR2a, Information Packets to members (prior to the 1st day of the month of their enrollment). As noted in the policy, United provides an information packet to new members before the first day of the month of enrollment and no more than 14 days after receiving notification of the member's enrollment. Onsite discussion confirmed

Standard	Score					Comments
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						the information packet includes an introduction letter and Member Handbook, along with information about how to access the Provider Directory. The Member ID card is sent in a separate mailing.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						A grid that lists covered benefits is found in the CHIP Member Handbook. It was noted that issues identified during the previous EQR were corrected. For Dental Services, page 32 of the CHIP Member Handbook includes exclusions for members over 21 years old. However, eligibility for CHIP does not include those over 21 years old. Page 38 of the Member Handbook does not indicate prior authorization is required for visits to non-contracted providers. *Recommendation: Remove exclusion information for members over 21 for dental service on page 32 of the CHIP Member Handbook. Revise the CHIP Member Handbook, page 38, to indicate prior authorization may be required for visits with non-contracted providers.*
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						Information about coverage for family planning services is noted in the CHIP Member Handbook, page 13. However, no information was noted in the CHIP Member Handbook indicating benefits include direct access for female members to a women's health specialist in addition to a PCP.

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						Recommendation: Revise the CHIP Member Handbook to include information that 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; information regarding co-payments and out-of-pocket maximums;						The CHIP Member Handbook includes information about copayments for the three coverage plans and copayment maximums.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Information about prior authorization requirements and processes is found throughout the CHIP Member Handbook.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						Information about processes for and restrictions on obtaining care from out of network providers is included in the CHIP Member Handbook.
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						Information about emergent and urgent care, examples of conditions for which each is appropriate, and processes for obtaining these types of care are included in the CHIP Member Handbook.
1.6 Policies and procedures for accessing specialty/referral care;						Page 24 of the CHIP Member Handbook instructs members about obtaining specialty care.
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including						The CHIP Member Handbook addresses obtaining prescriptions, the Preferred Drug List, the need for prior authorization when applicable, over-the-

Standard	Score					Comments
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applicable copayments and formulary restrictions;						counter medication coverage, injectable medications, and the Pharmacy Lock-In Program. It also informs members of the availability of a 3-day emergency supply of medication. The handbook also addresses coverage of durable medical equipment.
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;						Members are informed in the CHIP Member Handbook that they will be notified in writing within 14 days before a change in benefits and services. However, information was not identified in the CHIP Member Handbook regarding the timeframe for member notification of a provider's departure from the network. *Recommendation: Revise the CHIP Member Handbook to include information that members will be notified within 14 days of receiving notice that a provider is leaving the network.*
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;						The role of the PCP, provider types that may serve as a PCP, and information about processes for choosing and changing the PCP are included.
1.11 Procedure for making appointments and information						

Standard	Score					Comments
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regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						The Member Support section of the CHIP Member Handbook includes information about services and functions available through the member portal and the Member Services call center. Additionally, information about the NurseLine and communication assistance is included.
1.13 A description of the Well-Baby and Well-Child services which include:						Members are given an overview of preventive health services for children (well child program) as well as the schedule for wellness exam visits with the PCP.
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;						

Standard	Score					Comments
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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;						Members are instructed that to request disenroll or change health plans, they must contact DOM in writing or by telephone. Also provided is an explanation of for-cause disenrollment requests and circumstances that are appropriate for a for-cause disenrollment request.
1.15 Procedures for filing complaints/grievances and appeals;						The CHIP Member Handbook provides information about grievances, appeals, and independent external reviews. A copy of the grievance and appeal form is included.

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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 informs members that a complete list of network providers including addresses and telephone numbers is available on United's website or by contacting Member Services. An overview of the Provider Directory is also included, and members are instructed to contact Member Services to get a printed copy of the directory.
1.17 Instructions on reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						An overview of advance directives is found in the CHIP Member Handbook and includes the types of advance directives that may be enacted and definitions of terminology. As noted during the previous EQR, the CHIP Member Handbook, page 49, states, "Members who have any complaints on advance directives may contact the State Survey and Mississippi State Department of Health." This finding was initially noted during the previous EQR. *Recommendation: Revise the agency name indicated above on page 49 of the CHIP Member Handbook.*

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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					Per the process outlined in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, members are informed at least 14 days prior to implementation of any changes to covered services, benefits, or the process that the member should use to access benefits. The policy also states that members are provided with 15 days' written notice of termination of a provider from whom they have been receiving services or who they saw on a regular basis. 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					As noted in Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension, United's member materials are written so that they do not exceed a 6th-grade reading comprehension level, as confirmed by using the Flesch-Kincaid Readability Scale. Member materials are written in at least 12-point font, and large print materials are written in 18-point font. Member materials are submitted to DOM for approval prior to disseminating to members.
4. The CCO maintains and informs members of how to access a toll-free	X					Policy MBR1a, DOM's Limited English Proficiency Policy, states United ensures all member enrollment

Standard	Score					Comments
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vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.						notices and informational/instructional materials are available in any prevalent non-English languages in the State of Mississippi. Policy MBR1b2, Notification of Oral Interpretation Services (Free of Charge), states members are notified via the Member Handbook of the availability of cost-free translation and interpreter services. Interpreter services are available around the clock through the Language Line, and interpreters/relay services are available for members with visual or hearing impairments. Member materials are available in alternate formats, such as large font, Braille, audio tapes, etc.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
III C. Call Center						
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					The CHIP Member Handbook lists the hours of operation for the Member Services Call Center as 7:30 am to 5:30 pm Monday, Tuesday, Thursday, and Friday. Wednesday hours are 7:30 am to 8:00 pm. The first Saturday and Sunday of each month, the call center is available from 8:00 am to 5:00 pm. The NurseLine is available 24 hours a day, 7 days a week. The CHIP Member Handbook indicates a Mental Health Crisis Line is also available but does not indicate the hours of operation. This is a repeat

Standard	Score					Comments
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						finding from the previous EQR, for which a recommendation was offered. Onsite discussion confirmed the Mental Health Crisis Line is available 24 hours a day. *Recommendation: Add the hours of operation for the Mental Health Crisis Line to the CHIP Member Handbook.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Call Center staff use approved scripts when interacting with members. These scripts are reviewed at least annually, revised as needed, and presented to DOM for review and approval. The scripts are available to staff electronically. Onsite discussion confirmed call center staff receive routine education about the Medicaid program, the CAN and CHIP programs, crisis calls, etc. during quarterly and ad hoc staff meetings and periodic updates.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					As noted in the 2023 Quality Improvement and Population Health Management Program Description (CHIP), Member services call data is collected, analyzed, and monitored to identify opportunities for improvement, and action plans are developed based on identified opportunities. The Service Quality Improvement Subcommittee monitors trends related to member and provider call center activities. The CHIP 2022 Quality Improvement & Population Health Management Annual Evaluation Report, pages 65 – 66, states accessibility of telephonic customer

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						services is reviewed annually. Targets for call center performance/call metrics are defined by DOM. Results of performance throughout 2022 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 2022. SQIS minutes reflect reporting of call center metrics and performance at each meeting.
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					Policy MBR3b, Communication – Encouraging voluntary PCP selections, states the new member enrollment packet provides information about PCPs, including how to find a PCP, and instructs members to contact Member Services with any questions. Welcome calls are placed to newly enrolled members and they are encouraged to ask questions about their PCP. Policy MBR3a, Assignment of Primary Care Provider (PCP), states members who are not assigned to a PCP in the enrollment file received from DOM are assigned to a PCP based on several factors such as age, gender, zip code, etc. within 24 hours of receipt of the enrollment file. Members may request to change their PCP at any time.

Standard	Score					Comments
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						The PCP assigned to the member is indicated on Member ID cards.
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					No policy was identified that addresses processes and requirements for member disenrollment. The CHIP Member Handbook, page 45, addresses member disenrollment processes and requirements for mandatory and optional enrollees, and instructs that members must contact DOM in writing or by telephone to request disenrollment or to request a change in health plan. The handbook indicates members may request disenrollment without cause during the initial 90 days of enrollment, defines circumstances under which a member may request "for cause" disenrollment at any time, and describes circumstances under which a member may be disenrolled without requesting disenrollment. *Recommendation: Develop a policy to address processes and requirements related to member disenrollment.*
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					The CHIP 2023 Quality Improvement and Population Health Management Program Description states members are educated about population health activities and recommendations through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, and

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						events such as health fairs and other health promotion events. Members that are engaged with care managers are informed of services that are offered through the program in which they are enrolled. The CHIP Member Handbook includes brief information about preventive health services and wellness programs. Members are instructed to contact Member Services with any questions or to get more information.
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					All members are provided with prenatal education, pregnancy-specific health risk assessments, referrals, support to engage in care, and ongoing surveillance for emerging/worsening risks. The Healthy First Steps Program is in place to encourage high risk and rising risk pregnant members to engage in care and to support improved birth outcomes through care management services through the clinical Care Management team.
3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					
4. The CCO provides educational opportunities to members regarding	X					

Standard	Score					Comments
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health risk factors and wellness promotion.						
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					UnitedHealthcare contracts with Press Ganey vendor to do both the child and adult surveys. The surveys were fielded from Feb 2023 through May 2023. For MY2022, adult response rate was 16.1% (299 out of 1857) which is an improvement from last year's response rate of 14.4%. For year over year trending, the findings showed improvement in rating of health plan and rating of health care. The largest decline was the rate for customer service. The Child CCC response rate was 10.8% for MY2022 (212 out of 1972) which is an improvement over the previous year's response rate of 10.3%. Improvement was shown for the general population for coordination of care and ease of filling out forms. For the CCC population, improvement was demonstrated in ease of filling out forms, getting care quickly, and rating of specialist. The largest decline was rating of health care for general population respondents and customer service for CCC respondents.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from Adult and Child surveys.
3. The CCO reports the results of the member satisfaction survey to providers.	X					A draft copy of the letter to be sent to providers informing them of the CAHPS results with yearly trending was provided after the onsite.
4. The CCO reports the results of the member satisfaction survey and the impact of measures taken to address quality problems that were identified to the appropriate committee.	X					The survey results and opportunities for improvement were discussed in the Quality Management Committee on 9/11/2023.
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					Processes for the handling of member grievances are detailed in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance.
1.1 Definition of a grievance and who may file a grievance;	X					A grievance is defined in the CHIP Member Handbook, Provider Manual, and on United's website as "…an expression of dissatisfaction about any matter other than an adverse benefit determination."
1.2 The procedure for filing and handling a grievance;	X					Information on the verbal or written filing of grievances and for options for assistance is outlined in policy POL2015-01, Member Appeal, State Fair

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Hearing, the CHIP Member Handbook, the Provider Manual, and website.
1.3 Timeliness guidelines for resolution of the grievance;	X					The timelines for the acknowledgement, extension if needed, and resolution of grievances are clearly outlined in United's policy, the CHIP Member Handbook, Provider Manual, and website.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					Constellation Quality Health reviewed a sample of CHIP grievance files and found that all were resolved in a timely manner with the appropriate notifications to the filer.
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					

D. Quality Improvement

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

The review of Quality Improvement (QI) encompasses the QI program descriptions, work plans, program evaluations, and validation of performance measures and performance improvement projects.

United has developed a QI program that includes all aspects of health care quality. United's 2023 Quality Improvement and Population Health Management Program Descriptions for CAN and CHIP details the program's structure, objectives, scope, and methodology. The QI program operates in conjunction with Untied's Utilization Management program to improve the health and health care services provide to members.

The reduction of health disparities is addressed through United's Health Equity program. The goal of this program is to reduce health disparity and improve culturally and linguistically appropriate services. United has selected specific measures for the CAN and CHIP populations. For CAN, those measures include improving the HEDIS rates for Cervical Cancer Screening and Immunizations for Adolescents and improving the CAHPS score for Rating of Personal Doctor. For CHIP, the measures were to improve the HEDIS rates for Immunizations for Adolescents (Combo 2) in targeted counties and improve the CAHPS score for the Rating of Specialist. To evaluate the overall effectiveness of the Health Equity program, United conducted an evaluation of the program. The 2022 Healthy Equity Evaluation documents were provided for this EQR. The evaluations included all the results of the measures, a barrier analysis, and any opportunities for improvement. This information is used to determine changes or restructuring of the program if needed.

Annually, United develops a QI work plan to identify the planned activities related to program priorities that are intended to improve the provisions of population health, quality, safety of clinical care, and services. For CAN and CHIP there were five specific goals outlined in the 2023 QI Work Plan. Those goals include improving specific HEDIS measures, CAHPS measures, Provider satisfaction, EPSDT rates, and HEDIS measures associated with the Performance Improvement Projects. In both work plans there appeared to be a type regarding which Annual Program Descriptions were presented to the committee. United confirmed the 2023 QI Program Descriptions were presented to the committee instead of the 2022 program descriptions.

United's Quality Management Committee continues to be 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

of care rendered within the network. United's Chief Medical Officer chairs this committee and network providers specializing in OB/GYN, Internal Medicine, Psychiatry, Dentistry, Pediatrics, and Family Medicine are included as voting members. The Provider Advisory Committee meets and reports to the Quality Management Committee at least four times per year. A quorum of 51 percent of voting members present is required for all committee meetings.

A review of the committee minutes demonstrated both committees met the meeting frequency and quorum requirements.

An annual review of the overall effectiveness of the QI Program is conducted to assess how well resources have been deployed to meet the objectives of the program. The results of the annual evaluation are used to develop and prioritize next year's activities. The 2022 Quality Improvement & Population Health Management Annual Evaluation Report (CHIP and CAN) was detailed and contained a review and results of all aspects of the program. For goals that were not met, a root cause or barrier analysis was conducted and opportunities for approvements identified.

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, 2022, through December 31, 2022.

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 2022.

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 CCOs, 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 United's data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation — Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by United. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by United was acceptable.

