Constellation Quality Health

UnitedHealthcare Community Plan – Mississippi

2024 External Quality Review

Submitted: October 15, 2024

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 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 2024 External Quality Review (EQR) conducted by Constellation Quality Health (Constellation) 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 protocols developed by the Centers for Medicare & Medicaid Services (CMS) 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 providers, and an assessment of the CCO's 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'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

Policies, procedures, and standard operating procedures guide staff in conducting health plan activities. United uses national policies when possible and adjusts them, or uses riders/addenda, to include state-specific requirements. All policies and procedures are reviewed annually and are accessible by staff.

Review of the Organizational Chart and onsite discussion confirmed all key positions are filled and staffing is sufficient to ensure all required activities can be conducted. The Chief Executive Officer (CEO) position is filled on an interim basis by a regional CEO.

Documentation of processes to ensure compliance with laws, regulations, and contractual obligations and to guard against fraud, waste, and abuse (FWA) is comprehensive. The UnitedHealthcare Compliance Program and UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 address compliance leadership and oversight and provide an overview of the responsibilities and role of the Compliance Officer. Information about the responsibilities and activities of the Compliance Oversight Committee is included in the UnitedHealthcare Compliance Program and the UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2023-2024.

Compliance training is mandatory for all employees upon hire and annually. Training is also provided to governing body members, committee members, contractors, and suppliers. The UnitedHealth Group Code of Conduct outlines principles of ethics and integrity for employees, provides contact information for compliance resources, and includes references to specific policies related to topics addressed in the document. United maintains open lines of communication between the Compliance Officer and all employees. Employees are educated about reporting methods for compliance concerns and fraud, waste, and abuse. Reporting mechanisms allow for anonymous reporting and United enforces a no-retaliation policy for those reporting concerns.

United has implemented a Pharmacy Lock-in Program to manage members with inappropriate patterns of medication utilization. However, the CCO uses a corporate policy for this program which does not define Mississippi-specific requirements.

United exceeds the internal benchmarks and contractual requirements for claims payment timeliness and has robust processes to corroborate and validate member demographic and enrollment data. United has appropriate data collection and storage capabilities, as well as other processing procedures, to support Quality Improvement, Utilization Management, and other contractual requirements. Disaster recovery and business continuity plans are in place, with aggressive recovery time objectives and recovery point objectives noted.

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

United notifies primary care providers (PCPs) of member panel assignments via the secure provider portal within five business days of receiving the Member Listing Report from DOM. Providers may verify member eligibility/enrollment through the portal and by calling the health plan. United reported that staff monitor providers' panel status quarterly, and that 215 PCPs currently have closed panels.

The Provider Network File Questionnaire was reviewed and revealed that United uses the Network Database and CSP Facets as its data management systems. The printed Provider Directory is updated twice monthly, and the online directory is refreshed daily. Both the printed and online provider directories include all required elements. A variety of activities are conducted to ensure Provider Directory information is current and correct.

Geographic and appointment access standards for network providers are defined in policy and are compliant with contractual requirements. The adequacy of the network is assessed through analysis of quarterly geographic access reports and by conducting quarterly telephonic access studies. Additional factors considered include grievance and appeal data and the cultural, ethnic,

racial, and linguistic diversity of United's membership. Interventions are implemented to improve network adequacy when issues or gaps are identified. For 2023, goals were met for member-to-practitioner ratios and geographic access, except for 24-hour pharmacies. For appointment access, successful contact rates were low, but goals were met for all appointment access categories for all provider types. Overall, United met the requirements of the Network Adequacy Validation.

United has appropriate processes in place for new provider orientation and ongoing provider education. Orientation processes are addressed in policy, but no policy exists for ongoing provider education. The Provider Manual has been combined to include both CAN and CHIP and is a comprehensive resource for providers. Issues identified with the Provider Manual are related to lack of information about where to access the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule, lack of the statement about non-exclusivity requirements, and a discrepancy in the medical record retention timeframe.

United educates providers about medical record documentation standards and assesses provider compliance through an annual medical record review process. The sample size is 20 PCPs and 20 EPSDT providers. As noted in previous years, the number of records ultimately reviewed was small. Constellation suggests increasing the sample sizes to get a better representation of provider medical record documentation compliance.

United's 2023 provider satisfaction survey was administered by Escalent, an independent research company. The response rate was 1.1%, which is a slight increase over the previous year's rate of 1.0%. Results were presented to appropriate committees. The percentage of providers rating the overall satisfaction with United as 10 on a scale from zero to 10 decreased from 2022 to 2023, although ratings of eight or nine increased. Ratings of "excellent" or "good" were noted for service experience, the ease of the appeals process, and the ease of matching patients' prescription drug needs to the treatment plan. Areas with the lowest ratings included patient support, medical records, appeals, and reimbursement.

Constellation conducts Telephonic Provider Access Studies twice a year for each CCO. The results of the Telephone Access Study conducted by Constellation in Q3 2024 identified weaknesses related to the overall successful contact rate and provider directory accuracy.

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

Members are informed of their rights and responsibilities in new member materials, the CAN and CHIP Member Handbooks, the Provider Manual, and on United's website. Information is provided to new members about steps to select a PCP. Processes are in place for providing new members

with education about the health plan, benefits, services, access to 24-hour member assistance via the Call Center, and disenrollment. New member education is provided through an information packet that includes an introduction letter, the CAN and CHIP Member Handbook, and instructions for accessing information in the Provider Directory.

The CAN and CHIP Member Handbooks include information about preventive health services and wellness programs. Members are instructed to contact Member Services with any questions or to request information. Members are educated 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.

Processes for managing member grievances are described in policies, the CAN and CHIP Member Handbooks, the Provider Manual, and on the website. The term "grievance" is defined along with methods for filing a grievance. Applicable timeframes for acknowledging, resolving, or extending the resolution timeframes for grievances are clearly indicated in the member and provider materials. A sample of United's CAN and CHIP grievance files was reviewed. All reviewed files were processed timely with appropriate resolution notifications provided.

United contracts with a vendor, Press Ganey, to conduct adult and child member satisfaction surveys. The surveys were fielded from February 2023 through May 2024. For Measure Year (MY) 2023, the adult response rate was 14.7%, a decline from last year's rate of 16.1%. For year-over-year trending, the findings showed the top three measures as rating of personal doctor, how well doctors communicated, and getting care quickly; the bottom three measures were getting needed care, rating of specialist, and customer service.

The CAN Children with Chronic Conditions (CCC) response rate was 10.2%, a slight decline from last year's rate of 10.8%. The top three measures were rating of personal doctor, rating of health care, and rating of specialist. The bottom three measures were coordination of care, how well doctors communicate, and getting care quickly. The CHIP Child CCC response rate was 12.0%, a decline from last year's response rate of 14.4%. The top performing measures were getting needed care, rating of health care, and how well doctors communicate; the lowest three measures were getting care quickly, rating of personal doctor, and rating of health plan.

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 for CAN and CHIP to oversee the implementation and evaluation of quality improvement initiatives throughout the organization. The 2024 Quality Improvement and Population Health Management Program Description for CAN

and CHIP describes the program initiated by United. This document included a comprehensive scope of work for the QI Program, detailing responsibilities, roles, and functions of various positions within the program.

Information regarding the QI Program was found in the Provider Manual and providers are informed that a copy of the QI Program is available upon request. However, the CAN Member Handbook, page 47, instructs the member to send their request for additional information in writing. There was no information found in the CHIP Member Handbook regarding the QI Program.

United's QI Work Plan is a detailed document outlining planned activities related to program priorities. The work plan includes specific interventions with target completion dates, responsible parties, and oversight committees. The QI Work Plan is reviewed and updated at least quarterly and is submitted to the Quality Management Committee (QMC) for approval.

The QMC is responsible for the QI Program. It oversees the implementation, coordination, and integration of all activities; provides program direction; and reviews and approves various QI Program documents. The QMC is chaired by the Chief Medical Officer. The Provider Advisory Committee (PAC) evaluates and reviews clinical indicators, guidelines, quality of care complaints, appeals, grievances, inpatient quality issues, provider satisfaction survey results, and compliance with regulatory requirements. United's Chief Medical Officer also chairs this committee and network providers specializing in Obstetrics/Gynecology, Internal Medicine, Psychiatry, Dentistry, Pediatrics, and Family Medicine are included as voting members.

United provides direct feedback to PCPs about their performance via the Provider Profile Report, the Patient Care Opportunity Report, and information provided by clinical practice consultants. The Provider Profile Report offers direct feedback about key quality measures compared to a peer group within United's network. The Patient Care Opportunity Report helps identify gaps in care.

United conducts an evaluation to assess various aspects of the QI Program such as access to care, specialist appointment availability, medical records for providers, network adequacy, member satisfaction, prevention activities, quality improvement projects, and disparities monitoring. The 2023 Quality Improvement & Population Health Management Annual Evaluation Report for CAN and CHIP was comprehensive and covered all QI activities for United.

Validation of Performance Measures

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 National Committee for Quality

Assurance (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, 2023, through December 31, 2023.

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 MY2023.

All relevant HEDIS performance measures for the CAN and CHIP populations for the current review year (2023) were compared to the previous year (2022) and the changes from 2022 to 2023 are reported in the Quality Improvement section of this report. *Table 1: CAN HEDIS Measures with Substantial Changes in Rates* highlights the CAN HEDIS measures found to have substantial increases or decreases in rate from 2022 to 2023. 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	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Adult Body Mass Index (BMI) Assessment (ABA)	51.38%	66.11%	14.73
Substantial Decrease in Rate (>10% decrease)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
Counseling for Nutrition	51.09%	32.36%	-18.73
Counseling for Physical Activity	47.69%	30.41%	-17.28
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
30-Day Follow-Up: 13-17 Years	28.30%	16.13%	-12.17
7-Day Follow-Up: 13-17 Years	24.53%	6.45%	-18.08
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	77.08%	66.67%	-10.41

Table 2: CHIP HEDIS Measures with Substantial Change in Rates highlights the CHIP HEDIS measures with a substantial increase or decrease in rate from 2022 to 2023.

Table 2: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1-11 Years	41.03%	57.14%	16.11
Substantial Decrease in Rate (>10% decrease)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
Counseling for Nutrition	47.93%	36.98%	-10.95
Counseling for Physical Activity	48.66%	33.58%	-15.08
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
12-17 Years	74.16%	63.00%	-11.16

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The Adult and Child Core Set measures were compared for 2023 and the previous year (2022) and the changes from 2022 to 2023 are reported in the Quality Improvement section of this report. There were no CAN or CHIP Non-HEDIS measures that showed a substantial increase or decrease.

Validation of Performance Improvement Projects

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the CMS-developed protocol 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 Emergency Room (ER) Utilization. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in the table that follows. Details of each PIP's status and related interventions are included in the Quality Improvement section of this report.

Table 3: Performance Improvement Projects - CAN

Performance Improvement Project	Previous Validation Score	Current Validation Score
Reducing 30-Day Psychiatric Inpatient Readmission Rates	74/75=99% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Improving Pregnancy Outcomes	80/80=100%	94/95=99%

Performance Improvement Project	Previous Validation Score	Current Validation Score
	High Confidence in Reported Results	High Confidence in Reported Results
Respiratory Illness Management	80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Sickle Cell Disease Management Decreasing ER Utilization	74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results

United submitted the same CHIP PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care Visits, Follow Up After Hospitalization for Mental Illness, Obesity, and Member Satisfaction (Geeting Needed Care). All the CHIP PIPs scored in the "High Confidence in Reported Results" range as noted in the table that follows. Details of each project's status and related interventions are included in the Quality Improvement section of this report.

Table 4: Performance Improvement Projects – CHIP

Performance Improvement Project	Previous Validation Score	Current Validation Score
Adolescent Well Child Visits (AWC)/ Child and Adolescent Well Care Visits (WCV)	74/75 = 99% High Confidence in Reported Results	75/75=100% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	80/80 = 100% High Confidence in Reported Results	74/75 = 99% High Confidence in Reported Results
Reducing Adolescent and Childhood Obesity	94/95 = 100% High Confidence in Reported Results	94/95=100% High Confidence in Reported Results
Getting Needed Care CAHPS	94/95=100% High Confidence in Reported Results	94/95=100% High Confidence in Reported Results

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)

United's CAN and CHIP program objectives, scope of activities, and program structure are outlined in various policies and the Utilization Management (UM) Program Description. Optum's Behavioral Utilization Management Program Description outlines the structure of the behavioral health program that is offered by Optum Behavioral Health. The Pharmacy Program Description outlines the pharmacy program.

The Chief Medical Officer provides oversight of the CAN and CHIP UM Program. In collaboration with the Chief Medical Officer, the Behavioral Health Medical Director and Pharmacy Director provide oversight of their respective programs. Initial clinical reviews are conducted by licensed

health professionals using external and internal clinical criteria to make clinical determinations. Annually, United conducts Inter-Rater Reliability (IRR) testing for physicians and clinical reviewers. Non-clinical staff members provide nonclinical administrative benefit coverage approvals.

Constellation's review of a sample of approval files reflected that the reviews were completed in a timely manner and by appropriate staff. The review of a sample of denial files reflected that five CAN files and five CHIP files incorrectly informed members that an oral request for an appeal must be followed by a written request within 30 days.

United documents processes for managing member appeals in various policies, the CAN and CHIP Member Handbooks, the Provider Manual, and on the website. The definition of an appeal as an adverse benefit determination and steps for filing an appeal are documented consistently throughout member and provider information. The timeframes for appeal acknowledgment, resolution, and extension if needed are consistently outlined in United's materials. The UM Program Evaluation indicates that appeals are analyzed quarterly to evaluate and address trends. A sample of CAN and CHIP appeal files was reviewed for the 2024 EQR, and it was found that most of the appeals were resolved in a timely manner.

United's 2024 Care Management Model Program Description and Addendum, Optum's Behavioral Health Case Management Program Description, and various policies outline the health plan's approach and guidelines for physical and behavioral health care management services. The 2023 Quality Improvement and Population Health Management Program Description provides an outline of United's Population Health Management Program. Members are identified for care management through various resources and predictive modeling tools. Once a member is referred for care management services, a health risk assessment is conducted. After the assessment, the member is assigned to an appropriate risk level and a treatment plan is developed.

Disease management programs are also offered to members to address specific healthcare needs. The Provider Manual referred to the program as the Whole Person Model; however, the program was recently renamed and is now known as the Care Program Model. Transition of care management services are also offered to members.

Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. For this review, United reported six delegation agreements for CAN and five delegation agreements for CHIP.

United monitors each subcontractor's performance on an ongoing basis. Copies of each subcontractor's scorecards were provided for review. Results of these scorecards are reported to the appropriate committee and the committee recommends the next steps to remedy any identified performance issues.

Policy DVO-01, Operations / Delegated Vendor Oversight, the *CAN Contract, Section 15* and the *CHIP Contract, Section 14* require United to monitor each subcontractor's performance on an ongoing basis and subject it to a formal review at least once per year. The results of this monitoring are required to be included in the Annual Quality Management Program Evaluation. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation.

Corrective Action Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation requires the plan to submit a Corrective Action Plan (CAP) for each standard identified as not fully met. Technical assistance is provided until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which United implemented the actions to address deficiencies identified during the previous EQR and found United addressed and implemented appropriate corrective action for all findings from the previous EQR.

Details regarding the 2023 CAP can be found in *Attachment 4: Assessment of Corrective Action Plans from Previous EQR*.

Conclusions

Overall, United met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330*. *Table 5: 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 that were reviewed for United.

Table 5: 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)* • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. A	30	30	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• 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	23	96%
• 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	40	100%
• Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	6	4	67%
• 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%
• 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 preceding table, issues were noted with the following:

- For Coverage and Authorization of Services, there were five CAN and five CHIP denial files that incorrectly informed members that a written appeal request is required within 30 days of an oral appeal request.
- For Subcontractual Relationships and Delegation, there was no documentation of the annual audits conducted by United, and the ongoing monitoring and annual audit results were not included in the Annual Quality Management Program Evaluation as contractually required.

Table 6: Scoring Overview—CAN, provides an overview of the scoring of the current annual review for CAN as compared to the findings of the 2023 review. For 2024, 184 of 189 standards received a score of "Met." Four standards were scored as "Partially Met" and one standard was scored as "Not Met."

Table 6: Scoring Overview – CAN

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	31	0	0	0	0	31	100%
2024	30	1	0	0	0	31	96.8%
Provider Services							
2023	47	2	0	0	0	49	95.9%
2024	47	1	1	0	0	49	95.9%
Member Services							
2023	33	0	0	0	0	33	100%
2024	33	0	0	0	0	33	100%
Quality Improvement							
2023	19	0	0	0	0	19	100%
2024	19	0	0	0	0	19	100%
Utilization							
2023	52	2	0	0	0	54	96.3%
2024	53	1	0	0	0	54	98.1%
Delegation							
2023	2	0	0	0	0	2	100%
2024	2	1	0	0	0	3	66.7%
Totals							
2023	**184**	**4**	**0**	**0**	**0**	**188**	**97.9%**
2024	**184**	**4**	**1**	**0**	**0**	**189**	**97.4%**

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

Table 7: Scoring Overview—CHIP, provides an overview of the scoring of the current annual review for CHIP as compared to the findings of the 2023 review. For 2024, 181 out of 186 standards received a score of "Met." Four standards were scored as "Partially Met" and one standard was scored as "Not Met."

Table 7: Scoring Overview – CHIP

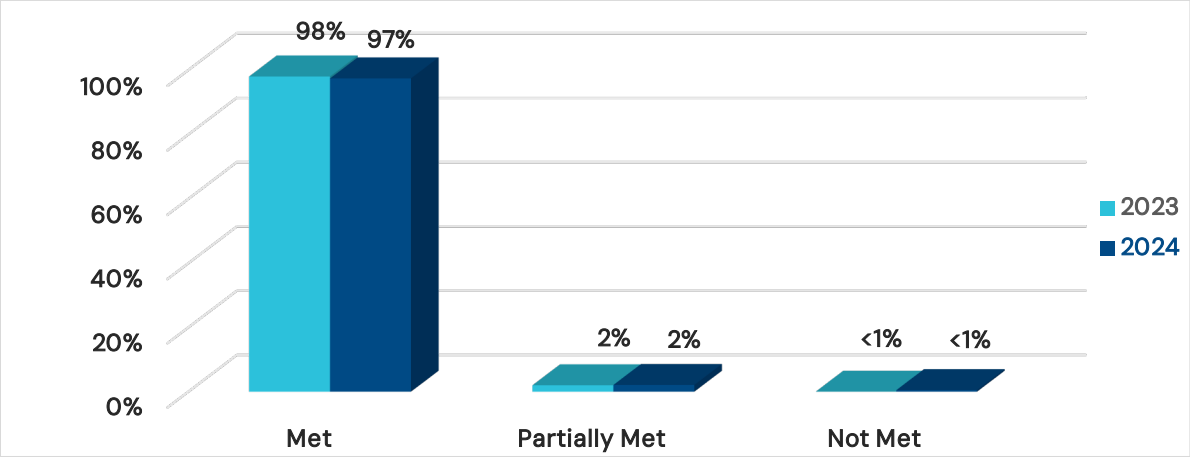
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	31	0	0	0	0	31	100%
2024	30	1	0	0	0	31	96.8%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Provider Services							
2023	46	1	0	0	0	47	95.8%
2024	45	1	1	0	0	47	95.7%
Member Services							
2023	32	0	0	0	0	32	100%
2024	32	0	0	0	0	32	100%
Quality Improvement							
2023	19	0	0	0	0	19	100%
2024	19	0	0	0	0	19	100%
Utilization							
2023	51	3	0	0	0	54	94.4%
2024	53	1	0	0	0	54	98.1%
Delegation							
2023	2	0	0	0	0	2	100%
2024	2	1	0	0	0	3	66.7%
Totals							
2023	**181**	**4**	**0**	**0**	**0**	**185**	**97.3%**
2024	**181**	**4**	**1**	**0**	**0**	**186**	**97.3%**

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

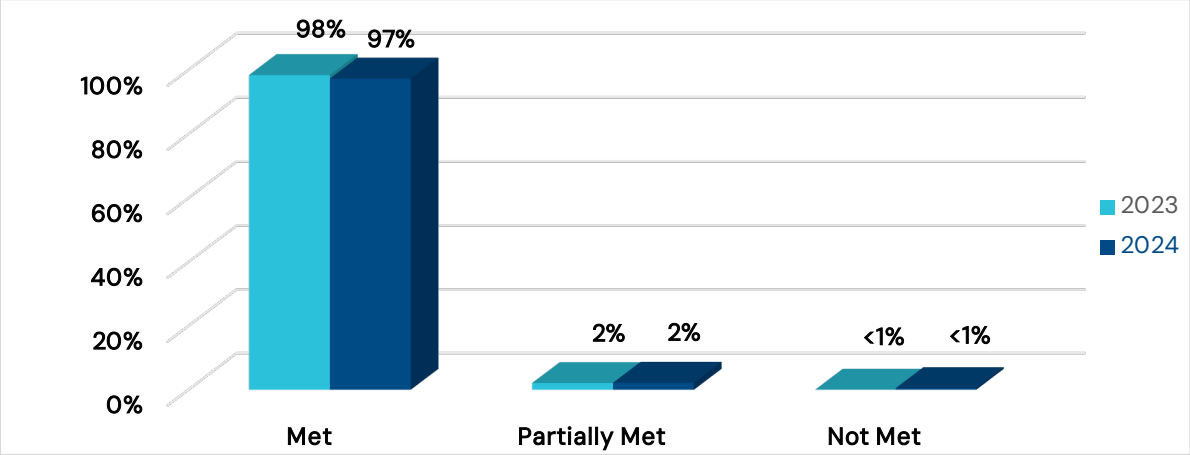
As shown in the figures below, the 2024 Annual EQR for CAN shows that United achieved "Met" scores for 97.4% of the standards reviewed, and 2.1% of the standards were scored as "Partially Met." For CHIP, 97.3% of the standards were scored as "Met" and 2.2% were scored as "Partially Met."

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 improvement. Specific details of strengths, weaknesses, recommendations, and corrective actions can be found in the sections that follow.