All relevant CAN HEDIS performance measures were compared for the current review year (MY 2022) to the previous year (MY 2021), and the changes from 2021 to 2022 are reported in *Table 29: CAN HEDIS Performance Measure Results*. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

Table 29: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	53.13%	51.38%	1.75%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
BMI Percentile	68.37%	69.10%	0.73%
Counseling for Nutrition	53.28%	51.09%	-2.19%
Counseling for Physical Activity	48.42%	47.69%	-0.73%
Childhood Immunization Status (cis)			
DTaP	72.51%	77.13%	4.62%
IPV	90.51%	92.94%	2.43%
MMR	88.32%	90.75%	2.43%
HiB	85.4%	89.54%	4.14%
Hepatitis B	91.24%	93.43%	2.19%
VZV	86.86%	90.27%	3.41%
Pneumococcal Conjugate	75.43%	77.62%	2.19%
Hepatitis A	76.4%	80.29%	3.89%
Rotavirus	71.05%	74.70%	3.65%
Influenza	32.12%	24.82%	-7.30%
Combination #3	68.86%	70.07%	1.21%
Combination #7	53.28%	57.91%	4.63%
Combination #10	23.60%	19.22%	4.38%
Immunizations for Adolescents (ima)			
Meningococcal	52.07%	51.58%	-0.49%
Tdap/Td	74.45%	76.16%	1.71%
HPV	19.22%	23.36%	4.14%
Combination #1	51.82%	51.34%	-0.48%
Combination #2	18.98%	22.63%	3.65%
Lead Screening in Children (lsc)	68.13%	67.15%	-0.98%
Breast Cancer Screening (bcs)	44.72%	47.26%	2.54%
Cervical Cancer Screening (ccs)	48.91%	54.99%	6.08%
Chlamydia Screening in Women (chl)			
16-20 Years	45.73%	47.48%	1.75%
21-24 Years	61.34%	58.96%	-2.38%
Total	48.25%	49.02%	0.77%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Appropriate Testing for Pharyngitis (3-17)	74.71%	74.59%	-0.12%
Appropriate Testing for Pharyngitis (18-64)	61.47%	65.03%	3.56%
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	72.75%	73.31%	0.56%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	22.65%	19.95%	-2.70%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	49.89%	50.76%	0.87%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Bronchodilator	76.36%	78.40%	2.04%
Asthma Medication Ratio (amr)			
5-11 Years	81.97%	82.22%	0.25%
12-18 Years	73.43%	78.52%	5.09%
19-50 Years	57.05%	61.42%	4.37%
51-64 Years	58.42%	56.25%	-2.17%
Total	73.36%	75.79%	2.43%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	57.42%	60.34%	2.92%
Persistence of Beta-Blocker Treatment After a Heart Attack	76.67%	52.94%	-23.73%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	75.73%	79.83%	4.10%
Statin Adherence 80% - 21-75 years (Male)	57.49%	58.48%	0.99%
Received Statin Therapy - 40-75 years (Female)	71.7%	71.66%	-0.04%
Statin Adherence 80% - 40-75 years (Female)	48.66%	47.53%	-1.13%
Received Statin Therapy - Total	73.76%	75.72%	1.96%
Statin Adherence 80% - Total	53.28%	53.26%	-0.02%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	90.51%	NA	NA
HbA1c Poor Control	45.26%	45.01%	-0.25%
HbA1c Adequate Control	46.47%	45.01%	-1.46%
Eye Exam for Patients with Diabetes (EED)	56.69%	59.61%	2.92%
Blood Pressure Control for Patients With Diabetes (BPD)	59.12%	64.48%	5.36%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	17.64%	21.99%	4.35%
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)	17.62%	21.92%	4.30%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	57.70%	61.09%	3.39%
Statin Adherence 80%	50.77%	52.05%	1.28%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	48.82%	49.07%	0.25%
Effective Continuation Phase Treatment	31.22%	30.90%	-0.32%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	44.56%	49.82%	5.26%
Continuation and Maintenance (C&M) Phase	59.32%	66.57%	7.25%
Follow-Up After Hospitalization for Mental Illness (fuh)			

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
6-17 years - 30-Day Follow-Up	61.70%	66.96%	5.26%
6-17 years - 7-Day Follow-Up	37.26%	39.86%	2.60%
18-64 years - 30-Day Follow-Up	51.85%	50.80%	-1.05%
18-64 years - 7-Day Follow-Up	29.52%	28.31%	-1.21%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	57.33%	59.84%	2.51%
7-Day Follow-Up	33.83%	34.77%	0.94%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	52.51%	55.73%	3.22%
6-17 years - 7-Day Follow-Up	32.96%	39.69%	6.73%
18-64 years - 30-Day Follow-Up	43.68%	40.15%	-3.53%
18-64 years - 7-Day Follow-Up	26.71%	24.91%	-1.80%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	47.05%	45.25%	-1.80%
Total- 7-Day Follow-Up	29.10%	29.75%	0.65%
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)	37.35%	41.63%	4.28%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	19.28%	30.14%	10.86%
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 - 7 days (Total)	18.53%	29.72%	11.19%
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	35.91%	41.07%	5.13%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	0.0%	28.30%	28.30%
7-Day Follow-Up: 13-17 Years	0.0%	24.53%	24.53%
30-Day Follow-Up: 18+ Years	6.17%	26.52%	20.35%
7-Day Follow-Up: 18+ Years	3.29%	15.65%	12.36%
30-Day Follow-Up: Total	5.43%	26.78%	21.35%
7-Day Follow-Up: Total	2.90%	16.94%	14.04%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16–64)	33.79%	31.64%	-2.15%
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	33.64%	31.28%	-2.36%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	69.47%	69.40%	-0.07%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	71.62%	74.16%	2.54%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	85.37%	77.08%	-8.29%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	57.86%	56.37%	-1.49%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood Glucose Testing (1–11)	33.63%	35.45%	1.82%
Cholesterol Testing (1–11)	24.65%	24.64%	-0.01%
Blood Glucose and Cholesterol Testing (1–11)	21.24%	21.90%	0.66%
Blood Glucose Testing (12–17)	47.33%	47.12%	-0.21%
Cholesterol Testing (12–17)	29.56%	31.64%	2.08%
Blood Glucose and Cholesterol Testing (12–17)	27.36%	28.85%	1.49%
Blood Glucose Testing (Total)	42.07%	42.71%	0.64%
Cholesterol Testing (Total)	27.68%	29.00%	1.32%
Blood Glucose and Cholesterol Testing (Total)	25.01%	26.22%	1.21%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.51%	1.22%	-0.29%
Appropriate Treatment for Upper Respiratory Infection (uri)			
Appropriate Treatment for Upper Respiratory Infection (3 Months–17 Years)	72.99%	73.42%	0.43%
Appropriate Treatment for Upper Respiratory Infection (18–64)	57.41%	56.30%	-1.11%
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	71.22%	71.70%	0.48%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months–17 Years)	45.13%	50.85%	5.72%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18–64)	41.65%	40.10%	-1.55%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	44.43%	49.35%	4.92%
Use of Imaging Studies for Low Back Pain (lbp)	69.51%	71.34%	1.83%
Use of Opioids at High Dosage (hdo)	0.84%	0.78%	-0.06%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	15.26%	17.99%	2.73%
Multiple Pharmacies	1.87%	1.39%	-0.48%
Multiple Prescribers and Multiple Pharmacies	1.21%	0.76%	-0.45%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	4.99%	5.67%	0.68%
18-64 years - >=31 Days covered	3.27%	3.65%	0.38%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	5.00%	5.66%	0.66%
Total - >=31 Days covered	3.28%	3.65%	0.37%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	84.01%	82.95%	-1.06%
45-64 Years	89.06%	88.95%	-0.11%
65+ Years	78.57%	78.38%	-0.19%
Total	85.99%	85.54%	-0.45%
Annual Dental Visit (adv)			
2-3 Years	48.43%	49.04%	0.61%
4-6 Years	66.21%	69.63%	3.42%
7-10 Years	68.38%	72.18%	3.80%
11-14 Years	65.20%	67.51%	2.31%
15-18 Years	58.18%	60.10%	1.92%
19-20 Years	41.90%	40.11%	-1.79%
Total	62.41%	64.97%	2.56%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	70.73%	72.34%	1.61%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%	4.26%	4.26%
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	67.27%	59.51%	-7.76%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.55%	5.85%	1.30%
Total: Initiation of AOD Treatment: 13-17 Years	65.98%	61.54%	-4.44%
Total: Engagement of AOD Treatment: 13-17 Years	4.10%	6.54%	2.44%
Alcohol abuse or dependence:	46.06%	44.14%	-1.92%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Initiation of AOD Treatment: 18+Years			
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	5.84%	5.37%	-0.47%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	40.04%	45.31%	5.27%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	16.67%	20%	3.33%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	40.03%	46.02%	5.99%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.52%	8.19%	2.67%
Total: Initiation of AOD Treatment: 18+ Years	40.11%	45.31%	5.20%
Total: Engagement of AOD Treatment: 18+ Years	7.85%	9.13%	1.28%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	47.36%	46.56%	-0.80%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	5.53%	5.25%	-0.28%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	40.21%	45.45%	5.24%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	16.6%	20.55%	3.95%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	43.7%	48.65%	4.95%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	5.39%	7.72%	2.33%
Total: Initiation of AOD Treatment: Total	42.56%	47.58%	5.02%
Total: Engagement of AOD Treatment: Total	7.50%	8.75%	1.25%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	93.67%	96.84%	3.17%
Postpartum Care	74.70%	79.56%	4.86%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 years	60.97%	57.10%	-3.87%
12-17 years	62.31%	61.27%	-1.04%
Total	61.81%	59.73%	-2.08%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	57.07%	60.02%	2.95%
15 Months-30 Months	60.51%	66.10%	5.59%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	43.57%	43.95%	0.38%
12-17 Years	36.72%	36.88%	0.16%
18-21 Years	19.15%	21.9%	2.75%

Measure/Data Element	HEDIS MY 2021 CAN Rates	HEDIS MY 2022 CAN Rates	Change
Total	39.16%	39.46%	0.30%

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 in the preceding table, the Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64) improved by 10.86 percentage points, Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days (Total) increased by 11.19 percentage points, and all the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measures improved by 12 to 28 percentage points.

The Persistence of Beta-Blocker Treatment After a Heart Attack decreased by 23.73 percentage points.

All relevant CHIP HEDIS performance measures were compared for MY 2022 and the previous year (MY 2021), and the change from 2021 to 2022 is reported in the table below. Rate changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 30: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	70.07%	72.26%	2.19%
Counseling for Nutrition	53.04%	47.93%	-5.11%
Counseling for Physical Activity	49.88%	48.66%	-1.22%
Childhood Immunization Status (cis)			
DTaP	82.97%	83.70%	0.73%
IPV	92.46%	91.24%	-1.22%
MMR	91.73%	91.97%	0.24%
HiB	88.56%	89.54%	0.98%
Hepatitis B	91.73%	88.08%	-3.65%
VZV	91.73%	92.21%	0.48%
Pneumococcal Conjugate	85.40%	82.48%	-2.92%
Hepatitis A	82.97%	86.13%	3.16%
Rotavirus	84.67%	83.21%	-1.46%
Influenza	39.17%	29.44%	-9.73%

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Combination #3	81.02%	76.40%	-4.62%
Combination #7	70.56%	68.13%	-2.43%
Combination #10	32.85%	26.28%	-6.57%
Immunizations for Adolescents (ima)			
Meningococcal	58.88%	51.82%	-7.06%
Tdap/Td	83.21%	87.83%	4.62%
HPV	23.36%	21.17%	-2.19%
Combination #1	58.64%	51.82%	-6.82%
Combination #2	22.38%	19.95%	-2.43%
Lead Screening in Children (lsc)	66.67%	64.72%	-1.95%
Chlamydia Screening in Women (chl)			
16–20 Years	37.92%	39.96%	2.04%
21–24 Years	NA	NA	NA
Total	37.92%	39.96%	2.04%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3–17 years	76.89%	76.20%	-0.69%
18–64 years	79.12%	74.05%	-5.07%
65+ years	NA	NA	NA
Total	77.00%	76.11%	-0.89%
Asthma Medication Ratio (amr)			
5–11 Years	86.74%	83.77%	-2.97%
12–18 Years	79.18%	80.21%	1.03%
19–50 Years	NA	NA	NA
51–64 Years	NA	NA	NA
Total	82.48%	81.9%	-0.58%
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	NA	NA	NA
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
Hemoglobin A1c (HbA1c) Testing	NA	-	NA
PoorHbA1cControl	NA	NA	NA
AdequateHbA1cControl	NA	NA	NA
Comprehensive Eye Exam for Patients With Diabetes (EED)	NA	NA	NA
Blood Pressure Control for Patients With Diabetes (BPD)	NA	NA	NA
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18–64)	NA	NA	NA

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
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
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	60.00%	54.05%	-5.95%
Effective Continuation Phase Treatment	35.00%	24.32%	-10.68%
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	36.52%	49.83%	13.31%
Continuation and Maintenance (C&M) Phase	51.79%	69.44%	17.65%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	66.51%	68.00%	1.49%
6-17 years - 7-Day Follow-Up	35.81%	42.00%	6.19%
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	65.78%	67.48%	1.70%
Total-7-day Follow-Up	35.11%	41.10%	5.99%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	60.71%	72.97%	12.26%
6-17 years - 7-Day Follow-Up	32.14%	45.95%	13.81%
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	60.61%	70.00%	9.39%
Total-7-day Follow-Up	36.36%	42.50%	6.14%
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	NA	NA	NA

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
Substance Use Disorder - 7 Days (13-17)			
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 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)	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

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
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)	32.00%	44.30%	12.30%
Cholesterol Testing (1-11)	21.33%	29.11%	7.78%
Blood Glucose and Cholesterol Testing (1-11)	21.33%	29.11%	7.78%
Blood Glucose Testing (12-17)	58.64%	54.27%	-4.37%
Cholesterol Testing (12-17)	29.63%	32.32%	2.69%
Blood Glucose and Cholesterol Testing (12-17)	29.01%	28.66%	-0.35%
Blood Glucose Testing (Total)	50.21%	51.03%	0.82%
Cholesterol Testing (Total)	27.00%	31.28%	4.28%
Blood Glucose and Cholesterol Testing (Total)	26.58%	28.81%	2.23%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.11%	1.21%	0.10%
Appropriate Treatment or Children with URI (uri)			
3 months-17 Years	66.47%	69.16%	2.69%
18-64 Years	59.65%	52.04%	-7.61%
65+ Years	NA	NA	NA
Total	66.23%	68.66%	2.43%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	28.13%	35.13%	7.00%
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)	28.21%	35.09%	6.88%
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	2.00%	0.00%	-2.00%
18-64 years - >=31 Days covered	0.00%	0.00%	0.00%

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
65+ – >=15 Days covered	NA	NA	NA
65+ – >=31 Days covered	NA	NA	NA
Total – >=15 Days covered	2.00%	0.00%	-2.00%
Total – >=31 Days covered	0.00%	0.00%	0.00%
Access/Availability of Care			
Annual Dental Visit (adv)			
2-3 Years	51.81%	52.71%	0.90%
4-6 Years	71.11%	72.72%	1.61%
7-10 Years	76.82%	77.92%	1.10%
11-14 Years	72.76%	73.41%	0.65%
15-18 Years	63.96%	63.52%	-0.44%
19-20 Years	55.45%	52.08%	-3.37%
Total	69.56%	70.19%	0.63%
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	58.97%	50.00%	-8.97%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	7.69%	12.50%	4.81%
Total Initiation of AOD Treatment: 13-17 years	56.10%	48.89%	-7.21%
Total Engagement of AOD Treatment: 13-17 years	7.32%	11.11%	3.79%
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

Measure/Data Element	HEDIS MY 2021 CHIP Rates	HEDIS MY 2022 CHIP Rates	Change
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	52.83%	46.15%	-6.68%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	5.66%	9.62%	3.96%
Initiation of AOD Treatment: Total	51.61%	43.33%	-8.28%
Engagement of AOD Treatment: Total	4.84%	8.33%	3.49%
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	57.50%	41.03%	-16.47%
12-17 Years	61.29%	74.16%	12.87%
Total	60.15%	64.06%	3.91%
Utilization			
Well-Child Visits in the First 30 Months of Life (w30)			
First 15 Months	68.93%	71.83%	2.90%
15 Months-30 Months	73.46%	74.38%	0.92%
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	44.35%	44.81%	0.46%
12-17 Years	40.16%	39.96%	-0.20%
18-21 Years	25.34%	24.93%	-0.41%
Total	41.11%	41.18%	0.07%

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

The CHIP HEDIS that showed a substantial increase included: the Follow-up care for children prescribed ADHD Medication Initiation Phase, the Continuation and Maintenance Phase, the Follow-Up After Emergency Department Visit for Mental Illness - the 30- and 7-Day Follow-up for 6 – 17 Year olds, the Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11), and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - 12-17 Year Olds.

The Antidepressant Medication Management – Effective Continuation Phase Treatment, and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – 1-11 Year Olds had a substantial decrease in the rate.