Table 8: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
United has established processes for policy development and ongoing review. Policies are housed in locations that are readily accessible by staff.	✓		

Strengths	Quality	Timeliness	Access to Care
All key positions are filled, and overall health plan staffing is sufficient.	✓		
United exceeds internal and state-defined guidelines for timeliness and percentage of clean claims paid.		✓	
United has well documented processes and procedures for their claims and enrollment systems, including multiple levels of checks to ensure data accuracy and completeness.	✓		
Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against FWA are addressed comprehensively in the Compliance Plan, FWA Plan, Mississippi Addendum to the FWA Plan, and related policies and procedures.	✓		
United has adopted a Code of Conduct that outlines principles of ethics and integrity, employee accountability, privacy, information security, etc. The Code of Conduct provides contact information for compliance resources and includes references to specific policies related to topics addressed in the document.	✓		
Compliance training is required for all employees upon hire and then annually. Training topics include the Code of Conduct, information privacy and security, and FWA. Additional specialized training for specific job functions may also be provided.	✓		
United ensures open communication between the Compliance Officer and employees, committee members, contractors, etc. United enforces a no-retaliation policy which prohibits any intimidation or retaliation for those making good faith reports.	✓		
A variety of internal monitoring and auditing activities are conducted to identify and mitigate compliance risks.	✓		
The Compliance Oversight Committee assists in developing and implementing United's Compliance Program. Committee minutes confirm quarterly meetings, with the establishment of a quorum prior to voting.	✓		
Provider Services			
United notifies PCPs of members assigned to their panels and ensures all providers can verify member eligibility and enrollment.			✓
United monitors provider panel statuses quarterly to ensure that there are sufficient providers accepting new patients.			✓
United appropriately documents geographic and appointment access standards for its provider network and conducts appropriate activities to evaluate the adequacy of the network.			✓
Although Indian Health Care Providers within the state of Mississippi decline to contract with United, the CCO allows eligible members to use these providers with no requirements for prior authorizations, and with claims paid at in-network rates.			✓
The Health Equity Program is in place to reduce disparities and improve culturally and linguistically appropriate services. Activities are conducted to monitor and evaluate the network's abilities to meet members' cultural and diversity needs.	✓		✓
United's website includes cultural competency information including training and education resources. The Provider Manual also provides an overview of cultural competence.	✓		✓
The printed and online provider directories include all required elements.			✓
Processes are in place for comprehensive initial provider orientation and ongoing education.	✓		
United adopts preventive health and clinical practice guidelines, educates providers about the guidelines, and assesses provider compliance with the guidelines.	✓		

Strengths	Quality	Timeliness	Access to Care
Annual medical record reviews are conducted to assess provider compliance with medical record documentation standards.	✓		
Member Services			
A sample of CAN and CHIP grievance files was reviewed for the 2024 EQR. All were acknowledged and resolved in a timely manner.	✓	✓	
Members are informed of their rights and responsibilities in many formats, including member materials and United's website.			✓
Members are informed of preventive health and disease management resources through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, health fairs, and other health promotion events.			✓
Quality Improvement			
United's Quality Improvement Program is structured and comprehensive with well-defined committees.	✓		
Utilization of data from various sources is used for quality monitoring.	✓		
United was fully compliant with all the Information System Standards and submitted valid and reportable rates for all HEDIS measures in the scope of the audit.	✓		
No concerns were identified with United's data processing, integration, and measure production for the reported CMS Adult and Child Core Set measures. United followed the measure specifications and produced reportable rates for the measures in the scope of the validation.	✓		
The Adult BMI Assessment (ABA) measure (CAN) and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), 1-11 Years measure (CHIP) rates improved more than 10 percentage points.	✓		
The PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and the rationale for each topic was documented.	✓		
All PIPs received validation scores in the High Confidence Range.	✓		
Utilization Management			
Constellation's review of the sample CAN and CHIP files indicated that they were completed in a timely manner.		✓	✓
United's timeliness goal of 95% for processing behavioral health prior authorization requests was maintained throughout the year.		✓	✓
Health programs are available to address the specific needs of pediatric members and their families, including Pediatric Specialty Programs for patients in the Neonatal Intensive Care Unit.	✓		
Delegation			
United has policies and procedures in place for monitoring each subcontractor's performance. Copies of each subcontractor's scorecards are reviewed during the Delegated Vendor Joint Oversight Committee meetings.	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Administration				
Information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program. However, this is a corporate policy and does not define the requirements for Mississippi. Additionally, Policy ID-31884 does not address the requirement for the provision of a 72-hour emergency supply of medication for members in the program, as required by the *CAN Contract, Section 11 (F) (3)* and the *CHIP Contract, Section 10 (G) (3)*. Page two, item 4.2 of the policy refers the reader to a state-specific policy. United staff confirmed that a state-specific policy has not been developed.	*Corrective Action Plan: Develop a policy to describe Mississippi-specific processes and requirements for the Pharmacy Lock-in Program.*			✓
Provider Services				
Results for the Q2 2024 appointment access study conducted by Aucera indicate successful contact rates are low, ranging from 12.81% to 30.68%.	*Recommendation: Continue interventions to improve provider contact information.*			✓
The Provider Manual, page 51, instructs providers to "Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant members" and states, "For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule." However, the Provider Manual does not instruct providers about where/how to access the EPSDT schedule.	*Recommendation: Revise the Provider Manual to include information about where/how providers can access the EPSDT schedule.*	✓		✓
A discrepancy in the requirement for medical record retention was noted on pages 67 and 74 of the Provider Manual. Onsite discussion confirmed providers are required to retain member medical records for 10 years, as stated on page 74 of the Provider Manual.	*Corrective Action Plan: Revise page 67 of the Provider Manual to document the correct timeframe for member medical record retention.*	✓		
The required statement about non-exclusivity requirements was not found in the Provider Manual. This statement was noted in the provider contract templates provided for review.	*Corrective Action Plan: Revise the Provider Manual to include the required non-exclusivity statement. Refer to the CAN Contract, Section 7 (H) (2) (s) and the CHIP Contract, Section 7 (H) (2) (s).*	✓		✓
No policy was found that addresses ongoing provider education.	*Recommendation: Develop a policy, or revise an existing policy, to include*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
	processes undertaken for ongoing provider education.			
United conducts annual medical record review audits to assess compliance with documentation standards. Results indicate 20 PCP providers and 20 EPSDT providers are sampled. However, as has been noted in previous years, the number of records actually reviewed is small due to providers charging a fee for records, using copy services, unresponsiveness, provider terminations, etc.	*Recommendation: Consider increasing the sample size for the medical record review to get a better representation of provider medical record documentation compliance.*	✓		
Response rates for provider satisfaction surveys (CAHPS) remain low and may affect generalizability of the results.	*Recommendation: Continued efforts should be made to enhance survey responses and advertise the importance of the survey to providers.*	✓		
Quality Management				
Information regarding the QI Program was found in the Provider Manual. However, the information found in the CAN Member Handbook, page 47, instructs the member to send their request for additional information in writing. There was no information found in the CHIP Member Handbook regarding the QI Program.	*Recommendation: Update the Member Handbook to include information regarding the QI Program and provide a phone number for members to call instead of requiring them to submit a written request for additional information. Also, include information in the CHIP Member Handbook regarding the QI Program.*	✓		
The following HEDIS MY 2023 measure rates were determined to be areas of opportunity for United since their rates had a greater than 10 percentage point decline: • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) declined more than 17% for the CAN population and more than 10% for the CHIP population in the Counseling for Nutrition and Counseling for Physical Activity indicators. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) declined by more than 12% in the 30-Day Follow-Up and 7-Day Follow-Up indicators for the CAN population aged 13-17 years. This measure, however, should be treated with caution due to the change in the	*Recommendation: Seek opportunities to improve the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure rate for the CAN and CHIP populations.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
measure criteria and the relatively small denominators. • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) declined more than 10% for the CAN population. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) declined by 11.16% for the CHIP population aged 12-17 years.				
Utilization Management				
United's current Pharmacy Benefit Manager is Gainwell. However, the Provider Manual still lists Optum Rx as the Pharmacy Benefit Manager. During the onsite discussion, it was clarified by United that Gainwell is the current Pharmacy Benefit Manager, with the change occurring on July 1, 2024.	*Recommendation: Update the Provider Manual to reflect the current pharmacy benefit manager.*	✓		
Constellation's review of the sample CAN and CHIP denial files found that five CAN files and five CHIP files incorrectly informed members that a written request was required within 30 days after an oral appeal request.	*Corrective Action Plan: Update the adverse benefit determination letters to accurately reflect that a written appeal request is not required to follow oral appeal requests, in accordance with the CAN Contract, Exhibit D and CHIP Contract, Exhibit E.*	✓		
United recently changed the name of the disease management program to Care Model Program; however, the Provider Manual references Whole Person Model as the name of the program.	*Recommendation: Update the Provider Manual to reflect the updated name of the disease management program as Care Model Program.*	✓		
Delegation				
Policy DVO-01, Operations / Delegated Vendor Oversight, the *CAN Contract, Section 15,* and the *CHIP Contract, Section 14* require United to monitor each subcontractor's performance on an ongoing basis and subject it to a formal review at least once per year. The results of this monitoring are required to be included in the Annual Quality Management Program Evaluation. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation.	*Corrective Action Plan: Conduct a formal annual audit of all subcontractors and include the results of this oversight monitoring in the Annual Quality Management Program Evaluation as required by the DOM CAN Contract, Section 15 and CHIP Contract, Section 14.*	✓		

METHODOLOGY

The process Constellation Quality Health (Constellation) uses for the EQR activities is based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization (MCO)/Prepaid Inpatient Health Plan (PIHP). The process 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 June 3, 2024, Constellation sent notification of the initiation of the annual EQR to UnitedHealthcare Community Plan – Mississippi (United) (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP) Coordinated Care Organizations (CCOs).

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with Constellation and the Mississippi Division of Medicaid (DOM) to provide United an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials Constellation requested.

The review consisted of two segments. The first was a desk review of materials and documents received from United on July 3, 2024, for review at Constellation's offices (see *Attachment 1*). The second segment was a virtual onsite review conducted on September 4, 2024, and September 5, 2024.

The onsite visit focused on areas not covered in the desk review or areas 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

The Administration review includes policy management processes, health plan staffing, information management systems capabilities, compliance, program integrity, and processes to ensure confidentiality of health information.

United uses policies, procedures, and standard operating procedures (SOPs) to provide guidance to staff about health plan activities, processes, and requirements. When possible, national policies are adjusted to include state-specific requirements or riders/addenda are used to specify state-specific exceptions or additions to national policies. New and revised policies are reviewed by the Steering Committee prior to review by additional committees. All policies and procedures are reviewed at least annually and are housed on a SharePoint site that is accessible by staff. Departmental leadership educates staff 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. United staff confirmed the Chief Executive Officer (CEO) position is filled on an interim basis by a regional CEO. All key positions are filled, and few vacancies are noted in other positions.

Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against fraud, waste, and abuse (FWA) are addressed comprehensively in the UnitedHealthcare Compliance Program (Compliance Plan), UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 (FWA Plan), UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2023-2024 (Mississippi Addendum to the FWA Plan), and related policies and procedures.

The Compliance Plan and FWA Plan address compliance leadership and oversight and provide an overview of the roles and responsibilities of the Compliance Officer related to developing, implementing, and maintaining the Compliance and the Anti-Fraud, Waste and Abuse Programs. Information about the Compliance Oversight Committee is included in the Compliance Plan and the Mississippi Addendum to the FWA Plan. The Compliance Oversight Committee is co-chaired by the Compliance Officer and the health plan's CEO. Additional members of the committee include senior leadership and department leaders. The quorum for this committee is established with the presence of 51% of the voting membership. Review of United's Compliance Oversight Committee minutes for May 2023 through February 2024 reflected quarterly meetings, the presence of a quorum for each meeting, and adequate attendance by members.

Compliance training is required for all employees, governing body members, members of compliance committees, contractors, and suppliers. For employees, the training is mandatory upon hire and then annually. In addition, United has adopted the UnitedHealth Group Code of Conduct (Code of Conduct) that outlines principles of ethics and integrity for employees to follow. The Code of Conduct addresses employee accountability, privacy and information security, government interactions, communication and marketing, work environment safety and support, etc. The Code of Conduct provides contact information for compliance resources and references to specific policies related to topics addressed in the document.

United maintains open lines of communication between the Compliance Officer and all employees, committee members, contractors, etc. Staff are informed of the ways they can report concerns related to compliance and potential or actual FWA. Reports may be made to department managers, senior leadership, the Compliance Officer, and additional resources, including the compliance hotline and the Compliance and Ethics HelpCenter. Reporting mechanisms allow for anonymous reporting telephonically and online. Staff are provided with contact information for all avenues for reporting concerns as well as information about possible disciplinary actions that may result from inappropriate activities and behaviors. To further encourage open communication, United enforces a no-retaliation policy which prohibits any intimidation or retaliation for those making good faith reports.

United has implemented a Pharmacy Lock-in Program to manage members with inappropriate patterns of medication utilization. Information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program. However, this is a corporate policy and does not define the specific requirements for Mississippi. Page two, item 4.2 of the policy refers the reader to a state-specific policy; however, United staff confirmed that a state-specific policy has not been developed.

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.

Health Information Systems

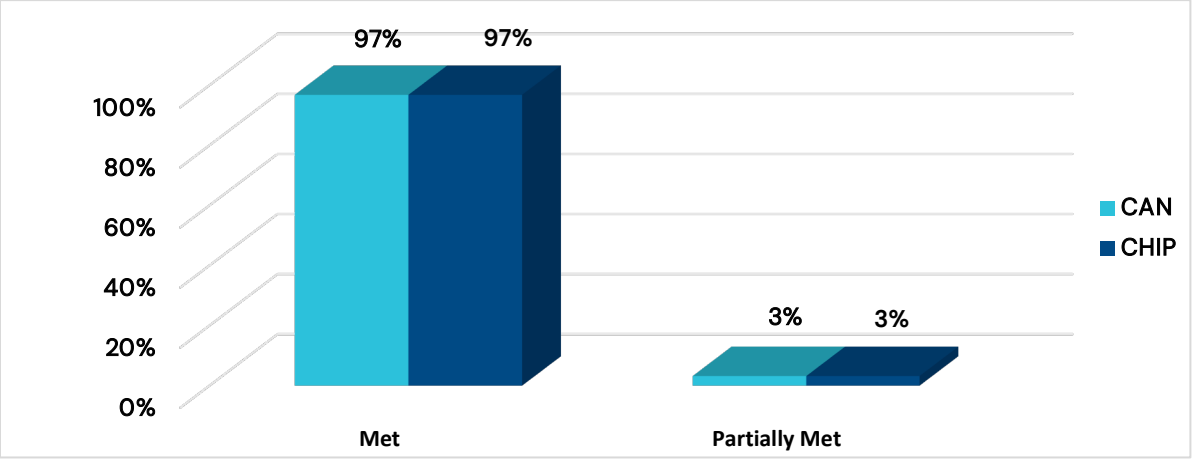
42 CFR § 438.242, 42 CFR § 457.1233 (d)

United provided proper, up-to-date Information Systems Capabilities Assessment (ISCA) documentation for both CAN and CHIP. The documentation confirmed that on average, United pays 99% of clean claims within 30 days and 99.99% of all claims within 90 days, exceeding both United's internal goal and contractual requirements. United uses Facets for claims and enrollment data and National Encounter Management Information System (NEMIS) for encounters, both which have robust processes and sufficient checks to ensure that enrollment

data and member demographic information are collected when available. United included all appropriate ISCA and related supporting documentation and adequately demonstrated their data collection and storage capabilities, processing procedures, claim data tabulation and processing activities, and other activities to support the Quality Improvement (QI) and Utilization Management (UM) Programs and other contractual requirements. United has both a documented disaster recovery and a business continuity plan in place. These are reviewed and updated yearly. Current systems ensure a 72 hour or less recovery time objective with the recovery point objective near zero hours.

As noted in *Figure 3: Administration Findings*, 97% of the Administration standards were scored as "Met" for both CAN and CHIP.

Figure 3: Administration Findings



Strengths, weaknesses, and corrective actions for the Administration section are included in the tables below.

Table 9: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
United has established processes for policy development and ongoing review. Policies are housed in locations that are readily accessible by staff.	✓		
All key positions are filled and overall health plan staffing is sufficient.	✓		
United exceeds internal and state defined guidelines for timeliness and percentage of clean claims paid.		✓	
United has well documented process and procedures for their claims and enrollment systems, including multiple levels of checks to ensure data accuracy and completeness.	✓		

Strengths	Quality	Timeliness	Access to Care
Processes to ensure compliance with laws, regulations, and contractual obligations and to guard against FWA are addressed comprehensively in the Compliance Plan, FWA Plan, Mississippi Addendum to the FWA Plan, and related policies and procedures.	✓		
United has adopted a Code of Conduct that outlines principles of ethics and integrity, employee accountability, privacy, information security, etc. The Code of Conduct provides contact information for compliance resources and includes references to specific policies related to topics addressed in the document.	✓		
Compliance training is required for all employees upon hire and then annually. Training topics include the Code of Conduct, information privacy and security, and FWA. Additional specialized training for specific job functions may also be provided.	✓		
United ensures effective and open communication between the Compliance Officer and all employees, committee members, contractors, etc. United enforces a no-retaliation policy which prohibits any intimidation or retaliation for those making good faith reports.	✓		
A variety of internal monitoring and auditing activities are conducted to identify and mitigate compliance risks.	✓		
The Compliance Oversight Committee assists in developing and implementing United's Compliance Program. Committee minutes confirm quarterly meetings, with the establishment of a quorum prior to voting.	✓		

Table 10: Administration Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program. However, this is a corporate policy and does not define the requirements for Mississippi. The policy includes phrases such as "when applicable," "if allowed by the plan," and "or other time frame required by the Plan." Additionally, Policy ID-31884 does not address the requirement for the provision of a 72-hour emergency supply of medication for members in the program, as required by the *CAN Contract, Section 11 (F) (3)* and the *CHIP Contract, Section 10 (G) (3)*. Page two, item 4.2 of the policy refers the reader to the state-specific policy. United staff confirmed that a state-specific policy has not been developed.	*Corrective Action Plan: Develop a policy to describe Mississippi-specific processes and requirements for the Pharmacy Lock-in Program.*			✓

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					Policies, procedures, and SOPs are established to provide guidance to staff about health plan activities, processes, and requirements. Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, outlines United's processes for developing, reviewing, revising, and implementing policies, procedures, and SOPs. When possible, national policies are adjusted to include state-specific requirements. Riders or addenda may also be used to specify state-specific exceptions or additions to national policies. Department Managers may adopt national policies approved by the National Quality Management Oversight Committee. New and revised policies are reviewed by the Steering Committee prior to review by additional committees, including the Health Quality Utilization Management Committee, the Service Quality Improvement Subcommittee, and the Quality Management Committee. All policies and procedures are reviewed at least annually and are housed on a SharePoint site that is accessible by staff. Departmental leadership educates staff about new and revised policies.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The Chief Executive Officer position is filled on an interim basis by a regional Chief Executive Officer.
1.2 *Chief Operating Officer;	X					
1.3 Chief Financial Officer;	X					
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					
1.6.1 *Provider contracting and education;	X					Staff includes: • Provider Relations (provider training and education, researching and responding to provider questions, etc.) • Provider Services (call center and chat functions, preliminary claims investigations, etc.) • Network Management (provider contracting and systems loading activities)
1.7 *Member Services Manager;	X					
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Utilization Management Coordinator;	X					
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					
1.13 *Compliance Officer.	X					
2. Operational relationships of CCO staff are clearly delineated.	X					Review of the Organizational Chart revealed that the lines of reporting were not displayed for several staff members. Onsite discussion confirmed that these staff report to enterprise (corporate) supervisors.
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					On average, United pays 99% of clean claims within 30 days and 99.99% of all claims within 90 days. This exceeds the metric set both internally by United and is compliant with *Miss. Code Ann. § 83-9-5*, both which define timeliness as 90% of clean claims paid in 30 days and 99% of all claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United has checks to ensure that both enrollment data and member demographic information are captured correctly. United also captures data on member and provider characteristics, such as member enrollment, place of service, provider type, distribution of claim

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						types, etc. to ensure data completeness. United can provide these data to oversight agencies.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					United included all appropriate ISCA documentation as well as supporting documents. The CCO adequately demonstrated its data collection and storage capability, processing procedures, and claim data tabulation and processing, as well as showed adequate support of Quality Management and Utilization Management program activities and other contractual requirements via attached flowcharts and technical layouts. The processes were reviewed and discussed during the onsite.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United has both a documented disaster recovery and a business continuity plan in place along with yearly updates (last updated on 1/1/2024) and plan review. Systems are in place to ensure a 72 hour or less recovery time objective with the recovery point objective near zero hours.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					United provided copies of the following: • UnitedHealthcare Compliance Program (Compliance Plan) • UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 (FWA Plan) • UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2023-2024 (Mississippi Addendum to the FWA Plan) • UnitedHealth Group Code of Conduct (Code of Conduct) • Related policies and procedures