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 2022 and the previous year (MY 2021). The change from 2021 to 2022 is reported in the tables that follow. Rate changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 31: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2021 Rate	MY 2022 Rate	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
Colorectal Cancer Screening (COL-AD)			
Ages 50 - 64	42.01%	42.69%	0.68%
Ages 65 - 75	39.06%	32.84%	-6.22%
Total	41.99%	38.76%	-3.23%
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.54%	0.67%	0.13%
Ages 65+	0.96%	0.00%	-0.96%
Total	0.54%	0.66%	0.12%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception – 3 days	11.46%	13.44%	1.98%
Most or moderately effective contraception – 60 days	43.33%	-	NA
Most or moderately effective contraception – 90 days	-	54.35%	NA
LARC - 3 Days	0.61%	0.92%	0.31%
LARC - 60 Days Reported	8.37%	-	NA
LARC - 90 Days Reported	-	11.37%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception rate	24.55%	23.63%	-0.92%
LARC rate	2.75%	2.43%	-0.32%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			

Measure	MY 2021 Rate	MY 2022 Rate	Change
Ages 18 – 64	22.50	24.43	1.93
Ages 65+	NA	NA	NA
Total	22.47	24.38	1.91
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 – 64	44.42	54.12	9.70
Ages 65+	0.00	230.41	230.41
Total	44.25	54.94	10.69
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 – 64	46.46	54.46	8.00
Ages 65+	381.68	0	-381.68
Total	46.94	54.35	7.41
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 – 39	1.45	3.06	1.61
HIV VIRAL LOAD SUPPRESSION (HVL – AD)			
Ages 18 – 64	19.22%	19.61%	0.39%
Ages 65+	NA	NA	NA
Total	19.13%	20.75%	1.62%
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 – 64	0.84%	0.83%	-0.01%
Ages 65+	NA	NA	NA
Total	0.84%	0.83%	-0.01%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 – 64	3.83%	4.36%	0.53%
Ages 65+	NA	NA	NA
Total	3.82%	4.35%	0.53%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	39.98%	37.32%	-2.66%
Prescription for Buprenorphine	38.63%	34.60%	-4.03%
Prescription for Oral Naltrexone	0.87%	2.01%	1.14%
Prescription for Long-acting, injectable naltrexone	0.00%	0.24%	0.24%
Prescription for Methadone	0.77%	1.54%	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)			

Measure	MY 2021 Rate	MY 2022 Rate	Change
Ages 12 - 17	0.92%	1.24%	0.32%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	29.25%	40.15%	10.90%
Age 2 Screening	41.80%	48.91%	7.11%
Age 3 Screening	41.03%	50.36%	9.33%
Total Screening	36.43%	46.47%	10.04%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	1.78%	1.68%	-0.10%
Most or moderately effective contraception – 60 days	46.52%	-	NA
Most or moderately effective contraception – 90 days	-	61.76%	NA
LARC - 3 Days	0.97%	1.26%	0.29%
LARC - 60 Days Reported	10.21%	-	NA
LARC - 90 Days Reported	-	15.97%	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	28.77%	29.03%	0.26%
LARC Rate	2.58%	2.68%	0.10%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	29.25%	50.73%	21.48%
Numerator 2 All Four Molars Sealed	17.32%	35.24%	17.92%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.20%	0.63%	0.43%
Ages 1-2	4.22%	22.28%	18.06%
Ages 3-5	11.52%	59.05%	47.53%
Ages 6-7	12.44%	64.66%	52.22%
Ages 8-9	12.46%	65.46%	53.00%
Ages 10-11	12.14%	63.66%	51.52%
Ages 12-14	10.98%	58.42%	47.44%
Ages 15-18	8.89%	48.36%	39.47%
Ages 19-20	5.02%	28.58%	23.56%
Total Ages <1-20	9.87%	50.98%	41.11%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	10.77%	9.59%	-1.18%

Measure	MY 2021 Rate	MY 2022 Rate	Change
Ages 3–5	24.97%	27.03%	2.06%
Ages 6–7	29.55%	31.47%	1.92%
Ages 8–9	29.31%	31.62%	2.31%
Ages 10–11	27.26%	30.71%	3.45%
Ages 12–14	24.26%	26.51%	2.25%
Ages 15–18	17.42%	19.01%	1.59%
Ages 19–20	8.10%	8.14%	0.04%
Total Ages 1–20	22.70%	24.11%	1.41%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1–2	0.92%	5.52%	4.60%
Ages 3–5	2.47%	25.44%	22.97%
Ages 6–7	2.75%	30.94%	28.19%
Ages 8–9	2.62%	31.27%	28.65%
Ages 10–11	2.00%	30.41%	28.41%
Ages 12–14	2.06%	26.32%	24.26%
Ages 15–18	1.54%	18.85%	17.31%
Ages 19–20	0.43%	8.14%	7.71%
Total Ages 1–20	2.00%	23.21%	21.21%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1–2	3.62%	2.95%	-0.67%
Ages 3–5	0.40%	0.38%	-0.02%
Ages 6–7	0.00%	0.00%	0.00%
Ages 8–9	0.00%	0.00%	0.00%
Ages 10–11	0.00%	0.00%	0.00%
Ages 12–14	0.00%	0.00%	0.00%
Ages 15–18	0.00%	0.00%	0.00%
Ages 19–20	0.00%	0.00%	0.00%
Total Ages 1–20	0.44%	0.40%	-0.04%

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 Non-HEDIS measures the Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate – Ages 65+ and the Total rate, the Developmental Screening in the First 3 Years of Live – Age 1 Screening and the Total rate, the Sealant Receipt on Permanent First Molars – at Least One Sealant and All Four Molars Sealed, the Oral Evaluation-Dental Services for ages 1 – 20 and the Total rate, and the Prevention Topical Floride for Children for ages 3 – 18 and the Total rate demonstrated a significant increase in the rate.

The Heart Failure Admission Rate – Ages 65+ showed a substantial decrease in the rate.

For the CHIP Non-HEDIS rates, there several rates that demonstrated a substantial increase those rates included the Sealant Receipt on Permanent First Molars – at Least One Sealant and All Four Molars Sealed, the Oral Evaluation- Dental Services for ages 1 – 20 and the Total rate, and the Prevention Topical Floride for Children for ages 3 – 20 and the Total rate. The Diabetes Short – Term Complications Admission Rate for ages 18-64 and the Total rate had a substantial decrease in the rate, as noted in *Table 32: CHIP Non-HEDIS Performance Measure Rates*.

Table 32: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2021 Rate	MY 2022 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	0.41%	0.29%	-0.12%
Total	0.41%	0.29%	-0.12%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	29.83	0.00	-29.83
Total	29.83	0.00	-29.83
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	0.00	0.00	0.00
Total	0.00	0.00	0.00
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	0.00	0.00	0.00
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			
Ages 18 - 64	NA	NA	NA
Total	NA	NA	NA
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NA	NA	NA
Total	NA	NA	NA
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NA	NA	NA
Total	NA	NA	NA
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	NA	NA	NA
Prescription for Buprenorphine	NA	NA	NA
Prescription for Oral Naltrexone	NA	NA	NA

Measure	MY 2021 Rate	MY 2022 Rate	Change
Prescription for Long-acting, injectable naltrexone	NA	NA	NA
Prescription for Methadone	NA	NA	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	0.63%	1.34%	0.71%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	38.10%	51.61%	13.51%
Age 2 Screening	47.82%	54.01%	6.19%
Age 3 Screening	44.83%	48.18%	3.35%
Total Screening	45.83%	51.15%	5.32%
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	NA	NA	NA
Most or moderately effective contraception – 60 days	NA	-	NA
Most or moderately effective contraception – 90 days	-	NA	NA
LARC - 3 Days	NA	NA	NA
LARC - 60 Days	NA	-	NA
LARC - 90 Days	-	NA	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	29.04%	27.51%	-1.53%
LARC Rate	2.48%	1.72%	-0.76%
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	28.63%	47.09%	18.46%
Numerator 2 All Four Molars Sealed	17.88%	32.89%	15.01%
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	NA	NA	NA
Ages 1-2	6.66%	32.91%	26.25%
Ages 3-5	11.26%	61.65%	50.39%
Ages 6-7	12.97%	69.39%	56.42%
Ages 8-9	13.62%	72.30%	58.68%
Ages 10-11	12.59%	69.90%	57.31%
Ages 12-14	11.96%	64.70%	52.74%
Ages 15-18	9.71%	54.04%	44.33%
Ages 19-20	5.48%	43.51%	38.03%

Measure	MY 2021 Rate	MY 2022 Rate	Change
Total Ages <1-20	11.21%	61.17%	49.96%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 1)			
Ages 1-2	19.29%	16.42%	-2.87%
Ages 3-5	30.71%	32.20%	1.49%
Ages 6-7	35.77%	38.29%	2.52%
Ages 8-9	37.19%	39.33%	2.14%
Ages 10-11	35.17%	37.08%	1.91%
Ages 12-14	30.63%	31.39%	0.76%
Ages 15-18	21.61%	21.68%	0.07%
Ages 19-20	13.93%	14.22%	0.29%
Total Ages 1-20	29.41%	30.27%	0.86%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 2)			
Ages 1-2	1.61%	11.27%	9.66%
Ages 3-5	2.77%	30.51%	27.74%
Ages 6-7	2.88%	37.75%	34.87%
Ages 8-9	3.03%	39.15%	36.12%
Ages 10-11	2.22%	36.92%	34.70%
Ages 12-14	2.46%	31.32%	28.86%
Ages 15-18	1.98%	21.63%	19.65%
Ages 19-20	0.82%	14.22%	13.40%
Total Ages 1-20	2.40%	30.27%	27.87%
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH) (Rate 3)			
Ages 1-2	0.05%	3.31%	3.26%
Ages 3-5	0.00%	0.43%	0.43%
Ages 6-7	0.00%	0.00%	0.00%
Ages 8-9	0.00%	0.00%	0.00%
Ages 10-11	0.00%	0.00%	0.00%
Ages 12-14	0.00%	0.00%	0.00%
Ages 15-18	0.00%	0.00%	0.00%
Ages 19-20	0.00%	0.00%	0.00%
Total Ages 1-20	0.20%	0.19%	0.00%

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, United submitted four PIPs. Topics for those PIPs included Reducing 30-Day Psychiatric Inpatient Readmission Rates, Improving Pregnancy Outcomes, Respiratory Illness Management, and the Sickle Cell Disease Management Decreasing ER Utilization PIP. 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 33: Reducing 30-Day Psychiatric Inpatient Readmission Rates PIP

Reducing 30-Day Psychiatric Inpatient Readmission Rates	
The Behavioral Health Readmissions PIP is aimed at reducing the 30-day psychiatric readmission rates. The goal is to improve care coordination and discharge planning for members who experience psychiatric admissions at five inpatient facilities and determine if the interventions help decrease psychiatric readmissions. For this validation, the PIP showed improvement in the latest rate from 21.4% in 2021 to 18.7% with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2021 to 19% in 2022. Individual facility rates were reported as well for each of the five facilities.	
Previous Validation Score	Current Validation Score
74/75=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 discharged from inpatient facilities. • Enhanced Case Management.	

Reducing 30-Day Psychiatric Inpatient Readmission Rates
• Direct referrals to Genoa Pharmacy. • Partial Hospitalization Programs and/or Intensive Outpatient Programs as a step down from Inpatient level of care.

Table 34: Improving Pregnancy Outcomes PIP

Improving 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. This PIP has a DOM goal rate of 94.92% for the HEDIS Timeliness of Prenatal care rate. The baseline rate was 92.21% and the remeasurement number three rate was 96.84%. This rate reflects an improvement in the visit rate and exceeds the goal rate.	
Previous Validation Score	Current Validation Score
80/80=100% 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 35: Respiratory Illness Management PIP

Respiratory Illness Management	
Respiratory Illness examines the appropriate medications (bronchodilators or systemic corticosteroids) for members with COPD exacerbations based on HEDIS measures, as well as the asthma medication ratio HEDIS measures. For bronchodilators, the baseline was 74.96%, 76.36% in 2021, and the 2022 rate was 78.40%, which demonstrates improvement. Corticosteroids improved from 42.24% at baseline, to 49.89% in 2021, and improving again in 2022 to 50.76%. The AMR baseline was 70.7% and increased to 75.79% for 2022.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Respiratory Illness Management
• 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.

Table 36: Sickle Cell Disease Management Decreasing ER Utilization PIP

Sickle Cell Disease Management Decreasing ER Utilization	
The goal of the Sickle Cell Disease PIP is to decrease emergency room utilization by monitoring the number of members five to 64 years of age who were identified as a persistent super user of emergency room services for sickle cell disease complications. The baseline rate was 36.28%, decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%. Thus, the most recent rate did not show improvement in year over year trending.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Outreach to providers encouraging the use of hydroxyurea for patients who do not have a pharmacy claim for hydroxyurea. • Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients. • Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments. • Telehealth campaigns and after-hour care newsletters. • Weekly interdisciplinary rounds for Case Management. • Provider education with the After Hour Care newsletter.	

Constellation Quality Health provided recommendations for the Behavioral Health Readmission and Sickle Cell PIPs. They are displayed in *Table 37: CAN Performance Improvement Project Recommendations*.

Table 37: 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 inpatient readmissions PIP showed improvement in the latest rate from 21.4% in 2021 to 18.7% with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2021 to 19% in 2022	Continue to monitor BH readmission rates and determine barriers to case management enrollment for re-admitters.
Sickle Cell Disease	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate was 36.28% a baseline, decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%.	Continue ongoing interventions such as the Sickle Cell Disease Program and daily dashboard reviews to assess patient tracking of ER utilization and medication non-adherence.

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 38: 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 declined from 40.16% to 39.96%. This is below the goal rate of 41.36%. The rate for 18 - 21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%.	
Previous Validation Score	Current Validation Score
80/80 = 100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)
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 members to receive educational materials regarding wellness visits and immunizations.

Table 39: 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. The Pip report showed that the 30-day follow up rate improved from 65.8% in 2021 to 67.48% in 2022, exceeding the goal rate of 59.42%. The 7-day follow up rate improved from 35.11% in 2021 to 41.1% in 2022. The goal rate for United is 38.95%.	
Previous Validation Score	Current Validation Score
74/75=99% High Confidence in Reported Results	80/80 = 100% High Confidence in Reported Results
Interventions	
• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay. • Continue demographic workflow to improve capture of current contact numbers for enrollees. • Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCP to communicate relevant treatment information involving member care. • Network notes and Optum news and updates for UBH clinicians and facilities. • Case management initiates calls to schedule follow-up appointments.	

Table 40: 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. The BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93% with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66% with a goal rate of 68.61%.	
Previous Validation Score	Current Validation Score

Reducing Adolescent and Childhood Obesity	
100/100=100% High Confidence in Reported Results	94/95=100% Hight Confidence in Reported Results
Interventions	
• Member and provider education. • Phone calls to noncompliant members. • After-hours and weekend clinic days. • 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 41: 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. The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%.	
Previous Validation Score	Current Validation Score
100/100=100% High Confidence in Reported Results	94/95=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.	

Constellation Quality Health provided recommendations for the Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV), Reducing Adolescent and Childhood Obesity, and Getting Needed Care CAHPS as displayed in *Table 42: CHIP Performance Improvement Project Recommendations*.

Table 42: CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Adolescent Well Child Visits (AWC)/ new measure Child and Adolescent Well Care Visits (WCV)	Was there any documented, quantitative improvement in processes or outcomes of care?	The WCV (adolescence well care visits) PIP showed the rate for the 12 – 17-year-olds declined from 40.16% to 39.96%. This is below the goal rate of 41.36%. The rate for 18 - 21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%.	Continue to assess interventions and consider sub-analysis of patient care reports to determine if specific subsets of the population are impacting the reduction in rates.
Reducing Adolescent and Childhood Obesity	Was there any documented, quantitative improvement in processes or outcomes of care?	The BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93% with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66% with a goal rate of 68.61%.	Continue to assess interventions and consider sub-analysis of patient care reports to determine if specific subsets of the population are impacting the reduction in rates.
Getting Needed Care CAHPS	Was there any documented, quantitative improvement in processes or outcomes of care?	The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%.	Continued analysis by Task Force and provider education should continue in efforts to improve satisfaction rates.

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

As noted in *Figure 6: Quality Improvement Findings*, 100% of the CAN and CHIP standards in the Quality Improvement section were scored as "Met."

Figure 6: Quality Improvement Findings

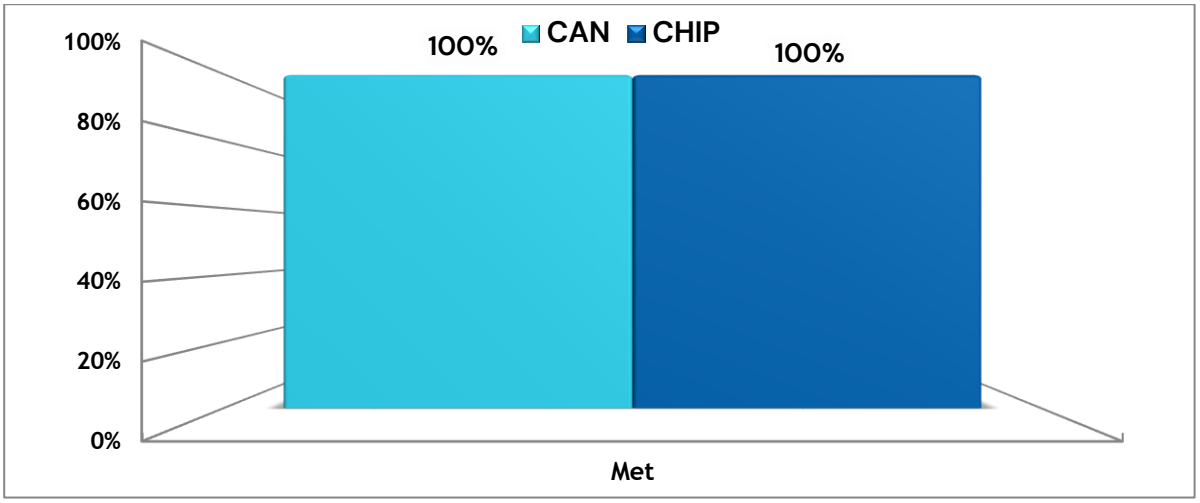

Table 43: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The 2022 Quality Improvement & Population Health Management Annual Evaluation Report (CHIP and CAN) was detailed and contained a review and results of all aspects of the program.	✓		
The CAN and CHIP PIPs met the validation requirements and received scores within the High Confidence range.	✓		
United's HEDIS auditor found that the CCO was fully compliant with all information systems Standards and determined that United submitted valid and reportable rates for all HEDIS measures in 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. Aqurate determined that United followed the measure specifications and produced reportable rates for most measures in the scope of the validation of PMs.	✓		
The following HEDIS MY 2022 measure rates had a greater than 10 percentage point improvement: • Follow-up After High -Intensity Care for Substance Use Disorder (FUI) (CAN), 7 days (18-64) and 7 days total indicators improved by over 10 percentage points. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) (CAN), all 6 indicators improved by over 12 percentage points. • Follow-up care for children prescribed ADHD Medication (ADD) (CHIP), both Initiation Phase and Continuation and Maintenance (C&M) Phase indicators improved by over 13 percentage points. • Follow-Up After Emergency Department Visit for Mental Illness (FUM) (CHIP), the 6–17-year-old 30-day and 7-day follow-up indicators improved by over 12 percentage points. • Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) (CHIP), the Blood Glucose testing for 1-11 indicator improved by over 12 percentage points. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) (CHIP), for the 12-17 age group indicator improved by over 12 percentage points.	✓		

Strengths	Quality	Timeliness	Access to Care
• Chronic Obstructive Pulmonary Disease (COPD) or Asthma in older adults' admission rate (PQI-05) (CAN). Age 65+ and Total indicators improved by over 10 percentage points. • Developmental Screening in the first 3 years of life (DEV-CH), Age 1 screening improved by over 10 percentage points for the CAN and CHIP population and Total screening indicator improved by over 10 percentage points for the CAN population. • Sealant Receipt on Permanent First Molars (SFM-CH) (CAN) (CHIP), all indicators improved by over 15 percentage points. • Topical Fluoride for Children (TLF-CH) all indicators besides the Ages 1-2 and Ages 19-20 indicators for Rate 2 improved by over 17 percentage points for the CAN population. All indicators besides the Ages 1-2 indictor for Rate 2 improved by over 13 percentage points for the CHIP population. • Oral Evaluation, Dental Services (OEV_CH), all indicators besides the Age <1 indicator improved by over 10 percentage points for the CAN and CHIP population.			

Table 44: Quality Improvement Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
In the CAN and CHIP work plans there was a typo regarding which QI Program Description was presented to the Quality Management Committee for approval.	Recommendation: Correct the information regarding the QI Program Descriptions that was presented to the Quality Management Committee for approval.	✓		
Several of the CAN and CHIP PIPs showed a decline in some of the rates being measured.	Recommendation: Assess the current interventions and consider any sub-analysis of reports to determine if specific subsets of the population are impacting improvements in the rates.	✓		
The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for United since their rates had a greater than 10% decline: • Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) (CAN) had a greater than 20 percentage point decline. This can be attributed to the small eligible population. • Antidepressant Medication Management (AMM) (CHIP), the Effective Continuation Phase Treatment indicator had a greater than 10 percentage point decline. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) (CHIP), 1-11 Years	Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
indicator had more than a 16 percentage point decline. • Hearth Failure Admission Rate (PQI-08) (CAN), the Age 65+ indicator declined by over 10 percentage points. • Diabetes Short-Term Complications Admission Rate (PQI01-AD) (CHIP), all indicators declined by over 10 percentage points.				
During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and United's vendor corrected the source code. United confirmed that the corrected source code was used to calculate the final rates.	Recommendation: Improve processes around oversight of the software vendor and ensure they are following specifications when calculating the DOM required performance measures.	✓		

QUALITY IMPROVEMENT—CAN

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					United has developed a QI program that includes all aspects of health care quality. United's 2023 Quality Improvement and Population Health Management Program Description details the program's structure, objectives, scope, and methodology. The QI program operates in conjunction with Untied's Utilization Management program to improve the health and health care services provide to members.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The reduction of health disparities is addressed through United's Health Equity program. The goal of this program is to reduce health disparity and improve culturally and linguistically appropriate services. United has selected three measures for this program. Those included improving the HEDIS rates for Cervical Cancer Screening and Immunizations for Adolescents and improving the CAHPS score for Rating of Personal Doctor. To evaluate the overall effectiveness of the Health Equity program, United conducted an evaluation of the program. The 2022 Healthy Equity Evaluation document was provided for this EQR. The evaluation included all the results of the three specific measures, a barrier analysis, and any

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						opportunities for improvement. This information is used to determine changes or restructuring of the program if needed.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, United develops a QI work plan to identify the planned activities related to program priorities that are intended to improve the provisions of population health, quality, safety of clinical care, and services. For CAN there were five specific goals outlined in the 2023 QI work plan. Those goals include improving specific HEDIS measures, CAHPS measures, Provider satisfaction, EPSDT rates, and HEDIS measures associated with the Performance Improvement Projects. There was a typo regarding which Annual Program Descriptions were presented to the Quality Management Committee. United confirmed the 2023 QI Program Descriptions were presented to the committee instead of the 2022 program descriptions. *Recommendation: Correct the information regarding the QI Program Descriptions that was presented to the Quality Management Committee for approval.*
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 continues to be 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 of care rendered within the network. United's Chief Medical Officer chairs this committee and network providers specializing in OB/GYN, Internal Medicine, Psychiatry, Dentistry, Pediatrics, and Family Medicine are included 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					The Provider Advisory Committee meets and reports to the Quality Management Committee at least four times per year. A quorum of 51 percent of voting members present is required for all committee meetings.
4. Minutes are maintained that document proceedings of the QI Committee.	X					A review of the committee minutes demonstrated both committees met the meeting frequency and quorum requirements.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate conducted the validation of performance measures following the CMS protocol. The validation included validating the data collection and reporting processes used to calculate the performance measure rates. United was found to meet the validation requirements. The Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) had a greater than 20 percentage point decline. This can be attributed to the small eligible population. Also, the Hearth Failure Admission Rate (PQI-08), the Age 65+ indicator declined by over 10 percentage points. During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and United's vendor corrected the source code. United confirmed that the corrected source code was used to calculate the final rates. *Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement. Improve processes around oversight of the software vendor and ensure they are following specifications when*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						calculating the DOM required performance measures.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					For this review, United submitted four PIPs. Topics for those PIPs included Reducing 30-Day Psychiatric Inpatient Readmission Rates, Improving Pregnancy Outcomes, Respiratory Illness Management, and Sickle Cell Disease Management Decreasing ER Utilization PIP.
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 and met the validation requirements. Two of the PIPs (Behavioral Health Readmission, and Sickle Cell PIPs) showed a decrease in some of the rates. *Recommendation: Assess the current interventions and consider any sub-analysis of reports to determine if specific subsets of the population are impacting improvements in the rates.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					United monitors provider compliance with clinical and preventive health as outlined in policy QM-01, Monitoring of Clinical and Preventive Health Guidelines. On an annual basis the health plan measures at least two clinical guidelines that address a high-volume or high-risk condition.
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					Per Standard Operating Procedure, 001, EPSDT Services – Tracking Process, any problems identified during the EPSDT exam that require referrals are tracked on a quarterly basis. Members identified with significant conditions receive additional outreach for case management 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					An annual review of the overall effectiveness of the QI Program is conducted to assess how well resources have been deployed to meet the objectives of the program. The results of the annual evaluation are used to develop and prioritize next year's activities. The 2022 Quality Improvement & Population Health Management Annual Evaluation

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Report contained a review and results of all aspects of the program. For goals that were not met, a root cause or barrier analysis was conducted and opportunities for approvements identified.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

QUALITY IMPROVEMENT—CHIP

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 QI program description for the CHIP population. The 2023 Quality Improvement and Population Health Management Program Description. This program description details the program's structure, objectives, scope, and methodology.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The reduction of health disparities is addressed through United's Health Equity program. The goal of this program is to reduce health disparity and improve culturally and linguistically appropriate services. For CHIP, United has selected measures for improving the HEDIS rates for Immunizations for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Adolescents Combo 2 in targeted counties and improve the CAHPS score for the Rating of Specialist.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, United develops a QI work plan to identify the planned activities related to program priorities that are intended to improve the provisions of population health, quality, safety of clinical care, and services. For CHIP there were five specific goals outlined in the 2023 QI work plan. Those goals include improving specific HEDIS measures, CAHPS measures, Provider satisfaction, Well Visit rates, and HEDIS measures associated with the Performance Improvement Projects. There appeared to be a typo regarding which Annual Program Descriptions were presented to the Quality Management Committee. United confirmed the 2023 QI Program Descriptions were presented to the committee instead of the 2022 program descriptions. *Recommendation: Correct the information regarding the QI Program Descriptions that was presented to the Quality Management Committee for approval.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 continues to be 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 of care rendered within the network. United's Chief Medical Officer chairs this committee and network providers specializing in OB/GYN, Internal Medicine, Psychiatry, Dentistry, Pediatrics, and Family Medicine are included 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	X					Aqurate conducted the validation of performance measures following the CMS protocol. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
requirements of the CMS protocol, "Validation of Performance Measures."						validation included validating the data collection and reporting processes used to calculate the performance measure rates. United was found to meet the validation requirements. The following HEDIS MY 2022 measure rates were determined to be areas of opportunities for United since these rates had a greater than 10% decline: • Antidepressant Medication Management (AMM), the Effective Continuation Phase Treatment indicator had a greater than 10 percentage point decline. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), 1-11 Years indicator had more than a 16-percentage point decline. • Diabetes Short-Term Complications Admission Rate (PQI01-AD), all indicators declined by over 10 percentage points. During source code review it was identified that the age of the member was being calculated per the discharge date for the following measures: PQI-01, PQI-05, PQI-08, PQI-15. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and United's vendor corrected the source code. United confirmed that the corrected source code was used to calculate the final rates.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Improve processes around monitoring HEDIS and non-HEDIS rate trends to identify opportunities for improvement. Improve processes around oversight of the software vendor and ensure they are following specifications when calculating the DOM required performance measures.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					United submitted the same four PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction, Follow Up After Hospitalization, and Obesity.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All the CHIP PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. Three of the PIPs (Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV), Reducing Adolescent and Childhood Obesity, and Getting Needed Care CAHPS PIPs) showed a decrease in some of the rates. *Recommendation: Assess the current interventions and consider any sub-analysis of reports to determine if specific subsets of the population are impacting improvements in the rates.*
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					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					United monitors provider compliance with clinical and preventive health as outlined in Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines. On an annual basis the health plan measures at least two clinical guidelines that address a high-volume or high-risk condition.
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					Per standard operating procedure, 001, EPSDT Services – Tracking Process, any problems identified during the EPSDT exam that require referrals are tracked on a quarterly basis. Members identified with significant conditions receive additional outreach for case management 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)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					United conducted a separate QI Program Evaluation for the CHIP population. The 2022 Quality Improvement & Population Management Annual Evaluation Report was provided. This evaluation detailed the review and results of all aspects of the program related to CHIP.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

E. 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 2023 CAN and CHIP Utilization Management (UM) Program Description, Pharmacy Program Description, and Optum's Behavioral Health Utilization Management Program Description and Work Plan outline United's CAN and CHIP UM objectives, scope of activities, and program structure for medical, behavioral health, and pharmacy services.

United's Chief Medical Officer provides overall oversight of the UM Program. The responsibilities of the Chief Medical Officer entail clinical supervision, developing and implementing medical and behavioral health components of the UM Program, conducting peer to peer clinical reviews, and oversight of the appeals process. The Behavioral Health Medical Director, in collaboration with the Chief Medical Officer, provides clinical management of the behavioral health program that includes consultations, supervision, and training. The Pharmacy Director provides oversight of the pharmacy program and is responsible for performing clinical reviews, monitoring to detect adverse drug utilization trends, and consultations.

Timeframes to complete authorization requests are outlined in various policies and in the CAN and CHIP UM Program Descriptions. During the previous EQR, Constellation Quality Health noted that the notice sent to members when United requested an extension was missing information regarding the member's right to file a grievance regarding the extension, as required by *42 CFR § 438.408 (c)*. This requirement was 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 this EQR, it is noted that United corrected the previously identified issue of informing the members of their right to file a grievance when an extension is requested in the members' notices, CAN and CHIP Provider Manuals, CAN and CHIP Member Handbooks, and policy. See *Table 45* for the specific issues, corrective actions, and United's responses.

Table 45: 2022 Utilization Management (UM) Program CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
1. The CCO formulates and acts within policies and procedures that describe its utilization management	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.	The issues identified during the previous EQR related to member rights to file a grievance if they disagree with an extension of the authorization determination timeframe were corrected.