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						As part of the Compliance Program, United has adopted a Code of Conduct that outlines principles of ethics and integrity for employees to follow, and addresses employee accountability, privacy and information security, government interactions, communication and marketing, work environment safety and support, etc. The Code of Conduct provides contact information for compliance resources and references to specific policies related to topics addressed in the document.
2.2 Identification of the Compliance Officer;						The Compliance Plan and FWA Plan address Compliance leadership and oversight and provide an overview of the roles and responsibilities of the Compliance Officer. These roles and responsibilities include: • Developing, implementing, and maintaining the Compliance and the Anti-Fraud, Waste and Abuse Programs. • Supporting the compliance framework and strategy for education and governance to ensure effective oversight of the Program. • Ensuring accountability for compliance with legal, regulatory, and other requirements. • Working closely with the Legal Department related to FWA enforcement actions and reporting. • Serving as the primary point of contact with the state for compliance oversight.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Maintaining open communication with senior leadership, the Compliance Oversight Committee, and employees.
2.3 Information about the Compliance Committee;						Information about the Compliance Committee is included in the Compliance Plan and the Mississippi Addendum to the FWA Plan.
2.4 Compliance training and education;						As noted in the Compliance Plan and Policy ID-6069, UnitedHealthcare Compliance Training & Education Policy, compliance training is required for all employees, governing body members, members of compliance committees, contractors, and suppliers. For employees, the training is mandatory upon hire and then annually. Training topics include the Code of Conduct, information privacy and security, and FWA. Additional specialized or targeted training for specific job functions may also be provided. Mandatory training is managed and tracked through United's online Learning Management System. Specialized or targeted training may be managed through the Learning Management System or by individual departments.
2.5 Lines of communication;						The Compliance Plan addresses lines of communication within the Compliance Program. As noted, United ensures effective and open communication between the Compliance Officer and all employees, committee members, contractors, etc. United encourages reporting through department managers, senior leadership, the Compliance Officer, and additional resources such as the compliance hotline and the Compliance and Ethics HelpCenter. Anonymous reports can be made telephonically or online. Contact information is included for:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The UHC Privacy mailbox and the Compliance & Ethics HelpCenter • The website for online reporting • The Healthcare Fraud Tip Line (telephonic and online) • The Employee Center (telephonic and online) • Enterprise Health & Safety (telephonic and online) • Corporate Security • The IT Help Desk To further encourage open communication, United enforces a no-retaliation policy which prohibits any intimidation or retaliation for those making reports. In addition to compliance training programs, United employs a communication and awareness strategy to increase knowledge and awareness of the compliance expectations through e-mail, newsletters, plan materials, posters, face-to-face meetings, etc.
2.6 Enforcement and accessibility;						Staff are informed of disciplinary actions that may result from identified compliance issues and/or FWA through the Code of Conduct, the Compliance Program, the Employee Handbook, and additional methods such as training, intranet sites, memos, newsletters, etc. Disciplinary actions may include verbal and/or written warnings, suspension, termination of employment, and possible legal action.
2.7 Internal monitoring and auditing;						The Compliance Plan provides information about risk assessment, auditing, and monitoring within United's Compliance Program. Auditing and monitoring activities include:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• An annual compliance risk assessment to evaluate and prioritize risks from external and internal sources and to determine how to address and mitigate risks. • Additional audits to assess organizational and supplier adherence to applicable regulatory requirements, including state and federal regulations. • Monitoring by the Compliance Department and other internal departments or functional areas to identify, prevent, and correct regulatory risks, and to verify compliance with laws, regulations, contractual requirements, and company policies. High-risk areas are prioritized. • Using a compliance dashboard that focuses on structures and processes to drive improved compliance outcomes.
2.8 Response to offenses and corrective action;						Information about United's process for responding to detected offenses and developing corrective actions is found in the Compliance Plan. United's Compliance Program supports interdepartmental coordination to respond promptly to any suspected misconduct by conducting timely inquiries and investigations. Corrective/disciplinary actions are implemented to address any underlying issues contributing to non-compliance to decrease the potential for recurrence. United reports potential non-compliance or fraudulent activity to federal and state regulatory authorities and reports suspected instances of FWA to law enforcement and/or regulatory authorities as required by federal and state regulations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Exclusion status monitoring.						Policy ID-5881, New Hire and Periodic Employee Sanction Review, describes processes for monitoring employees and contractors for sanctions and exclusions. The monitoring includes monthly checks against specific databases, including the Office of Inspector General/General Services Administration, the System for Award Management, and applicable State Medicaid sanction lists. After the onsite, United confirmed that the Social Security Death Master File check is conducted "as part of both the Pre-employment check and the Annual Background check. This is managed by talent acquisition operations."
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee assists in developing and implementing United's Compliance Program and ensuring compliance with laws, detecting violations, and monitoring training. As noted in the Mississippi Addendum to the FWA Plan, the Compliance Committee is co-chaired by the Compliance Officer and the health plan's CEO, and a quorum is established with the presence of a minimum of 51 percent of the committee membership. Members include senior leaders, department leaders, and the Compliance Officer. Additional attendees may be invited as needed to provide relevant information or assist with issues under review. United submitted a copy of the Community and State Health Plan Compliance Oversight Committee Charter for Mississippi. The charter outlines the purpose,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						composition, roles, responsibilities, and operation of the Compliance Oversight Committee. Review of United's Compliance Committee minutes for May 2023 through February 2024 reflected quarterly meetings, the presence of a quorum for each meeting, and adequate attendance by members. It was noted that voting members may appoint a designee for attendance and votes as needed.
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 policies.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Compliance Plan indicates all credible reported, suspected, or identified concerns of misconduct are reviewed promptly for further action. Compliance, Legal, and/or Investigations personnel make timely inquiries and conduct preliminary investigations of suspected misconduct. Corrective and/or disciplinary actions are taken in response to findings to reduce the potential for recurrence and ensure ongoing compliance with regulatory requirements. As noted in the FWA Plan, Special Investigations Units (SIUs) perform retrospective investigations of credible suspicions of fraud committed against health plans and programs to identify suspect claim and provider patterns and behavior so that appropriate action based on the findings may be taken. The SIUs are staffed by qualified investigators who are experienced in health care and prescription drug fraud and abuse and who have knowledge of industry business practices and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						systems, infrastructure, and federal and state law enforcement and litigation practices. The Mississippi Addendum to the FWA Plan addresses FWA investigations for Mississippi. It covers the responsibilities, procedures, reporting requirements, and detailed steps for conducting investigations, audits, and provider on-site visits. The document outlines the roles of the SIU, Optum Program Integrity, Office of Program Integrity, and the health plan in managing investigations, reporting requirements, and compliance with standards and regulations. It also specifies the process for referrals to the Medicaid Fraud Control Unit for prosecution. Policy ID 4.0, Preliminary Investigative Process, provides comprehensive information about the preliminary investigation process for credible allegations of fraud against the health care plan and its programs.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The Mississippi Addendum to the FWA Plan describes United's procedures for payment suspensions initiated by DOM and the CCO, including the requirement to suspend payments to providers upon notification of a credible allegation of fraud; the process for suspending payments within 24 hours of notification: notifying providers in writing of payment suspensions; and the requirement for providers to return any funds paid in error while a suspension is in effect. The document describes the CCO's responsibilities regarding withholding payments in cases of fraud investigations. Additionally, the document specifies the process for suspending payments to providers once notification is received from the Office of Program Integrity and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						outlines procedures for withholding payments, future enrollment, and payment suspensions of non-par providers.
7. The CCO implements and maintains a Pharmacy Lock-In Program.		X				Information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program. However, this is a corporate policy and includes phrases such as "when applicable," "if allowed by the plan," and "or other time frame required by the Plan." It does not define the requirements for Mississippi. Additionally, Policy ID-31884 does not address the requirement for the provision of a 72-hour emergency supply of medication, as required by the *CAN Contract, Section 11 (F) (3).* Page two, item 4.2 of the policy refers the reader to a state-specific policy. A state specific policy was requested from United, but another copy of the same policy was provided. United confirmed during onsite discussion that a state-specific policy has not been developed. *Corrective Action Plan: Develop a policy to describe Mississippi-specific processes and requirements for the Pharmacy Lock-in 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					Policies, procedures, and SOPs are established to provide guidance to staff about health plan activities, processes, and requirements. Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, outlines United's processes for developing, reviewing, revising, and implementing policies, procedures, and SOPs. When possible, national policies are adjusted to include state-specific requirements. Riders or addenda may also be used to specify state-specific exceptions or additions to national policies. Department Managers may adopt national policies approved by the National Quality Management Oversight Committee. New and revised policies are reviewed by the Steering Committee prior to review by additional committees, including the Health Quality Utilization Management Committee, the Service Quality Improvement Subcommittee , and the Quality Management Committee. All policies and procedures are reviewed at least annually and are housed on a SharePoint site that is accessible by staff. Departmental leadership educates staff about new and revised policies.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
1.2 *Chief Operating Officer;	X					
1.3 Chief Financial Officer;	X					
1.4 Chief Information Officer;	X					
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 *Provider Services Manager;	X					
1.6.1 *Provider contracting and education;	X					Staff includes: • Provider Relations (provider training and education, researching and responding to provider questions, etc.) • Provider Services (call center and chat functions, preliminary claims investigations, etc.) Network Management (provider contracting and systems loading activities)
1.7 *Member Services Manager;	X					
1.7.1 Member services and education;	X					
1.8 Grievance and Appeals Coordinator;	X					
1.9 Utilization Management Coordinator;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9.1 *Medical/Care Management Staff;	X					Onsite discussion confirmed Utilization Management staffing includes approximately 56 staff; however, these staff are not displayed on the Organizational Chart. UM prior authorization and inpatient review staff include both in-state and out-of-state staff. Case Management staff includes a Care Coordinator, nine Case Managers, and eight Community Health Workers, all located within Mississippi.
1.10 Quality Management Director;	X					
1.11 *Marketing and/or Public Relations;	X					
1.12 *Medical Director;	X					
1.13 *Compliance Officer.	X					
2. Operational relationships of CCO staff are clearly delineated.	X					Review of the Organizational Chart revealed that the lines of reporting were not displayed for several staff members. Onsite discussion confirmed that these staff report to enterprise (corporate) supervisors.
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					On average, United pays 99% of clean claims within 30 days and 99.99% of all claims within 90 days. This exceeds the metric set both internally by United and is compliant with *Miss. Code Ann. § 83-9-5*, both which define timeliness as 90% of clean claims paid in 30 days and 99% of all claims within 90 days.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United has checks to ensure that both enrollment data and member demographic information are captured correctly. United also captures data on member and provider characteristics, such as member enrollment, place of service, provider type, distribution of claim types, etc. to ensure data completeness. United can provide these data to oversight agencies.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					United included all appropriate CHIP-related ISCA documentation as well as supporting documents. The CCO adequately demonstrated their data collection and storage capability, processing procedures, and claim data tabulation and processing, as well as showed adequate support of Quality Management and Utilization Management program activities and other contractual requirements via attached flowcharts and technical layouts. The processes were reviewed and discussed during the onsite.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United has both a documented disaster recovery and a business continuity plan in place along with yearly updates (last updated on 1/1/2024) and plan review. Systems are in place to ensure a 72 hour or less recovery time objective with the recovery point objective near zero hours.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste, and abuse.	X					United provided copies of the following: • UnitedHealthcare Compliance Program (Compliance Plan) • UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2023-2024 (FWA Plan)

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• UnitedHealthcare Community Plan of Mississippi Fraud, Waste and Abuse Program 2023-2024 (Mississippi Addendum to the FWA Plan) • UnitedHealth Group Code of Conduct (Code of Conduct) • Related policies and procedures
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						As part of the Compliance Program, United has adopted a Code of Conduct that outlines principles of ethics and integrity for employees to follow, and addresses employee accountability, privacy and information security, government interactions, communication and marketing, work environment safety and support, etc. The Code of Conduct provides contact information for compliance resources and references to specific policies related to topics addressed in the document.
2.2 Identification of the Fraud and Abuse Compliance Officer;						The Compliance Plan and FWA Plan address Compliance leadership and oversight and provide an overview of the roles and responsibilities of the Compliance Officer. These roles and responsibilities include: • Developing, implementing, and maintaining the Compliance and the Anti-Fraud, Waste and Abuse Programs. • Supporting the compliance framework and strategy for education and governance to ensure effective oversight of the Program.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Ensuring accountability for compliance with legal, regulatory, and other requirements. • Working closely with the Legal Department related to FWA enforcement actions and reporting. • Serving as the primary point of contact with the state for compliance oversight. • Maintaining open communication with senior leadership, the Compliance Oversight Committee, and employees.
2.3 Information about the Compliance Committee;						Information about the Compliance Committee is included in the Compliance Plan and the Mississippi Addendum to the FWA Plan.
2.4 Compliance training and education;						As noted in the Compliance Plan and Policy ID-6069, UnitedHealthcare Compliance Training & Education Policy, compliance training is required for all employees, governing body members, members of compliance committees, contractors, and suppliers. For employees, the training is mandatory upon hire and then annually. Training topics include the Code of Conduct, information privacy and security, and FWA. Additional specialized or targeted training for specific job functions may also be provided. Mandatory training is managed and tracked through United's online Learning Management System. Specialized or targeted training may be managed through the Learning Management System or by individual departments.
2.5 Lines of communication;						The Compliance Plan addresses lines of communication within the Compliance Program. As noted, United ensures effective and open communication between the Compliance Officer and all employees, committee members, contractors, etc. United encourages

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reporting through department managers, senior leadership, the Compliance Officer, and additional resources such as the compliance hotline and the Compliance and Ethics HelpCenter. Reports can be made anonymously telephonically or online. Contact information is included for: • The UHC Privacy mailbox and the Compliance & Ethics HelpCenter • The website for online reporting • The Healthcare Fraud Tip Line (telephonic and online) • The Employee Center (telephonic and online) • Enterprise Health & Safety (telephonic and online) • Corporate Security • The IT Help Desk To further encourage open communication, United enforces a no-retaliation policy which prohibits any intimidation or retaliation for those making good faith reports. In addition to compliance training programs, United employs a communication and awareness strategy to increase knowledge and awareness of the compliance expectations through e-mail, newsletters, plan materials, posters, face-to-face meetings, etc.
2.6 Enforcement and accessibility;						Staff are informed of disciplinary actions that may result from identified compliance issues and/or FWA through the Code of Conduct, the Compliance Program, the Employee Handbook, and additional methods such as training, intranet sites, memos, newsletters, etc. Disciplinary actions may include verbal and/or written warnings, suspension, termination of employment, and possible legal action.