Standard	EQR Comments	2023 EQR Findings
program, including but not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic);	*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.*	
United's 2022 Response: The member notice (page 3), CAN UM Program Description (page 15), policy (II.a.vi. on page 2 of Rider to Clinical Review Criteria Policy), Provider Manual (page 38), and CAN Member handbook (page 66) has been revised regarding the member's right to file a grievance. SUPPORTING DOCUMENTATION: 05, 06, 09, 17, 18, 20 2022.12.20 Member Notice of Extension.docx 06 2022.12.20 CAN UM Program Description.docx 06, 18 2022.12.21 Rider to Clinical Review Criteria Policy.docx 01, 06, 08, 09 2022.12.15 CAN-Care Provider-Manual RED DRAFT.docx 03, 04, 06-09, 16 2022.12.20 CAN Member handbook.pdf United's follow-up response: The CAN UM Member Notice of Extension (page 3) and CAN Provider Manual (page 30) has been revised regarding a member's right to file a grievance. SUPPORTING DOCUMENTATION: 06 2023.01.10 CAN UM Member Notice of Extension.doc 01, 06, 08, 09 2023.01.10 CAN-Care Provider-Manual RED DRAFT.docx		
CHIP		
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to: 1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	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.*	The issues identified during the previous EQR related to member rights to file a grievance if they disagree with an extension of the authorization determination timeframe were corrected.
United's 2022 Response: The member notice (page 3), CHIP UM Program Description (page 15), policy (II.a.vi. on page 2 of Rider to Clinical Review Criteria Policy), Provider Manual (page 36), and CHIP Member handbook (page 66) has been revised regarding the member's right to file a grievance. SUPPORTING DOCUMENTATION: 05, 06, 09, 17, 18, 20 2022.12.20 Member Notice of Extension.docx 18 2022.12.20 CHIP UM Program Description.docx 06, 18 2022.12.21 Rider to Clinical Review Criteria Policy.docx 12, 13, 18-20 2022.12.20 CHIP Care Provider Manual REDDRAFT.docx 12, 15, 18-20 2022.12.22 CHIP Member handbook.pdf		

Standard	EQR Comments	2023 EQR Findings
The CHIP UM Member Notice of Extension (page 3) has been revised regarding the member's right to file a grievance. SUPPORTING DOCUMENTATION: 18 2023.01.10 CHIP UM Member Notice of Extension.doc		

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

Clinical reviews are conducted by actively licensed professionals that hold current licensure within their clinical specialties and utilize external and internal clinical guidelines such as State Regulations, InterQual, and Behavioral Health Level of Care Guidelines in performing clinical determinations. Level II medical necessity reviews are conducted by a licensed physician. Nonclinical staff provide administrative support through intake, administrative coverage approvals, etc.

United conducts an annual Inter-Rater Reliability (IRR) test for physicians and non-physician clinical reviewers. UM Clinical staff and Medical Directors participated in an online Inter-Qual Inter Rater Reliability Assessment. Based upon the results, the clinicians and physicians exceeded the target goal of 90%. Also, during onsite discussion, United shared that monthly case review audits are conducted for quality assurance.

Constellation's review of the sample approval files reflected that the reviews were performed by appropriate licensed healthcare professionals and there was consistency in applying appropriate clinical criteria.

Review of the denial files indicated that the adverse benefit decisions were appropriately communicated to the provider and described the reasoning for the denial and appeals process.

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. The CAN and CHIP Member Handbook, Provider Manual, and Pharmacy Program Description provide an overview of the PDL.

During the previous EQR, Constellation Quality Health identified that the links provided in the CAN Member Handbook to access the PDL and a listing of over the counter (OTC) medicines resulted in an error message indicating "page not found." It is noted during this EQR that the embedded links in the CAN Member Handbook worked appropriately in providing access to the PDL and listing of the over-the-counter medicines. Please see *Table 46* for an overview of the identified issue and United's response.

Table 46: 2022 Medical Necessity Determinations CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	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 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.*	The issues identified during the previous EQR related the imbedded links in the Member Handbook to the listing of OTC medicines and the PDL were corrected.
United's Response: The CAN Member handbook has been revised to ensure the embedded links for PDL and OTC medications listed in the CAN Member handbook are functional. SUPPORTING DOCUMENTATION: 03, 04, 06-09, 16 2022.12.20 CAN Member handbook.pdf https://www.uhccommunityplan.com/ms/medicaid/mississippican/find-a-provider-or-pharmacy		

Appeals

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

United's processes for handling appeals are outlined in policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, CAN and CHIP Member Handbook, Provider Manual, and website. Appeals are defined as an adverse benefit determination and indicate that appeals may be filed at any time by the member, legal guardian, authorized representative, or service provider. The timelines for the appeals acknowledgment, resolution, and extension if needed are consistently outlined in United's materials specific to the Contract guidelines. The UM Program Evaluation indicates that appeals are analyzed quarterly to evaluate and address trends. Information is reported to the Healthcare Quality and Utilization Management Committee and Provider Advisory Committee.

Review of the Appeals documents verbal and written filing processes revealed the following issues:

- Policy USCMM 0712, Appeal Process and Record Documentation, states that "The consumer/representative or provider may initiate the appeal process or in writing via mail, facsimile, or electronic medium, or verbally if expedited."
- Policy UCSMM.07.11, Appeal Review Timeframes, states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date."
- The CHIP download on United's website indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and

return the appeal with 30 days of the filing." This does not align with process guidelines for filing verbally or in writing.

A sample of CAN and CHIP appeals files were reviewed for the 2023 EQR. The Acknowledgement Letters in three CAN files and four CHIP files were addressed to the provider or Appeals Department, but language appeared to be communicating to the member. The Resolution Letters for four CAN files and three CHIP files were addressed to the provider, but the language within the resolution letter appeared to be communicating with the member. There were two CAN Files and two CHIP files wherein a Written Consent or Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf. Overall, the sample files reviewed for both CAN and CHIP found that appeals were processed in a timely manner. Post onsite, United cited an appeal system flagging error that may have led to improper letter creation and provided documentation of some instances of the members being mailed a copy of the letter that were addressed to the provider.

The 2022 EQR deficiency findings are described in the following table along with United's response for addressing previous Corrective Action.

Table 47: Previous Appeals CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
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: 1.2 The procedure for filing an appeal;	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.*	The issues identified during the previous EQR related to requiring a verbal appeal to follow a written appeal were corrected.
United's 2022 Response: CAN Member handbook (page 66), and CAN Provider Manual (page 34) have been revised to remove the requirement that a verbal appeal must be followed with a written appeal. Once CAN Member handbook and CAN Provider Manual changes receive State approval, United will update their website to align (see proposed revisions). SUPPORTING DOCUMENTATION: 08, 09, 19, 20 2022.12.29 Proposed Website Revisions		

Standard	EQR Comments	2023 EQR Findings
03, 04, 06-09, 16 2022.12.20 CAN Member handbook.pdf 01, 06, 08, 09 2022.12.15 CAN-Care Provider-Manual RED DRAFT.docx		
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	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.*	The issues identified during the previous EQR related member rights to file a grievance if they disagree with United's request to extend the appeal processing timeframe were corrected.
United's 2022 Response: The member notice (page 3), CAN Member Handbook (page 66), and Provider Manual (page 38) have been revised to include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal. Once CAN Member handbook and CAN Provider Manual changes receive State approval, United will update their website to align (see proposed revisions). SUPPORTING DOCUMENTATION: 05, 06, 09, 17, 18, 20 2022.12.20 Member Notice of Extension.docx 03, 04, 06-09, 16 2022.12.20 CAN Member handbook.pdf 01, 06, 08, 09 2022.12.15 CAN-Care Provider-Manual RED DRAFT.docx 08, 09, 19, 20 2022.12.29 Proposed Website Revisions United's follow-up response: The CAN Member Handbook (page 67) and CAN Provider Manual (pages 34,35) has been revised to include the member's right to file a grievance if they disagree with the request of an extension. SUPPORTING DOCUMENTATION: 03, 04, 06-09, 16 2023.01.09 CAN Member handbook.pdf 01, 06, 08, 09 2023.01.10 CAN-Care Provider-Manual RED DRAFT		
2. The CCO applies the appeal policies and procedures as formulated.	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.	The issues identified during the previous EQR related appeal acknowledgement and resolution letters were corrected.

Standard	EQR Comments	2023 EQR Findings
	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.*	
United's Response: United will continue to work on a solution to improve the appeal resolution notifications to include clear and concise language, and removal of duplicate information within the response. Beginning Q1 2023, the monitoring plan will consist of: • Modifications to resolution letter templates to eliminate duplicate information. • Implementation of additional quality measures being put in place to review and edit notifications before letters are generated and mailed. Quarterly meetings with the appeals and grievance team to review samples of the resolution notifications to ensure improvements are being made. Results of the letter reviews will be presented during quarterly Policy Advisory Committee (PAC) and Health Quality and Utilization Management Committee (HQUM) meetings.		
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: 1.2 The procedure for filing an appeal;	United's website, the 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.*	The issues identified during the previous EQR related to requiring a verbal appeal to follow a written appeal were corrected.
United's Response: CHIP Member handbook (page 54), and the CHIP Care Provider Manual (page 32) have been revised to remove the requirement that a verbal appeal must be followed with a written appeal. Once CHIP Member handbook and CHIP Provider Manual changes receive state approval, United will update their website to align (see proposed revisions). SUPPORTING DOCUMENTATION: 08, 09, 19, 20 2022.12.29 Proposed Website Revisions 12, 15, 18-20 2022.12.22 CHIP Member handbook.pdf 12, 13, 18-20 2022.12.20 CHIP Care Provider Manual REDDRAFT.docx		
1.5 Timeliness guidelines for resolution of the appeal;	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	The issues identified during the previous EQR related member rights to file a grievance if they disagree with United's

Standard	EQR Comments	2023 EQR Findings
	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.*	request to extend the appeal processing timeframe were corrected.
United's 2022 Response: The member's notice (page 3), CHIP Member Handbook (page 54), and CHIP Care Provider Manual (page 36) have been revised to include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal. Once CHIP Member handbook and CHIP Provider Manual changes receive state approval, United will update their website to align (see proposed revisions). SUPPORTING DOCUMENTATION: 05, 06, 09, 17, 18, 20 2022.12.20 Member Notice of Extension.docx 12, 15, 18-20 2022.12.22 CHIP Member handbook.pdf 12, 13, 18-20 2022.12.20 CHIP Care Provider Manual REDDRAFT.docx 08, 09, 19, 20 2022.12.29 Proposed Website Revisions United's follow-up response: The CHIP Care Provider Manual (pages 32, 34) have been revised to include the member's right to file a grievance if they disagree with United's request to extend the timeframe for processing an appeal. SUPPORTING DOCUMENTATION: 12, 13, 18-20 2023.01.10 CHIP Care Provider Manual REDDRAFT.docx		
1.6 Written notice of the appeal resolution;	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 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. <u>This was an issue identified during the 2021 EQR and not corrected.</u> *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).*	The issues identified during the previous EQR related member rights to request and receive benefits and can be held liable for the cost were corrected.
United's 2022 Response: The "Your Additional Rights" enclosure for CHIP appeals letters has been revised to include the requirement that members have the right to request and receive benefits and can be held liable for the cost. The enclosure has been deployed into production since 9/21/2022. SUPPORTING DOCUMENTATION: 21, 22 2022.12.20 Your Additional Rights enclosure for CHIP appeals letters.docx		

Standard	EQR Comments	2023 EQR Findings
2. The CCO applies the appeal policies and procedures as formulated.	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 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.*	The issues identified during the previous EQR related appeal acknowledgement and resolution letters were corrected.
United's 2022 Response: United will continue to work on a solution to improve the appeal resolution notifications to include clear and concise language, and removal of duplicate information within the response. Beginning Q1 2023, the monitoring plan will consist of: • Modifications to resolution letter templates to eliminate duplicate information. • Implementation of additional quality measures being put in place to review and edit notifications before letters are generated and mailed. • Quarterly meetings with the appeals and grievance team to review samples of the resolution notifications to ensure improvements are being made. Results of the letter reviews will be presented during quarterly PAC and HQUM meetings. The resolution letter template (page 1) was revised to include language that instructs the member to "Please see the attached pages for what you can do next if you disagree with our decision." Each letter will include "Your Additional Rights" enclosures which state the member's right to request and receive benefits while the Independent External Review is pending. SUPPORTING DOCUMENTATION: 21, 22 2022.12.20 Your Additional Rights enclosure for CHIP appeals letters.docx 22 2022.12.20 Resolution Letter Template		

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

The 2023 CAN and CHIP Care Management Model Program Description and Addendum and various policies provide a descriptive overview of the program's scope and case

management process for members. Optum's CAN and CHIP Behavioral Health Complex Case Management Program Description outlines the care management program specific to behavioral health care. The CAN and CHIP Quality Improvement and Population Health Management Program Description describes the program's objectives and population health management activities.

Members are referred for care management services through various referral sources such as pharmacy data, self-referrals, claims data, and additional referral sources. During onsite discussion, the health plan shared that IPro is a predictive modeling system that is utilized to aid in identifying potential members for care management. Also, providers are informed of the care management program and referral process through various methods.

New members are screened for appropriateness of case management services by completion of a health risk assessment (HRA). This screening aids in identifying member risk level, service needs, and refer members to appropriate case management services and specialized programs. If a member's needs do not coincide with a risk level, the care manager will implement clinical judgement based upon the completed assessment to assign the member to an appropriate risk level. After the completion of the assessment, an individualized care plan is developed to address the member's identified needs.

Transitional case management is also offered to members to provide transitions of care for members across healthcare settings and providers. The transition coordinator's activities include care coordination, monitoring, data tracking, and analyzing care transitions. The Interdisciplinary Team of physicians, care managers, and nurses work collaboratively to ensure proper care coordination. A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, there were three CHIP transitional care management files that did not have ongoing documentation of notes that entail a follow-up schedule of the members' progress and process of case closure.

As noted in *Figure 7: Utilization Management Findings*, 96% of the Utilization Management standards were scored as "Met for CAN and 94% of the standards were scored as "Met" for CHIP.