Standard	Score					Comments
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2.7 Internal monitoring and auditing;						The Compliance Plan provides information about risk assessment, auditing, and monitoring within United's Compliance Program. Auditing and monitoring activities include: • An annual compliance risk assessment to evaluate and prioritize risks from external and internal sources and to determine how to address and mitigate risks. • Additional audits to assess organizational and supplier adherence to applicable regulatory requirements, including state and federal regulations. • Monitoring by the Compliance Department and other internal departments or functional areas to identify, prevent, and correct regulatory risks, and to verify compliance with laws, regulations, contractual requirements, and company policies. High-risk areas are prioritized. • Using a compliance dashboard that focuses on structures and processes to drive improved compliance outcomes.
2.8 Response to offenses and corrective action;						Information about United's process for responding to detected offenses and developing corrective actions is found in the Compliance Plan. United's Compliance Program supports interdepartmental coordination to respond promptly to any suspected misconduct by conducting timely inquiries and investigations. Corrective/disciplinary actions are implemented to address any underlying issues contributing to non-compliance to decrease the potential for recurrence. United reports potential non-compliance or fraudulent activity to federal and state regulatory authorities and reports suspected instances of FWA to law

Standard	Score					Comments
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						enforcement and/or regulatory authorities as required by federal and state regulations.
2.9 Exclusion status monitoring.						Policy ID-5881, New Hire and Periodic Employee Sanction Review, describes processes for monitoring employees and contractors for sanctions and exclusions. The monitoring includes monthly checks against specific databases, including the Office of Inspector General/General Services Administration, the System for Award Management, and applicable State Medicaid sanction lists. After the onsite, United confirmed that the Social Security Death Master File check is conducted "as part of both the Pre-employment check and the Annual Background check. This is managed by talent acquisition operations."
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee assists in developing and implementing United's Compliance Program and ensuring compliance with laws, detecting violations, and monitoring training. As noted in the Mississippi Addendum to the FWA Plan, the Compliance Committee is co-chaired by the Compliance Officer and the health plan's CEO, and a quorum is established with the presence of a minimum of 51 percent of the committee membership. Members include senior leaders, department leaders, and the Compliance Officer. Additional attendees may be invited as needed to provide relevant information or assist with issues under review. United submitted a copy of the Community and State Health Plan Compliance Oversight Committee Charter

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for Mississippi. The charter outlines the purpose, composition, roles, responsibilities, and operation of the Compliance Oversight Committee. Review of United's Compliance Committee minutes for May 2023 through February 2024 reflected quarterly meetings, the presence of a quorum for each meeting, and adequate attendance by members. It was noted that voting members may appoint a designee for attendance and votes as needed.
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.
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Compliance Plan indicates all credible reported, suspected, or identified concerns of misconduct are reviewed promptly for further action. Compliance, Legal, and/or Investigations personnel make timely inquiries and conduct preliminary investigations of suspected misconduct. Corrective and/or disciplinary actions are taken in response to findings to reduce the potential for recurrence and ensure ongoing compliance with regulatory requirements. As noted in the FWA Plan, SIUs perform retrospective investigations of credible suspicions of fraud committed against health plans and programs to identify suspect claim and provider patterns and behavior so that appropriate action based on the findings may be taken. The SIUs are staffed by qualified investigators who are experienced in health care and prescription drug fraud and abuse and who have knowledge of industry business practices and systems,

Standard	Score					Comments
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						infrastructure, and federal and state law enforcement and litigation practices. The Mississippi Addendum to the FWA Plan addresses FWA investigations for Mississippi. It covers the responsibilities, procedures, reporting requirements, and detailed steps for conducting investigations, audits, and provider on-site visits. The document outlines the roles of the SIU, Optum Program Integrity, Office of Program Integrity, and the health plan in managing investigations, reporting requirements, and compliance with standards and regulations. It also specifies the process for referrals to the Medicaid Fraud Control Unit for prosecution. Policy ID 4.0, Preliminary Investigative Process, provides comprehensive information about the preliminary investigation process for credible allegations of fraud against the health care plan and its programs.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The Mississippi Addendum to the FWA Plan describes United's procedures for payment suspensions initiated by DOM and the CCO, including the requirement to suspend payments to providers upon notification of a credible allegation of fraud; the process for suspending payments within 24 hours of notification; notifying providers in writing of payment suspensions; and the requirement for providers to return any funds paid in error while a suspension is in effect. The document describes the CCO's responsibilities regarding withholding payments in cases of fraud investigations. Additionally, the document specifies the process for suspending payments to providers once notification is received from the Office of Program Integrity and

Standard	Score					Comments
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						outlines procedures for withholding payments, future enrollment, and payment suspensions of non-par providers.
7. The CCO implements and maintains a Pharmacy Lock-In Program.		X				Information about the Pharmacy Lock-in Program is found in Policy ID-31884, C&S High Prescription Utilization Program. However, this is a corporate policy and includes phrases such as "when applicable," "if allowed by the plan," and "or other time frame required by the Plan." It does not define the requirements for Mississippi. Additionally, Policy ID-31884 does not address the requirement for the provision of a 72-hour emergency supply of medication for members in the Pharmacy Lock-in Program, as required by the *CHIP Contract, Section 10 (G) (3)*. Page two, item 4.2 of the policy refers to the state-specific policy. A state specific policy was requested from United, but another copy of the same policy was provided. United confirmed during onsite discussion that a state-specific policy has not been developed. *Corrective Action Plan: Develop a policy to describe Mississippi-specific processes and requirements for the Pharmacy Lock-in 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 Provider Services review 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

Newly contracted providers are identified through a monthly Network Notification report. A Provider Advocate contacts these providers within 30 days of their contract effective date to answer any immediate questions and to schedule an orientation session at the provider's earliest convenience. This process is detailed in Policy PS14, Provider Orientation Plan, and the corresponding SOP. United staff confirmed there is no established policy for ongoing provider education. United provided a summary of dates and related information for provider education, including participation at Medical Association events, DOM Managed Care Provider Workshops, mass virtual education events, and provider outreaches.

The Provider Manual includes information for both the CAN and CHIP programs and serves as a comprehensive resource for providers to operate effectively within United's network. United addressed the corrective action resulting from the previous year's EQR to revise the CAN Care Provider Manual to include the required timeframe for medical record retention and to revise the CAN and CHIP Care Provider Manuals to include information about requirements for a Primary Care Physician (PCP) to request reassignment of a member to another PCP.

Issues identified with the Provider Manual in the current EQR include:

- Chapter 5 instructs providers to follow the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedule for members and to refer to the EPSDT schedule for details about diagnosis codes, screening information, examinations, and immunization requirements. However, the Provider Manual does not include information about where/how to access the EPSDT schedule.
- A discrepancy was noted in documentation of the requirement for member medical record retention. Page 74 of the Provider Manual references a 10-year retention timeframe, while page 67 references a five-year retention timeframe. Onsite discussion confirmed providers are required to retain member medical records for 10 years.

- The Provider Manual did not include a statement about non-exclusivity requirements as required by the *CAN Contract, Section 7 (H) (2) (s)* and the *CHIP Contract, Section 7 (H) (2) (s)*.

Provider Advocate contact newly contracted providers within 30 days of their contract effective date to answer any immediate questions and to schedule an orientation session at the provider's earliest convenience. This process is detailed in Policy PS14, Provider Orientation Plan, and the corresponding SOP. United staff confirmed there is no established policy for ongoing provider education. United provided a summary of dates and related information for provider education, including participation at Medical Association events, DOM Managed Care Provider Workshops, mass virtual education events, and provider outreaches.

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- The Provider Manual did not include a statement about non-exclusivity requirements as required by the *CAN Contract, Section 7 (H) (2) (s)* and the *CHIP Contract, Section 7 (H) (2) (s)*.

United defines medical record documentation standards for providers in policy, educates providers about the documentation standards through the Provider Manual, and assesses provider compliance with the medical record documentation standards through an annual medical record review process. United contracted with a vendor, Episource, to conduct the 2023 medical record review for PCPs and EPSDT providers. For each, 20 providers were randomly sampled. However, as has been noted in previous years, the number of records reviewed was

small (six PCP records and 12 EPSDT provider records). United staff reported this is due to multiple factors, such as providers charging a fee/using copy service, unresponsiveness, provider terminations, etc. Constellation suggests that United consider increasing the sample size for the medical record review to get a better representation of provider medical record documentation compliance.

Practice Guidelines

§ 438.236, § 457.1233

United adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) from nationally recognized entities to ensure equitable and evidence-based care for all members and to identify safe and effective health services. The CPGs and PHGs are reviewed every 12 months and as needed for updates. United educates providers about the guidelines through provider newsletters and the health plan's website and notifies the providers annually about the availability of guidelines. The Provider Manual encourages providers to use the clinical guidelines as a resource for clinical decision-making and indicates providers are monitored for the use of the PHGs. This monitoring primarily occurs through the annual medical record review process.

Provider Satisfaction Survey Validation

United's 2023 provider satisfaction survey was administered by Escalent, an independent research company. Of the 2,524 sampled providers, only 30 responded, creating a response rate of 1.1%, which is a slight increase over the previous year's rate of 1.0%. United presented the results of the provider satisfaction survey to the Quality Management Committee (QMC) in June 2023 and to the Provider Advisory Committee (PAC) in February 2024.

The percentage of providers rating the overall satisfaction with United as 10 on a scale from zero to 10 decreased from 2022 to 2023, although ratings of eight or nine increased. Service experience was scored as excellent or good by 67% of providers; the ease of the appeals process was scored as excellent or good by 56%; and the ease of matching patients' prescription drug needs to the treatment plan was scored as excellent or good by 72% of providers. Areas with the lowest ratings included patient support, medical records, appeals, and reimbursement.