Figure 7: Utilization Management Findings

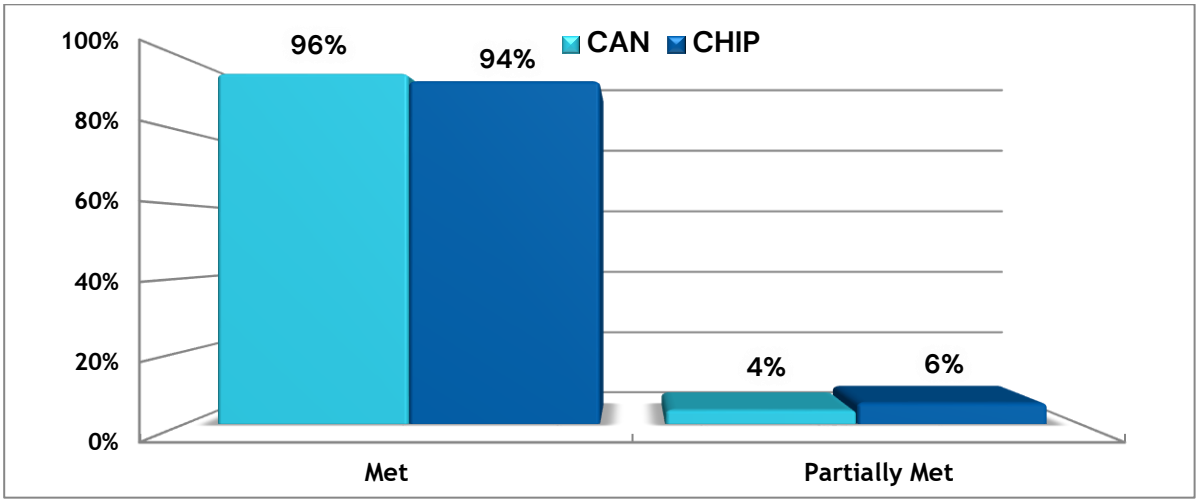

Table 48: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Approval files were completed in a timely manner according to contractual standards.		✓	
Denial files provided a clear understanding of the reasoning of the Adverse Benefit Decision and the appeals process.	✓		
Inter-Rater Reliability results were 99% for Clinicians and Medical Directors and 96% for Behavioral Health UM Reviewers, exceeding the targeted goal of 90%.	✓		
The 2023 EQR found that appeals files were processed in a timely manner overall.		✓	

Table 49: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy USCMM 0712, Appeal Process and Record Documentation, states that "The consumer/representative or provider may initiate the appeal process or in writing via mail, facsimile, or electronic medium, or verbally if expedited."	Corrective Action Plan: Revise policy USCMM 0712, Appeal Process and Record Documentation, to correct the wording on page 2, Section A, #4 that indicates that appeals may be filed verbally if expedited.	✓		
Policy UCSMM.07.11, Appeal Review Timeframes, states that "A verbal Appeal shall be followed by a written Appeal that is signed	Corrective Action Plan: Revise Policy UCSMM.07.11 Appeal Review Timeframes, to correct the wording on page 3 that	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
by the Member within thirty (30) calendar days of the filing date."	states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date."			
The CHIP download on United's website indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing." This does not align with process guidelines for filing verbally or in writing.	Corrective Action Plan: Correct the CHIP download on the United website that indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing."	✓		
The Acknowledgement Letters in 3 CAN files and 4 CHIP files were addressed to the provider or Appeals Department, but language appeared to be communicating to the member.	Corrective Action Plan: Ensure that processes are in place to review the language within the acknowledgement letters so that they accurately address the filer.	✓		
The Resolution Letters for 4 CAN files and 3 CHIP files were addressed to the provider, but the language within the resolution letter appeared to be communicating with the member.	Corrective Action Plan: Ensure that processes are in place to review the language within the resolution letters so that it accurately addresses the filer.	✓		
2 CAN Files and 2 CHIP files found that a Written Consent or Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf.	Corrective Action Plan: Ensure that processes are in place to ensure that Written Consent or Appointment of Representative Forms are in place as needed.	✓		
The 2023 Care Management Model Program Description and Addendum and Policy NCM 002, Case Management Process, provide an overview of the Health Risk Assessment. Policy NCM 002, Case Management Process, is applicable to CAN and CHIP members as shared during onsite discussion. However, the policy does not reference CHIP Line of Business.	Recommendation: Please add CHIP reference to Policy NCM, 002 Case Management Process, as this is applicable to CHIP Contract, Section 8 (A) (1).	✓		
A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, there were three CHIP transitional care management files that did not have ongoing documentation of notes that entail a follow-up schedule of the members' progress and process of case closure.	Corrective Action: Please ensure to obtain and accurately document a follow-up schedule of the members' process receiving transitional care management services.	✓		

UTILIZATION MANAGEMENT—CAN

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's 2023 Utilization Management Program Description and Addendum outline United's UM objectives, scope of activities, and program structure. Optum is responsible for oversight and management of behavioral services. Optum's Behavioral Health Utilization Management Program Description provides an overview of the behavioral health program structure, roles and responsibilities of clinical staff, and the UM determinations process.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Policy MS Rider 06.16, Initial Review Timeframes, and Policy 06.16 UCSMM Initial Review Timeframes, outline United's procedural guidelines to ensure timeliness of the utilization management process.
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 provides overall oversight of the UM Program. The responsibilities of the Chief Medical Officer entail clinical supervision, developing and implementing medical and behavioral health components of the UM Program, conducting peer to peer clinical reviews, and oversight of the appeals process. The Behavioral Health Medical Director, in collaboration with the Chief Medical Officer, provides clinical management of the behavioral health program that includes consultations, supervision, and training. The Pharmacy Director provides oversight of the pharmacy program and is responsible for performing clinical reviews, monitoring to detect adverse drug utilization trends, and consultations.
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 § 4*						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					The CAN UM Program Description and Policy UCSMM 06.10 Rider 1, Clinical Review Criteria, describe that UM Reviewers utilize external and internal clinical guidelines such as State

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Regulations, InterQual, Behavioral Health Level of Care Guidelines, etc. in performing clinical determinations.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation's review of the sample approval files reflected consistency in utilizing InterQual or United's State Specific Level of Care Guidelines in performing clinical determinations.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The Member Handbook, Provider Manual, and Pharmacy Program Description provide an overview of the Preferred Drug List (PDL). Also, the over-the-counter medications (OTC) are available at no cost to the member.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					United's Policy UCSMM 04.11, Consumer Safety, and Member Handbook provide a descriptive outline of the emergency care and post-stabilization requirements.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					Clinical reviews are conducted by actively licensed professionals that hold current licensure within their clinical specialties. Level II medical necessity reviews are conducted by a licensed physician. Nonclinical staff provide administrative support through intake, administrative coverage approvals, etc. Review of the CAN approval files indicated that the reviews were performed by appropriate licensed professionals.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					
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	X					Review of the sample denial files yielded that the clinical reviewers appropriately requested additional information prior to referring for a second level review.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
making the decision to deny services.						
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					Review of the denial files indicated that the adverse benefit decisions were appropriately communicated to the provider and described the reasoning for the denial and appeals process.
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					Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, outlines United's processes for handling appeals. Information is also provided in the Member Handbook, the Provider Manual, and the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeals are defined as an adverse benefit determination in the Member Handbook, Care Provider Manual, and POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. These materials clearly indicate that appeals may be filed at any time by the member,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						legal guardian, authorized representative, or service provider.
1.2 The procedure for filing an appeal;		X				Policy USCMM 0712, Appeal Process and Record Documentation, states that "The consumer/representative or provider may initiate the appeal process or in writing via mail, facsimile, or electronic medium, or verbally if expedited." *Corrective Action Plan: Revise policy USCMM 0712 Appeal Process and Record Documentation, to correct the wording on page 2, Section A, #4 that indicates that appeals may be filed verbally if expedited.* Policy UCSMM.07.11, Appeal Review Timeframes, states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date." *Corrective Action Plan: Revise Policy UCSMM.07.11 Appeal Review Timeframes, to correct the wording on page 3 that states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date."*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The CHIP download on United's website indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing." This does not align with process guidelines for filing verbally or in writing.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Appeal resolution timeframes are documented in policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN Member Handbook, Provider Manual, and on United's website.
1.6 Written notice of the appeal resolution as required by the contract;	X					

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				The Acknowledgement Letters 3 CAN files were addressed to the provider or Appeals Department, but language appeared to be communicating to the member. *Corrective Action Plan: Ensure that processes are in place to review the language within the acknowledgement letters so that they accurately address the filer.* The Resolution Letters for 4 CAN files were addressed to the provider, but the language within the resolution letter appeared to be communicating with the member. *Corrective Action Plan: Ensure that processes are in place to review the language within the resolution letters so that it accurately addresses the filer.* 2 CAN files lacked a Written Consent or Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Ensure that processes are in place to ensure that Written Consent or Appointment of Representative Forms are in place as needed.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The UM Program Evaluation indicates that appeals are analyzed quarterly to evaluate and address trends. Information is reported to the Healthcare Quality and Utilization Management Committee and Provider Advisory Committee.
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 2023 Care Management Model Program Description and Addendum and various policies and procedures provide a descriptive overview of the program's scope and case management process for members. Optum's Behavioral Health Complex Case Management Program Description outlines the care management program specific to behavioral health care. The Quality Improvement and Population Health Management Program Description describes the program's objectives in promoting population health management activities.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					Members are referred for care management services through various referral sources such as pharmacy data, self-referrals, claims data, and additional referral sources as identified in the Behavioral Health Complex Case Management Program Description and Care Management Model Program Description and Addendum. During onsite discussion, the health plan shared that IPro is a predictive modeling system that is utilized to aid in identifying potential members for care management. As described in Policy NCM 001, Identification of High Risk Members for Case Management, all new members are screened for the appropriateness of case management services by completion of a health risk assessment (HRA). This screening aids to identify any treatment for the members and refer them to appropriate case management services and specialized programs. Also, providers are informed of the care management program and referral process through provider orientation, provider educational materials, and the Provider Manual as described in Policy NCM 007, Informing and Educating Providers.
3. A health risk assessment is completed within 30 calendar days for members	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
newly assigned to the high or medium risk level.						
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					Policy MS Rider 002, Case Management Process, identifies that the Health Risk Assessment (HRA) is reviewed by a qualified professional. Additionally, an individualized care plan is developed by the care manager in collaboration with the member, caregiver with member's consent, and other interdisciplinary team members as needed.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as MSDH's						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
7.9 Monitoring and follow-up with members and providers including						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					The United Healthcare Care Management Model Program Description and Addendum identifies that members that are assigned to high-risk level receive services that are also included in low and medium risk level services. Also, pregnant members with any known potential risk factors will be stratified in various risk level categories such as Healthy, Rising Risk, or High Risk status. Re-stratification based upon new utilization information and claims data occurs monthly to identify any additional potential needs for pregnant members.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma,	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
hypertension, obesity, congestive heart disease, and organ transplants.						
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, and Policy NCM 021, Management of Transitions, describe the process of managing transitions of care for members across healthcare settings. The transition coordinator's activities include care coordination, monitoring, data tracking, and analyzing care transitions.
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					The Interdisciplinary Team of physicians, care managers, nurses work collaboratively to ensure proper care coordination as described in Policy MS 021, Transitional Care Management, and Policy NCM 021, Management of Transitions.
4. The CCO meets other Transition of Care requirements.	X					
V F. Annual Evaluation of the Utilization Management Program						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

UTILIZATION MANAGEMENT—CHIP

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 Utilization Management Program Description, Behavioral Health Utilization Behavioral Health Utilization Management Program Description and Work Plan, and Pharmacy Program Description outline the objectives, scope of activities, and mechanisms for monitoring physical health, behavioral health, and pharmacy services for members. The CHIP Care Management Model Program Description and Addendum outlines United's disease management programs.
1.1 Structure of the program;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Lines of responsibility and accountability;	X					The CHIP Utilization Program Description, Optum Behavioral Health Utilization Management Program Description and Work Plan, Policy UCSMM 02.10, Staff Qualifications and Credentials, Policy UCSMM 02.11, Orientation Training and Support Tools, and Policy UCSMM 02.12, Performance Assessment and Incentives describe the process of personnel onboarding, ongoing support, and quality assurance mechanisms to ensure optimal staff performance. Also, United maintains accountability through recruitment, ongoing training, monitoring, performance reviews, etc.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					Policy USMM 07.11, Appeals Timeframes and Policy 07.12, Appeals Process Records and Documentation describe United's appeals process. Appeals may be initiated verbally or in writing.
1.7 The absence of direct financial incentives and/or quotas to	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provider or UM staff for denials of coverage or services.						
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
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 § 4*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					UM reviewers utilize external and internal clinical guidelines such as State Regulations, InterQual, Behavioral Health Level of Care Guidelines, etc. in performing clinical determinations as described in the CHIP UM Program Description and Policy UCSMM 06.10, Rider 1.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of the sample approval files reflected that appropriate criteria of InterQual or United's State Specific Level of Care Guidelines were utilized in performing clinical determinations.
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					United conducts annual Inter-Rater Reliability (IRR) testing for physicians and non-physician clinical reviewers to assess consistency in clinical criteria application. Clinical staff, including medical directors, participated in an online Inter-Qual Inter-Rater Reliability Assessment. Based upon the results, the Clinicians and Medical Directors received a passing score of 99% or higher. The overall results of the Behavioral Health Clinicians were 96%, exceeding the target goal of 90%. During onsite discussion, United shared that monthly case review audits are also conducted for quality assurance and supervision.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					The CHIP Member Handbook, Provider Manual, and Pharmacy Program Description provide an overview of the Preferred Drug List (PDL).
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					
7. Utilization management standards/criteria are available to providers.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					Review of the denial files yielded that the clinical reviewers appropriately requested additional information prior to referring for a second level review.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					The sample denial file review reflected that Adverse Benefits Decisions were reviewed by an appropriate licensed physician as reflected in Policy UCSMM 06.15, Peer Clinical Review.
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					
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	X					Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, outline United's processes for handling appeals.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:						Information is also provided in the Member Handbook, the Provider Manual, and the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeals are defined as an adverse benefit determination in the Member Handbook, Care Provider Manual, and POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance. These materials clearly indicate that appeals may be filed at any time by the member, legal guardian, authorized representative, or service provider.
1.2 The procedure for filing an appeal;		X				Policy USCMM 0712, Appeal Process and Record Documentation, states that "The consumer/representative or provider may initiate the appeal process or in writing via mail, facsimile, or electronic medium, or verbally if expedited." *Corrective Action Plan: Revise policy USCMM 0712 Appeal Process and Record Documentation, to correct the wording on page 2, Section A, #4 that indicates that appeals may be filed verbally if expedited.* Policy UCSMM.07.11, Appeal Review Timeframes, states that "A verbal Appeal shall be followed by a

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						written Appeal that is signed by the Member within thirty (30) calendar days of the filing date." Corrective Action Plan: Revise Policy UCSMM.07.11 Appeal Review Timeframes, to correct the wording on page 3 that states that "A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date." The CHIP download on United's website indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing." This does not align with process guidelines for filing verbally or in writing. *Corrective Action Plan: Correct the CHIP download on the United website that indicates that "If you file your appeal by calling us, we will put your appeal in writing and send it to you for your signature. You must sign and return the appeal with 30 days of the filing."*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
new information, by a practitioner with the appropriate 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 POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN Member Handbook, Provider Manual, and on United's website.
1.6 Written notice of the appeal resolution;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.		X				The Acknowledgement Letters for 4 CHIP files were addressed to the provider or Appeals Department, but language appeared to be communicating to the member. *Corrective Action Plan: Ensure that processes are in place to review the language within the acknowledgement letters so that they accurately address the filer.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Resolution Letters for 3 CHIP files were addressed to the provider, but the language within the resolution letter appeared to be communicating with the member. *Corrective Action Plan: Ensure that processes are in place to review the language within the resolution letters so that it accurately addresses the filer.* 2 CHIP files lacked a Written Consent or Appointment of Representative Form was not submitted when a provider filed an appeal on the member's behalf. *Corrective Action Plan: Ensure that processes are in place to ensure that Written Consent or Appointment of Representative Forms are in place as needed.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The UM Program Evaluaiton indicates that appeals are analyzed quarterly to evaluate and address trends. Information is reported to the Healthcare Quality and Utilization Management Committee and Provider Advisory Committee.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 2023 CHIP Care Management Model Program Description and Addendum and various policies provide a descriptive overview of the program's scope and case management process for members. Optum's Behavioral Health Complex Case Management Program Description outlines the care management program specific to behavioral health care. The Quality Improvement and Population Health Management Program Description describes the program's objectives and the population health programs.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					A detailed health risk assessment is completed within 30 days for newly assigned members to evaluate the member's medical, behavioral, social, and psychological needs. The goal of the assessment is to aid in identifying the member's existing needs, assigning the member to the appropriate risk level and care coordination.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, if a member's needs do not coincide with a risk level, the care manager will implement clinical judgement based upon the completed assessment to assign the member to an appropriate risk level as described in Policy NCM 012, Risk Stratification Process.
4. The detailed health risk assessment includes all required elements:						The 2023 Care Management Model Program Description and Addendum and Policy NCM 002, Case Management Process, provide an overview of the Health Risk Assessment. Policy NCM 002 Case Management Process is applicable to CAN and CHIP members as shared during onsite discussion. However, the policy does not reference CHIP Line of Business. United submitted post onsite a redlined updated version of the policy. However, based upon review and submission, a continual recommendation is to add the CHIP reference to the stated policy. *Recommendation: Please add CHIP reference to Policy NCM 002, Case Management Process, as this is applicable to CHIP Contract, Section 8 (A) (1).*
4.1 Identification of the severity of the member's conditions/disease state;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					Within the Health Risk Assessment, an evaluation of the member's environmental needs, current living arrangements, etc. is conducted as described in Policy NCM 002, Case Management Process, and the Care Model Program Description and Addendum.
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					As described in Policy NCM 012, Risk Stratification Process and the CHIP United Healthcare Care Management Model Program Description and Addendum, once a risk level assessment is completed, predictive modeling scores aids in identifying a change in a member's risk level, and the risk level is adjusted accordingly by an assigned care coordinator/case manager.
7. The CCO utilizes care management techniques to ensure comprehensive,	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
coordinated care for all members through the following minimum functions:						
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), the Special						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as 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	X					United's CHIP Care Management Model Program Description and Addendum identifies that members that are assigned to the medium risk level

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
specific services required by the contract.						receive specific services that are also included in low risk level services.
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.	X					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					The United Healthcare Care Management Program Description and Addendum provides a descriptive overview of United's transitional care management program. Policy NCM 023, Medically Fragile Children Care Coordination, describes that a care coordinator participates in hospital discharge planning and conducts an assessment to ensure all transition needs are met.