Table 11 indicates the section of the EQR Survey Validation Worksheet that needs improvement, along with the reason and recommendation.

Table 11: Provider Satisfaction Survey Validation Results—CAN and CHIP

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with	Of the 2,524 sampled providers, only 30 responded, creating a response rate of 1.1%, which is a very slight increase over last	Continued efforts should be made to enhance survey responses and advertise the

Section	Reason	Recommendation
generalization of the results?	year's rate of 1.0%. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with caution.	importance of the survey to 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 conducted a validation review of United's provider network following the 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 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, and 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 in Q3 2024 identified weaknesses related to the overall successful contact rate and provider directory accuracy. The State has time/distance requirements documented for primary care, Obstetrics/Gynecology (OB/GYN), and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated that United and its information systems are

capable of meeting the State's requirements. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

An overview of the results for each activity is documented below.

Provider Network File Questionnaire

The Provider Network File Questionnaire was reviewed and revealed that United uses the Network Database and CSP Facets as its data management systems. Verification is conducted through a portal update based on status information from the State. The member-facing directory is updated bi-weekly (two times per month) for the paper-based directory; the online directory is refreshed according to a schedule with the most current provider data available at the time of data inquiry, based on a six-hour or overnight feed.

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)

United notifies PCPs of member panel assignments via the secure provider portal within five business days of receiving the Member Listing Report from DOM. All providers may verify member eligibility/enrollment through the portal and by calling the health plan. United staff reported that United monitors providers' panel status quarterly and as needed. It was also reported that 215 PCPs (5%) currently have closed panels. This is a decrease from the previous year's rate of >9%.

Policy PS3, Geographic Access Standards, defines the geographic access standards for United's network; the standards defined in the policy are compliant with contractual requirements. As noted in this policy, United runs quarterly geographic access reports to evaluate the network for compliance with the geographic access standards and to identify any network gaps. Results are reported to the Service Quality Improvement Subcommittee for reporting, tracking, and trending. The Quarterly Report on Accessibility of MississippiCAN Members and the Quarterly Report on Accessibility of MississippiCHIP Members, both dated July 1, 2024, confirm the use of correct urban and rural parameters to evaluate geographic access for all provider types. 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.

The 2023 Quality Improvement & Population Health Management Annual Evaluation Reports for CAN and CHIP state that United monitors the adequacy of its network annually using multiple factors, including geographic access to providers, member grievance and appeal data, and the cultural, ethnic, racial, and linguistic needs of its membership. For identified issues, interventions are implemented to improve network adequacy. For 2023, goals were met for member-to-

practitioner ratios and geographic access, except for 24-hour pharmacies. The reports further explained that "There are insufficient 24-hour pharmacies in the state to meet this goal. The Division of Medicaid has given a waiver for this contract requirement."

United's Provider Directories include all required elements. Activities are conducted to ensure Provider Directory information is current and correct. These activities include "ongoing quality reviews through provider data attestations, phone call campaigns to providers, and other methods," a monthly comparison of a sample of provider records against the information collected, and using the results of the activities to update the Provider Directory as needed.

Appointment access standards for network providers are defined in policy and are compliant with contractual requirements. To evaluate provider compliance with the appointment access standards, United contracts with Aucera, formerly known as DialAmerica, to conduct quarterly telephonic surveys. Goals are set at 80% for both successful contact rates and provider compliance with appointment access standards. Results for the Q2 2024 access study conducted by Aucera indicate successful contact rates are low, ranging from 12.81% to 30.68%. Goals were met for all appointment access categories for all provider types.

United has established its Health Equity Program "to reduce health disparity and improve culturally and linguistically appropriate services." Activities conducted to monitor and evaluate the network's abilities to meet members' cultural and diversity needs include:

- Assessing member and provider race, ethnicity, and languages every three years.
- Analyzing Healthcare Effectiveness Data and Information Set (HEDIS) data to identify trends and evaluating Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to evaluate member satisfaction.
- Identifying and prioritizing opportunities to reduce disparities and enhance culturally and linguistically appropriate services.

United's website includes cultural competency resources, including training and education resources. The Provider Manual also provides an overview of cultural competence and provides information about the language interpretation line and alternate member materials.

Provider Access and Availability Study

Constellation conducts Telephonic Provider Access Studies twice a year for each CCO. Full details of these call studies are reported to DOM separately. For the most recent studies conducted for United in Q3 2024, a decline in the successful answer rate was noted from the Q1 2024 rates for both CAN and CHIP. See *Table 12* and *Table 13*.

Table 12: CAN Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q1 2024	64 of 94	68%	.022
Q3 2024	44 of 95	45%	

Table 13: CHIP Provider Access Study Results for Current and Previous Review Cycle

Review Cycle	Successful Contacts	Answer Rate	Fisher's exact p-value
Q1 2024	68 of 94	72%	.010
Q3 2024	38 of 98	39%	

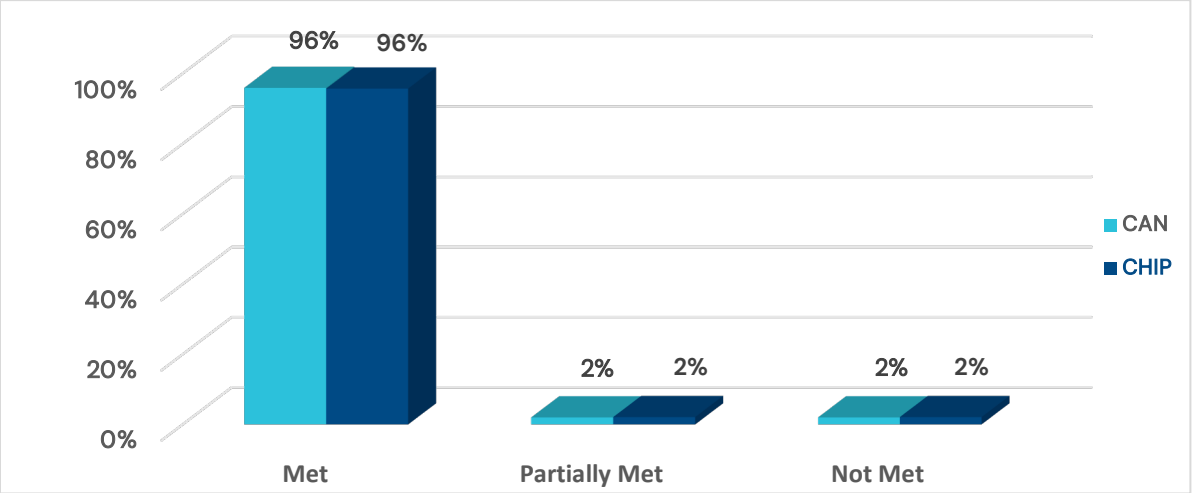
CAN: Of the 101 PCPs contacted, six calls were answered by voicemail and omitted from the denominator in the success rate formula. After accounting for the voicemail answered calls, the Phase 1 success rate was 46% (44 out of 95), a decline of 22% from the Q1 2024 study. Compliance for appointment availability increased by 61% for routine appointments and 27% for urgent appointments from the previous study. However, provider directory accuracy declined, as demonstrated in a 51% decline from 92% in Q1 2024 to 41% in Q3 2024.

CHIP: Of the 102 PCPs contacted, four were answered by voicemail and omitted from the denominator in the success rate formula. After accounting for voicemail answered calls, the Phase 1 success rate was 39% (38 of 98), a decline of 33% from the Q1 2024 study. Improvement was demonstrated for compliance with appointment availability, with a 54% increase for routine appointments and a 10% increase for urgent appointments from the previous study. However, provider directory accuracy declined, as demonstrated in a 56% decline from 93% in Q1 2024 to 37% in Q3 2024.

The next call study will take place in Q1 2025.

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

Figure 4: Provider Services Findings



Strengths, weaknesses, recommendations, and corrective actions for the Provider Services section are included in the tables below.

Table 14: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
United notifies PCPs of members assigned to their panels and ensures all providers can verify member eligibility and enrollment.			✓
United monitors provider panel statuses quarterly to ensure that there are sufficient providers accepting new patients.			✓
United appropriately documents geographic and appointment access standards for its provider network and conducts appropriate activities to evaluate the adequacy of the network.			✓
Although Indian Health Care Providers within the state of Mississippi decline to contract with United, the CCO allows eligible members to use these providers with no requirements for prior authorizations, and with claims paid at in-network rates.			✓
The Health Equity Program is in place to reduce disparities and improve culturally and linguistically appropriate services. Activities are conducted to monitor and evaluate the network's abilities to meet members' cultural and diversity needs.	✓		✓
United's website includes Cultural Competency information including training and education resources. The Provider Manual also provides an overview of cultural competence.	✓		✓
The printed and online provider directories include all required elements.			✓
Processes are in place for comprehensive initial provider orientation and ongoing education.	✓		
United adopts preventive health and clinical practice guidelines, educates providers about the guidelines, and assesses provider compliance with the guidelines.	✓		

Strengths	Quality	Timeliness	Access to Care
Annual medical record reviews are conducted to assess provider compliance with medical record documentation standards.	✓		

Table 15: Provider Services Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Results for the Q2 2024 appointment access study conducted by Aucera indicate successful contact rates are low, ranging from 12.81% to 30.68%.	*Recommendation: Continue interventions to improve provider contact information.*			✓
The Provider Manual, page 51, instructs providers to "Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant members" and states, "For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule." However, the Provider Manual does not instruct providers about where/how to access the EPSDT schedule.	*Recommendation: Revise the Provider Manual to include information about where/how providers can access the EPSDT schedule.*	✓		✓
A discrepancy in the requirement for medical record retention was noted on pages 67 and 74 of the Provider Manual. Onsite discussion confirmed providers are required to retain member medical records for 10 years, as stated on page 74 of the Provider Manual.	*Corrective Action Plan: Revise page 67 of the Provider Manual to document the correct timeframe for member medical record retention.*	✓		
The required statement about non-exclusivity requirements was not found in the Provider Manual.	*Corrective Action Plan: Revise the Provider Manual to include the required non-exclusivity statement. Refer to the CAN Contract, Section 7 (H) (2) (s) and the CHIP Contract, Section 7 (H) (2) (s).*	✓		✓
No policy was found that addresses ongoing provider education.	*Recommendation: Develop a policy, or revise an existing policy, to include processes undertaken for ongoing provider education.*	✓		
United conducts annual medical record review audits to assess compliance with documentation standards. Results indicate 20 PCP providers and 20 EPSDT providers are sampled. However, as has been noted in previous years, the number of records reviewed is small due to providers charging a	*Recommendation: Consider increasing the sample size for the medical record review to get a better representation of provider medical record documentation compliance.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
fee for records, using copy services, unresponsiveness, provider terminations, etc.				
Response rates for provider satisfaction surveys (CAHPS) remain low and may affect generalizability of the results.	*Recommendation: Continued efforts should be made to enhance survey responses and advertise the importance of the survey to 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					As noted in Policy PS10, PCP Panel Notification, United makes member panel details available to all participating PCPs via the secure provider portal within five business days of receiving the Member Listing Report from DOM. Postcards are also sent to providers to remind them to check the portal for panel changes.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, states, "Participating and non-participating providers may access member enrollment information via the secure, password-protected online provider portal. Furthermore, member ID cards include a telephone number that all providers, including out-of-network providers, may call to verify member enrollment."
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Onsite discussion confirmed United monitors providers' panel status quarterly and can run ad hoc reports. Currently, only 215 PCPs (5%) have closed panels. This is a decrease from the previous year when the health plan reported 413 PCPs (>9%) with closed panels.
1.4 Members have two PCPs located within a 15-mile radius for urban	X					Policy PS3, Geographic Access Standards, defines the geographic access standards United uses for PCP