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				A sample of care management files were reviewed and indicated that appropriate comprehensive assessments were conducted to identify the treatment needs for members. However, based upon the review and additional information submitted post onsite, there were three CHIP transitional care management files that did not have ongoing documentation of notes that entail a follow-up schedule of the members' progress and process of case closure. *Corrective Action: Please ensure to obtain and accurately document a follow-up schedule of the members' process receiving care management services.*
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						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

F. Delegation

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

United delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include case management, utilization management, network management, and call center services.

For this review, United reported six delegation agreements, as shown in *Table 50: Delegated Entities and Services*.

Table 50: Delegated Entities and Services

Delegated Entities	Delegated Services
Optum Behavioral Health	Case management, utilization management, quality management, network contract management
Dental Benefit Providers	Call center services, claims processing timeliness, network adequacy
Medical Transportation Management (MTM)	Claims processing, quality management, call center operations, network adequacy
eviCore National	Radiology and Cardiology utilization management services, prior authorization handling, call center services
MARCH Vision Care	Network contract management, call center operations, claims processing
OptumRX	Network adequacy, call center services, claims processing timeliness, prior authorization handling

All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Policy DVO-01, Delegated Vendor Oversight Strategy, describes the processes for oversight and monitoring of delegated entities. Per policy, United will measure compliance and performance of all delegated vendor relationships and take appropriate action for non-compliant and/or underperforming goals/metrics. The Delegated Services Manager and Vendor Oversight Coordinator performs yearly targeted audits of delegated vendor assignments, to include items such as member and provider correspondence/material, notification timeliness, and handbooks, portals, and websites. Each subcontractor's performance is subject to a formal review at least once a year. For the 2022 EQR, Constellation found this annual review was not conducted for some of the delegated entities. The table that follows provides an overview of these deficiencies with United's response.

Table 51: 2022 Delegation CAP Items

Standard	EQR Comments	2023 EQR Findings
CAN		
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.	Delegate oversight documentation submitted for review confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated 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. Annual evaluation 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. •epicoria 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).*	The issues related to delegation oversight were corrected.
United's 2022 Response: In addition to the monthly scorecards, beginning Q1 2023, each noted entity delegated to conduct service or activity that is ultimately a health plan responsibility, will be subjected to a formal evaluation of the services they provided for the prior year. Policy DVO-01, Delegated Vendor Oversight (page 4), will also be revised to include a formal evaluation at least once a year per Section 15 (B) of the CAN contract. Formal annual evaluations for OptumRX and Optum Behavior Health are included within the supporting documentation. SUPPORTING DOCUMENTATION:		

Standard	EQR Comments	2023 EQR Findings
11, 23 2022.12.20 OptumRx Annual Evaluation.pdf 11, 23 2022.12.20 Optum Behavioral Health Annual Evaluation.pdf 11, 23 2022.12.20 Policy DVO-01, Delegated Vendor Oversight.docx UHC's follow-up response: Formal annual oversight evaluations for MTM, epicora National, and MARCH Vision Care will be completed by the end of Q1 2023.		
CHIP		
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.	Oversight documentation submitted confirmed formal annual oversight is conducted for some delegated activities; however, not all activities that are delegated 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. 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. *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).*	The issues related to delegation oversight were corrected.
United's 2022 Response: In addition to the monthly scorecards, beginning Q1 2023, each noted entity delegated to conduct service or activity that is ultimately a health plan responsibility, will be subjected to a formal evaluation of the services they provided for the prior year. Policy DVO-01, Delegated Vendor Oversight (page 4), will also be revised to include a formal evaluation at least once a year per Section 15 (B) of the CAN contract. Formal annual evaluations for OptumRX and Optum Behavior Health are included within the supporting documentation. SUPPORTING DOCUMENTATION:		

Standard	EQR Comments	2023 EQR Findings
11, 23 2022.12.20 OptumRx Annual Evaluation.pdf 11, 23 2022.12.20 Optum Behavioral Health Annual Evaluation.pdf 11, 23 2022.12.20 Policy DVO-01, Delegated Vendor Oversight.docx United's follow-up response: Formal annual oversight evaluations for MTM, epicora National, and MARCH Vision Care will be completed by the end of Q1 2023.		

For this EQR, United provided the annual evaluation for all entities. United measures compliance and performance of all delegated vendors. No issues were identified.

As shown in *Figure 8: Delegation Findings*, 100% of the Delegation standards were scored as "Met" for CAN and CHIP.

Figure 8: Delegation Findings

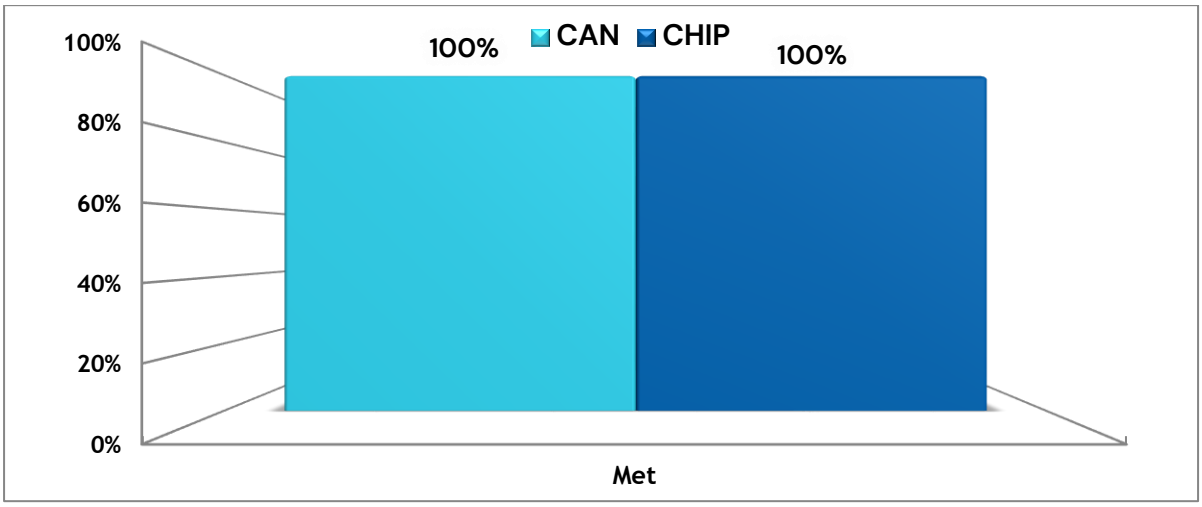

Table 52: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
United measures compliance and performance of all delegated vendors. No issues were identified.	✓		

DELEGATION—CAN

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					For this review, United reported six delegation agreements. Those delegated entities included Optum Behavioral Health, Dental Benefit Providers, Medical Transportation Management, eviCore National, MARCH Vision Care, and OptumRX. All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process.
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					Each subcontractor's performance is subject to a formal review at least once a year. For the 2022 EQR, Constellation found this annual review was not conducted for some of the delegated entities. For this EQR, United provided the annual evaluation for all entities.

DELEGATION—CHIP

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					For this review, United reported six delegation agreements. Those delegated entities included Optum Behavioral Health, Dental Benefit Providers, Medical Transportation Management, eviCore National, MARCH Vision Care, and OptumRX. All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process.
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					Each subcontractor's performance is subject to a formal review at least once a year. For the 2022 EQR, Constellation found this annual review was not conducted for some of the delegated entities. For this EQR, United provided the annual evaluation for all entities.

Attachments

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

Attachment 1: Initial Notice and Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
3600 Glenwood Avenue, Suite 120, Raleigh, NC 27612 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

July 5, 2023

J. Michael Parnell
President & CEO
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 2023 External Quality Review (EQR) of UnitedHealthcare Community Plan - Mississippi is being initiated. The review will include the MississippiCAN Program (MSCAN) and Mississippi CHIP Program (MS CHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME) and 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 **October 4, 2023,** and **October 5, 2023,** for the MississippiCAN and Mississippi CHIP Programs.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **August 4, 2023**.

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

UnitedHealthcare Community Plan - Mississippi

External Quality Review 2023 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. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, key managers responsible for the functions, and any vacancies. For all staff required in the MSCAN Contract, Section 1 (M), indicate whether the staff are in-state, the number of FTEs, and any required credentials. For contractually required key positions, provide the percentage of time allocated to the MSCAN contract and the CHIP contract, as well as any other lines of business.

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 that support the adequacy of the provider base for the MSCAN Program, including any:
    - **a.** Geographic access assessments
    - **b.** Enrollee demographic studies
    - **c.** Population needs assessments
    - **d.** Calculation of provider-to-enrollee ratios
    - **e.** Analysis of in-network and out-of-network utilization data
    - **f.** 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 completed Provider Network File Questionnaire

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

8. 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.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for MSCAN.

10. The Quality Improvement work plans for MSCAN for 2022 and 2023.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN Program that have been planned and completed during the previous year and any interim information available for 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.

13. Minutes of <u>all committee meetings</u> 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.

14. Membership lists and a committee matrix for all MSCAN committees, including the professional specialties of any non-staff members. <u>Please indicate which members are voting members and include committee charters if available</u>.

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

16. Copies of the most recent physician profiling activities conducted to measure provider performance for the MSCAN Program.

17. Reports of medical record reviews completed in 2022 and 2023 and a copy of the tools used to complete these reviews for MSCAN providers.

18. A complete list of all MSCAN members enrolled in the Care Management Program from August 2022 through July 2023. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis that triggered the need for care management.

19. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for August 2022 to July 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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 along 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 members about the MSCAN Program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Include any training plans and initial provider orientation materials used for educating providers about the MSCAN Program.

24. A copy of the grievance, complaint, and appeal logs for the MSCAN Program for the months of August 2022 through July 2023.

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. Please include:
    - **a.** Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    - **b.** Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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 specialties.

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 enrollment 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 policies 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 2022 through July 2023.

33. Provide a listing of delegates conducting activities for the MSCAN Program. 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	Delegated Functions	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management 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 2022 (MY 2022) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2022 1NCQA 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

Folder	Requested Document	Description
		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) CSV and Excel workbooks for MSCAN for MY 2022.
c.	HEDIS MY 2022 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 for MY 2022.
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.

Folder	Requested Document	Description
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 MSCAN:
    - **a.** Twenty-five medical necessity denial files for the MSCAN Program for the months of August 2022 through July 2023. Of the 25 requested files, include five behavioral health and five pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used to make the denial determination for each file.
    - **b.** Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN Program for the months of August 2022 through July 2023, including any medical information and approval criteria used to make the decision.

      Note: Appeal, Grievance, and Care Management files will be selected from the logs received with the desk materials. The CCO will then be asked 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.

UnitedHealthcare Community Plan - Mississippi

External Quality Review 2023 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. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, key managers responsible for the functions, and any vacancies. For all staff required in the CHIP Contract, Section 1 (L), indicate whether the staff are in-state, the number of FTEs, and any required credentials. For contractually required key positions, provide the percentage of time allocated to the CHIP contract and the MSCAN contract, as well as any other lines of business.

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 that support the adequacy of the provider base for the CHIP Program, including any:
    a. Geographic access assessments
    b. Enrollee demographic studies
    c. Population needs assessments
    d. Calculation of provider-to-enrollee ratios
    e. Analysis of in-network and out-of-network utilization data
    f. 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 completed Provider Network File Questionnaire

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

8. 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.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs for CHIP.

10. The Quality Improvement work plans for CHIP for 2022 and 2023.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the CHIP Program that have been planned and completed during the previous year and any interim information available for 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.

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

14. Membership lists and a committee matrix for all CHIP committees, including the professional specialties of any non-staff members. <u>Please indicate which members are voting members and include committee charters if available</u>.

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

16. Copies of the most recent physician profiling activities conducted to measure provider performance for the CHIP Program.

17. Reports of medical record reviews completed in 2022 and 2023 and a copy of the tools used to complete these reviews for CHIP providers.

18. A complete list of all CHIP members enrolled in the Care Management Program from August 2022 through July 2023. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis that triggered the need for care management.

19. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for August 2022 to July 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center Personnel.

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 along 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 members about the CHIP Program.

23. A copy of any provider newsletters, educational materials, and/or other mailings. Include any training plans and initial provider orientation materials used for educating providers about the CHIP Program.

24. A copy of the grievance, complaint, and appeal logs for the CHIP Program for the months of August 2022 through July 2023.

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. Please include:
    a. Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    b. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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.

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

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

31. A sample provider contract for the CHIP Program.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*

b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and enrollment 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 policies 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 2022 through July 2023.

33. Provide a listing of delegates conducting activities for the CHIP Program. 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	Delegated Functions	Methods of Oversight

34. Sample contracts for all delegated functions (for example, a sample utilization management 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 2022 (MY 2022) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2022 [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 MS CHIP	Please submit auditor locked Interactive Data Submission System (IDSS) CSV and Excel workbooks for MS CHIP for MY 2022.
c.	HEDIS MY 2022 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 for MY 2022.
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	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

Folder	Requested Document	Description
	the HEDIS measures	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.

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 CHIP:
    a. Twenty-five medical necessity denial files for the CHIP Program for the months of August 2022 through July 2023. Of the 25 requested files, include five behavioral health and five pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used to make the denial determination for each file.
    b. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP Program for the months of August 2022 through July 2023, including any medical information and approval criteria used to make the decision.

    Note: Appeal, Grievance, and Care Management files will be selected from the logs received with the desk materials. The CCO will then be asked 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.

Attachment 2: Materials Requested for Onsite Review

UnitedHealthcare Community Plan – Mississippi CAN and CHIP

External Quality Review 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Minutes for the Compliance Oversight Committee for 8/23/22 and any additional meetings in 2022.

3. Policy ID 5787, Practitioner Sanctions Monitoring Policy

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

5. A copy of any policy addressing member voluntary and involuntary disenrollment processes, requirements, etc. for CAN and CHIP.

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

Attachment 3: EQR Validation Worksheets

- Member Satisfaction Survey Validation CAN
- Member Satisfaction Survey Validation CHIP
- HEDIS PM Validation CAN
- HEDIS PM Validation CHIP
- PIP Validation CAN
- PIP Validation CHIP
- Network Validation CAN
- Network Validation CHIP

EQR Survey Validation Worksheet

Plan Name	**United CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2022
Review Performed	2023

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.

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:* Press Ganey Adult CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2022
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:* Press Ganey Adult CAHPS Report MY2022

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:* Press Ganey Adult CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Adult CAHPS Report MY2022

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: Press Ganey Adult CAHPS Report MY2022
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: Press Ganey Adult CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. Documentation: Press Ganey Adult CAHPS Report MY2022
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: Press Ganey Adult CAHPS Report MY2022
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: Press Ganey Adult CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. Documentation: Press Ganey Adult CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability was documented. Documentation: Press Ganey Adult CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. Documentation: Press Ganey Adult CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. Documentation: Press Ganey Adult CAHPS Report MY2022
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: Press Ganey Adult CAHPS Report MY2022

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: Press Ganey Adult CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. Documentation: Press Ganey Adult CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. Documentation: Press Ganey Adult CAHPS Report MY2022

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: Press Ganey Adult CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 16.1% (299 out of 1857) which is an improvement from last year's response rate of 14.4%response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. Documentation: Press Ganey Adult CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. Documentation: Press Ganey Adult CAHPS Report MY2022
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: Press Ganey Adult CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	**United CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2022
Review Performed	2023

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.

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: Press Ganey Child CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. Documentation: Press Ganey Child CCC CAHPS Report MY2022
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: Press Ganey Child CCC CAHPS Report MY2022

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: Press Ganey Child CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. Documentation: Press Ganey Child CCC CAHPS Report MY2022

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:* Press Ganey Child CCC CAHPS Report MY2022
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:* Press Ganey Child CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
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:* Press Ganey Child CCC CAHPS Report MY2022
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:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. Documentation: Press Ganey Child CCC CAHPS Report MY2022
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: Press Ganey Child CCC CAHPS Report MY2022

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:* Press Ganey Child CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. Documentation: Press Ganey Child CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. Documentation: Press Ganey Child CCC CAHPS Report MY2022

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:* Press Ganey Child CCC CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 10.8% for MY2022 (212 out of 1972) which is an improvement over the previous year's response rate of 10.3%. This response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
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:* Press Ganey Child CCC CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	**United CHIP**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD (CCC)**
Validation Period	2022
Review Performed	2023

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.

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:* Press Ganey CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. Documentation: Press Ganey CCC CAHPS Report MY2022
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: Press Ganey CCC CAHPS Report MY2022

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: Press Ganey CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. Documentation: Press Ganey CCC CAHPS Report MY2022

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: Press Ganey CCC CAHPS Report MY2022
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: Press Ganey CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. Documentation: Press Ganey CCC CAHPS Report MY2022
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: Press Ganey CCC CAHPS Report MY2022
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: Press Ganey CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. Documentation: Press Ganey CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. Documentation: Press Ganey CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing, and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. Documentation: Press Ganey CCC CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. Documentation: Press Ganey CCC CAHPS Report MY2022
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: Press Ganey CCC CAHPS Report MY2022

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: Press Ganey CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. Documentation: Press Ganey CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. Documentation: Press Ganey CCC CAHPS Report MY2022

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: Press Ganey CCC CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child CCC response rate was 14.4% for MY2022 (283 out of 1972) which is an improvement over the previous year's response rate of 13.0%. This response rate is lower than the NCQA target rate and may introduce bias into the generalizability of the findings. Documentation: Press Ganey CCC CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. Documentation: Press Ganey CCC CAHPS Report MY2022
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: Press Ganey CCC CAHPS Report MY2022

EQR Survey Validation Worksheet

Plan Name	**United CAN and CHIP**
Survey Validated	**PROVIDER SATISFACTION SURVEY**
Validation Period	2022
Review Performed	2023

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.

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:* Escalent MY 2022 Provider Satisfaction Survey Results Report
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results Report
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results Report
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results Report
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Escalent MY 2022 Provider Satisfaction Survey Results Report
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results Report
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Of the 3,334 sample providers, only 33 responded, creating a response rate of 1.0%. This is a decrease from last year's rate of 1.2%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution. D*ocumentation:* Escalent MY 2022 Provider Satisfaction Survey Results Report
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Escalent MY 2022 Provider Satisfaction Survey Results 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:* Escalent MY 2022 Provider Satisfaction Survey Results Report

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)
Reporting Year:	2023
Review Performed:	10/4/2023

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	

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

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:	2023
Review Performed:	10/4/2023

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.

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:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	COLORECTAL CANCER SCREENING (COL-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

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:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	HIV VIRAL LOAD SUPPRESSION (HVL- AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	ORAL EVALUATION, DENTAL SERVICES (OEV-CH)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

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:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

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:	2023
Review Performed:	10/4/2023

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).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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	Not Met	0
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	70
Measure Weight Score	75
Validation Findings	93.33%

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	HEART FAILURE ADMISSION RATE (PQI-08-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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	Not Met	0
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	70
Measure Weight Score	75
Validation Findings	93.33%

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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**	**Not Met**	**0**
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	**70**
Measure Weight Score	**75**
Validation Findings	**93.33%**

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)
Reporting Year:	2023
Review Performed:	10/4/2023

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).	Not Met	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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**	**Not Met**	**0**
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	**70**
Measure Weight Score	**75**
Validation Findings	**93.33%**

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)
Reporting Year:	2023
Review Performed:	10/4/2023

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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.

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:	**2023**
Review Performed:	**10/4/2023**

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.

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:	**2023**
Review Performed:	**10/4/2023**

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.	**NA**	
N4 Numerator Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	

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

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

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:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL - AD)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**ORAL EVALUATION, DENTAL SERVICES (OEV-CH)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

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:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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).	**Not Met**	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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	Not Met	0
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	70
Measure Weight Score	75
Validation Findings	93.33%

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI-08)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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).	**Not Met**	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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	Not Met	0
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	**70**
Measure Weight Score	**75**
Validation Findings	**93.33%**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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).	**Not Met**	During source code review it was identified that the age of the member was being calculated per the discharge date. However, the measure specifications state that the calculation must be based on the admission date. Aqurate provided feedback and UHC's vendor corrected the source code. UHC confirmed that the corrected source code was used to calculate the final rates.

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	Not Met	0
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	**70**
Measure Weight Score	**75**
Validation Findings	**93.33%**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PM Validation Worksheet

Plan Name:	**United Healthcare - MSCHIP**
Name of PM:	**PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TLF-CH)**
Reporting Year:	**2023**
Review Performed:	**10/4/2023**

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.

EQR PIP Validation Worksheet

Plan Name:	United CAN
Name of PIP:	BEHAVIORAL HEALTH READMISSIONS (CLINICAL)
Reporting Year:	2022
Review Performed:	2023

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 were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers 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 improvement in

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		the latest rate from 21.4% in 2021 to 18.7% with a goal of 14.2%. The case management enrollment indicator had a decline from 28% in 2022 to 19% in 2022. Recommendation: Continue to monitor BH readmission rates and determine barriers to case management enrollment for re-admitters.
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 for at least one indicator
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	United CAN
Name of PIP:	IMPROVED PREGNANCY OUTCOMES
Reporting Year:	2022
Review Performed:	2023

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 were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported for baseline and remeasurement 1 In table format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Repeated measures were included in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of baseline in relation to benchmark rates.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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 baseline rate was 92.21% and the remeasurement #3 rate was 96.84%. This rate reflects an improvement in the visit rate and exceeds the goal 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 was 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 analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**United CAN**
Name of PIP:	**RESPIRATORY ILLNESS**
Reporting Year:	2022
Review Performed:	2023

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 were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services were addressed.
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	All relevant populations were included.
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:

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
		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 measured changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specified data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
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	Systematic method of collecting data was being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart 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	Baseline and repeat measurements were documented.
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	Project documentation included both qualitative and quantitative discussion of 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 and barriers that were addressed by interventions were noted.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
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	For bronchodilators, the baseline was 74.96%, 76.36% in 2021, and the 2022 rate was 78.40%, which demonstrates improvement. Corticosteroids improved from 42.24% at baseline, to 49.89% in 2021, and improving again in 2022 to 50.76%. The AMR baseline was 70.7% and increased to 75.79% for 2022.
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 related to the interventions implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**United CAN**
Name of PIP:	**SICKLE CELL DISEASE**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	In 2018, a low percentage of members were compliant with taking their Hydroxyurea.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported in table format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Repeated measures were included in the report.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of baseline and remeasurements 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		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The rate was 36.28% a baseline, decreasing to 28.5% in 2021 and then slightly increasing to 28.91% in 2022. The goal is to reduce the rate to 27.65%. Thus, the most recent rate did not show improvement in the year over year trending. Recommendation: Continue ongoing interventions such as the Sickle Cell Disease Program and daily dashboard reviews to assess for patient tracking of ER utilization and medication non-adherence.
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	Unable to judge.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**United CHIP**
Name of PIP:	**MEMBER SATISFACTION**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	There was a downward trend from 2016 to 2017 for getting needed care.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Aims of the study were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	HEDIS 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	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The goal is to improve the rate to the NCQA quality compass percentile rate regarding getting needed care – easy to see a specialist CAHPS child survey item. The rate declined from 90.3% to 87%, which is below the plan goal of 92.7%. Recommendation: Continued analysis by Task Force and provider education should continue in efforts to improve satisfaction rates.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Unable to judge, as improvement was not reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**United CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	FUH rate was below the target rate of 66.6% for 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 were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling was not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling was not utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	Results showed that the 30-day follow up rate improved from 65.8% in 2021 to 67.48% in 2022, exceeding the goal rate of 59.42%. The 7-day follow up rate improved from 35.11% in 2021 to 41.1% in 2022. The goal rate for UHC is 38.95%.
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 related to interventions that were implemented.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**United CHIP**
Name of PIP:	**REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	2022
Review Performed:	2023

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 were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	HEDIS sampling specifications were used.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	MET	HEDIS sampling specifications were used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	MET	HEDIS sampling specifications were used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	BMI percentile documentation improved from 70.07% in 2021 to 72.28% in 2022. The goal rate is 79.68%. Counseling on nutrition declined slightly from 53.04% to 47.93% with a goal rate of 72.26%. Counseling for physical activity declined slightly from 49.88% to 48.66% with a goal rate of 68.61%. Recommendation: Consider sub-analysis of patient care reports to determine if specific subsets of the population are impacting the reduction in rates for counseling indicators.
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	Unable to judge, as improvement was not reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR PIP Validation Worksheet

Plan Name:	**United CHIP**
Name of PIP:	**WELL-CHILD VISITS/ADOLESCENT WELL-CARE**
Reporting Year:	2022
Review Performed:	2023

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 were stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	This project included all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Measure was 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 was administrative.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Measure was administrative.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measure was clearly defined.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measured changes in health status and processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Sources of data were noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualifications of personnel were listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The WCV (adolescence well care visits) PIP showed the rate from 12- 17-year-olds declined from 40.16% to 39.96% - this is below the goal rate of 41.36%. The rate for 18–21-year-olds also declined from 25.34% to 24.93%, although above the goal rate of 24.53%. Recommendation: Continue to assess interventions and consider sub-analysis of patient care reports to determine if specific subsets of the population are impacting the reduction in rates.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Unable to judge, as improvement was not reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR NETWORK ADEQUACY VALIDATION WORKSHEET

Plan Name:	**United CAN**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the CCO to the EQRO? **(1)**	**MET**	Data sources for appropriate timepoints were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? **(1)**	**MET**	All variables were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? **(1)**	**MET**	Missing data was addressed.
1.4 Do the CCO's data enable valid, reliable, and timely calculations of the indicators? **(1)**	**MET**	Data allowed valid and reliable calculations.
1.5 Did the CCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? **(1)**	**MET**	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the CCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? **(1)**	**MET**	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? **(1)**	**MET**	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? **(1)**	**NA**	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the CCO include appropriate calculations and sound methodology? **(5)**	**MET**	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.1 Are the methods selected by the CCO appropriate for the state? **(10)**	**MET**	Methods aligned with State standards.
2.2 Are the methods selected by the CCO appropriate to the state Medicaid and CHIP population(s)? **(10)**	**MET**	Methods aligned with populations.

2.3 Are the methods selected by the CCO adequate to generate the data needed to calculate the indicators according to the State's expectations? **(10)**	**MET**	Methods generated required data for NA assessment.
2.4 Does the CCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? **(1)**	**MET**	Provider network file questionnaire indicated appropriate provider classification.
2.5 If the CCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? **(1)**	**MET**	Sound sampling methods were applied, wherein necessary.
2.6 If the CCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? **(1)**	**MET**	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. **(1)**	**MET**	Random sampling was utilized wherein required.
2.8 Does the CCO's approach for measuring time/distance indicators match the state's expectation? **(1)**	**MET**	Approach for time/distance aligned with State requirements.
2.9 Does the CCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? **(1)**	**MET**	Ratio calculations were conducted according to State requirements.
2.10 Does the CCO's approach for determining the maximum wait time for an appointment match the state's expectation? **(1)**	**MET**	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? **(10)**	**MET**	Methods are objective and use of third-party vendors were used wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? **(10)**	**MET**	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF CCO NETWORK ADEQUACY RESULTS		
3.1 Did the CCO produce valid results? **(10)**	**MET**	Results were judged to be valid.
3.2 Did the CCO produce accurate results? **(10)**	**MET**	Results were judged to be accurate.
3.3 Did the CCO produce reliable and consistent results? **(10)**	**MET**	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the CCO accurately interpret its results? **(10)**	**MET**	Findings were interpreted and analyzed by CCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION OF AND REPORTING OF RESULTS

Step	Possible Score	Score
Step 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	NA	NA
1.9	5	5
Step 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Step 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	**100**	**100**

Project Score	99
Project Possible Score	99
Project Rating Score	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 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.*

EQR NETWORK ADEQUACY VALIDATION WORKSHEET

Plan Name:	**United CHIP**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the CCO to the EQRO? **(1)**	**MET**	Data sources for appropriate timepoints were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? **(1)**	**MET**	All variables were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? **(1)**	**MET**	Missing data was addressed.
1.4 Do the CCO's data enable valid, reliable, and timely calculations of the indicators? **(1)**	**MET**	Data allowed valid and reliable calculations.
1.5 Did the CCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? **(1)**	**MET**	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the CCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? **(1)**	**MET**	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? **(1)**	**MET**	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? **(1)**	**NA**	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the CCO include appropriate calculations and sound methodology? **(5)**	**MET**	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.1 Are the methods selected by the CCO appropriate for the state? **(10)**	**MET**	Methods aligned with State standards.
2.2 Are the methods selected by the CCO appropriate to the state Medicaid and CHIP population(s)? **(10)**	**MET**	Methods aligned with populations.
2.3 Are the methods selected by the CCO adequate to generate the data needed to calculate the indicators according to the State's expectations? **(10)**	**MET**	Methods generated required data for NA assessment.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
2.4 Does the CCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? **(1)**	**MET**	Provider network file questionnaire indicated appropriate provider classification.
2.5 If the CCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? **(1)**	**MET**	Sound sampling methods were applied, wherein necessary.
2.6 If the CCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? **(1)**	**MET**	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. **(1)**	**MET**	Random sampling was utilized wherein required.
2.8 Does the CCO's approach for measuring time/distance indicators match the state's expectation? **(1)**	**MET**	Approach for time/distance aligned with State requirements.
2.9 Does the CCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? **(1)**	**MET**	Ratio calculations were conducted according to State requirements.
2.10 Does the CCO's approach for determining the maximum wait time for an appointment match the state's expectation? **(1)**	**MET**	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? **(10)**	**MET**	Methods are objective and use of third-party vendors were used wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? **(10)**	**MET**	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF CCO NETWORK ADEQUACY RESULTS		
3.1 Did the CCO produce valid results? **(10)**	**MET**	Results were judged to be valid.
3.2 Did the CCO produce accurate results? **(10)**	**MET**	Results were judged to be accurate.
3.3 Did the CCO produce reliable and consistent results? **(10)**	**MET**	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the CCO accurately interpret its results? **(10)**	**MET**	Findings were interpreted and analyzed by CCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION OF AND REPORTING OF RESULTS

Step	Possible Score	Score
Step 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	NA	NA
1.9	5	5
Step 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Step 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	100	100

Project Score	99
Project Possible Score	99
Project Rating Score	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 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.*