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
counties or two PCPs within 30 miles for rural counties.						access within its network. The standards defined in the policy are compliant with the contractual requirements. The Quarterly Report on Accessibility of MississippiCAN Members (July 1, 2024) confirms the use of correct urban and rural parameters to evaluate the geographic access of PCPs. The percentages of members with appropriate access to PCPs are 99.2% (adult and child – urban) and 100% (adult and child – rural). This report also confirmed that United contracts with Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The document indicates 100% of urban members have the appropriate access to FQHCs and 99.4% of urban members have the appropriate access to RHCs. For rural access, 100% of members have the appropriate access to both FQHCs and RHCs. Onsite discussion confirmed that the Indian Health Care Providers within the state of Mississippi decline to participate in the CCO's network. However, United allows eligible members to use these providers as if they were in network and with no requirements for authorization. United's 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					Policy PS3, Geographic Access Standards, defines the geographic access standards United uses for non-PCP access for its network. The standards defined in the policy are compliant with contractual requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Quarterly Report on Accessibility of MississippiCAN Members (July 1, 2024) confirms the use of correct urban and rural parameters to evaluate the geographic access of non-PCP providers within the network.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					As noted in Policy PS3, "Geographic access reports are developed on a quarterly basis to assess network compliance with the stated contract 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." The 2023 Quality Improvement & Population Health Management Annual Evaluation Report for CAN states "Annually, Network Adequacy is monitored and reviewed using multiple data points to verify members have access for needed healthcare services. Performance against standards is evaluated based on goals, benchmarks, and any state specific requirements. Goals are established based on state contract requirements and historical trends. Analyses of the following network areas were performed: • Cultural, ethnic, racial, and linguistic needs of its membership. • Availability and Accessibility of Primary Care Physicians and High Volume/High Impact Specialists. • Member Experience, Complaints/Grievances, and Appeals. Opportunities for improvement are identified when goals are not met, and interventions are deployed for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the high priority opportunities to improve network adequacy based on the summary of network accessibility, availability, and member experience." The assessment indicated goals were met for member-to-practitioner ratios and geographic access, except for 24-hour pharmacies. The report documented that "There are insufficient 24-hour pharmacies in the state to meet this goal. The Division of Medicaid has given a waiver for this contract requirement."
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					The 2024 Quality Improvement and Population Health Management Program Description (QI Program Description) for CAN addresses United's Health Equity Program. As stated, the goal of the program is "to reduce health disparity and improve culturally and linguistically appropriate services." The QI Program Description lists activities conducted to monitor and evaluate the network's abilities to meet members' cultural and diversity needs. These activities include: • Assessing race, ethnicity, and languages by collecting race/ethnicity and language information from both practitioners and members. The language profile of the member population is assessed every three years to determine if changes are needed in language services. United makes practitioner languages available to members via the Provider Directory. • Analyzing HEDIS data to identify trends and develop action plans, and evaluating CAHPS survey results to assess member satisfaction with health care experience, customer service, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Identifying and prioritizing opportunities to reduce disparities and enhance culturally and linguistically appropriate services. United's website includes cultural competency resources, including training and education resources. The Provider Manual also provides an overview of cultural competence and provides information about the language interpretation line and member materials.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Policy PS3, Geographic Access Standards, describes the process followed when network gaps or inadequacies are discovered through routine monitoring. The process includes conducting an analysis to specify the geographic area with the inadequacy and the members who are affected. This is followed by conducting research to determine if there are any non-participating providers in the area of the identified gaps. If providers are identified, United engages with them to encourage them to contract with the CCO. If no non-participating providers are identified, DOM is notified immediately. Case Management staff work with impacted members to ensure their access to needed medical services and to ensure continuity of care.
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. United uses the Network Database and 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 (two times per month)

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for the paper-based directory; the online directory is refreshed according to a schedule with the most current provider data available at the time of data inquiry, based on a six-hour or overnight feed.
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 ID-5776, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions, outlines procedures for quality of care (QOC) investigations, implementation of resulting action plans, and disciplinary actions that may be taken against network practitioners. For imminent patient safety concerns, the case is referred to Quality Intervention Services. For other cases, medical records and other relevant information are requested and reviewed by a Clinical Reviewer. If no QOC issue is identified, the Clinical Reviewer may close the case. Case findings of potential moderate or serious QOC issues are referred to the Medical Director. The Medical Director will make a determination and may seek input from a Specialty Reviewer. Resulting action may include closing the case, implementing an Improvement Action Plan, referral to the Professional Review Committee, termination from network participation, etc. Policy PS13, Provider Terminations, addresses provider termination by United (for cause and not for cause). DOM is notified in writing of the intent to terminate a provider 60 calendar days prior to the effective date. The provider is also notified in writing of the termination, including the reasons and effective date. For every provider termination, United identifies

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members who will be impacted and submits a provider termination work plan and supporting documentation to DOM.
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. The appointment access standards for PCPs, specialists, behavioral health providers, and dental providers are also documented correctly in the Provider Manual. The 2023 Quality Improvement & Population Health Management Annual Evaluation Report for CAN states "In order to monitor members' appropriate and timely access to care by primary care physicians and specialists, UnitedHealthcare has established standards for appointment access and after-hours care. Performance against appointment access standards is measured at least annually using a variety of methods." United conducts this monitoring by evaluating CAHPS survey results and complaints/grievances related to appointment access.
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					United contracts with Aucera, formerly DialAmerica, to conduct quarterly telephonic surveys to assess provider compliance with appointment access standards. United reported that goals are set at 80% for both successful contact rates and provider compliance with appointment access standards.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Results for the Q2 2024 access study conducted by Aucera indicate: • The successful contact rate for PCPs was 20.26%, a decrease from last year's rate 23.47%. For pediatrics providers, the successful contact rate was 30.68%, an increase from the previous year's rate of 29.55%. Goals were met for all appointment access categories for PCPs and pediatrics providers. • For OB/GYN providers, the successful contact rate was 19.54%, a decrease from the previous year's rate of 24.14%. Goals were met for all appointment categories. • For behavioral health providers, the successful contact rate was 12.81%, a decrease from the previous year's rate of 18.93%. Goals were met for all appointment categories. When asked about interventions to address the low successful contact rates, United reported they are working with the Data Cleanse Team to get updated provider contact information. *Recommendation: Continue interventions to improve provider contact information.*
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					The printed and online provider directories include all required elements.

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					Last year, United submitted Policy NQM-052, Web-Based Directory Usability Testing, and a related MS Rider. Onsite discussion confirmed these policies have been retired and the CCO is using the Provider Directory Maintenance Schedule SOP. This SOP indicates printed Provider Directories are updated twice monthly and online directories are updated at least daily. Additionally, a document titled "2024 MS DOM EQRO Audit Provider Directory Validation Narrative" provided an overview of activities conducted to ensure Provider Directory information is current and correct. These activities include: • Conducting "ongoing quality reviews through provider data attestations, phone call campaigns to providers, and other methods." • Conducting a monthly comparison of a sample of provider records against the information collected through the data attestations, phone call campaigns, and other methods referenced above. • Using the results of the activities to update the Provider Directory as needed.
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 time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated that United and its

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information systems can meet the State's requirements. Policies and procedures also 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					New providers are identified through a monthly Network Notification report. These providers are contacted within 30 days of their contract effective date by a Provider Advocate to answer any immediate questions and to schedule the orientation. This process is detailed in Policy PS14, Provider Orientation Plan. As noted in the corresponding SOP, new provider orientation sessions are scheduled at the provider's earliest convenience. The orientation is conducted by Provider Advocates following the Provider Orientation Checklist. The full provider orientation session covers: • An overview of member benefits • Claims processes, including corrected claims and reconsiderations • Prior authorization processes • Provider roles and responsibilities • A discussion of provider's member panel • Referral/collaboration with specialists and behavioral health providers • Appointment access standards

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Accessing information/United's website/online portal • Call center phone number • The Provider Manual
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols;	X					The Provider Manual provides an overview of Case Management, Disease Management, and Care Coordination/Health Education services provided by United for its members.
2.2 Billing and reimbursement practices;	X					The Provider Manual addresses claim processes, general billing guidelines, fee schedules, modifier codes, claim forms, clean claims and submission requirements, coding, etc.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					The Provider Manual directs the reader to the health plan's website to obtain detailed information about member benefits. Chapter 4: Medical Management provides an overview of specific member benefits, limitations, non-covered services, etc. The Provider Manual also provides copayment/out of pocket information and guidelines about appropriate use of emergency rooms. United addressed the recommendations from the previous EQR by including information in the Provider Manual that prior authorization is required for visits with out-of-network providers.
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					Referral guidelines are addressed in the Provider Manual. Members may self-refer to certain services and providers without needing a referral from the PCP. However, out-of-network referrals require prior

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						authorization. In cases of complex medical needs, specialists may serve as the member's PCP.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					Appointment access standards are appropriately documented in the Provider Manual. PCPs are expected to follow up with members who miss appointments to ensure continuity of care, address potential barriers to accessing healthcare, reschedule necessary visits, provide guidance, and support adherence to treatment plans.
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					Chapter 5 of the Provider Manual provides information about EPSDT services, including associated member ages, elements included in EPSDT services, etc. The Provider Manual, page 51, states: • "Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant members." • "For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule." However, the Provider Manual does not instruct providers about where/how to access the EPSDT schedule. *Recommendation: Revise the Provider Manual to include information about where/how providers can access the EPSDT schedule.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					The Provider Manual states PCPs and specialists serving as PCPs have a responsibility to "Follow up with members who are not compliant with the EPSDT screening requirement and EPSDT services."
2.8 Medical record handling, availability, retention, and confidentiality;		X				The Provider Manual addresses requirements for maintaining the confidentiality of member medical records, provision of medical records to members, medical record review by the CCO, record storage, and confidentiality requirements. The review revealed a discrepancy in the requirement for member medical record retention: • Page 74 states providers must retain member medical records for at least "10 years from the close of the Mississippi CHIP and MississippiCAN program agreement" between the State and United or other period as required by law. • Page 67 states, "Medical records are generally kept for a minimum of 5 years unless federal requirement mandates a longer time frame (i.e., immunization and tuberculosis records required for lifetime)." Onsite discussion confirmed providers are required to retain member medical records for 10 years, as stated on page 74 of the Provider Manual. *Corrective Action Plan: Revise page 67 of the Provider Manual to document the correct timeframe for member medical record retention.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					The Provider Manual describes the roles and responsibilities of the PCP and indicates PCPs may request that a member be transferred to another PCP due to an "inability to start or maintain a professional relationship or if the member is noncompliant. The PCP must provide care for the member until a transfer is complete." Instructions are provided for PCPs who wish to request a member transfer.
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					The Provider Manual addresses available translation services and the availability of member materials in alternate languages. It provides specific contact numbers for interpreter services and emphasizes the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						importance of documenting language needs in medical records.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					The Provider Manual provides information about the expectation for provider participation in quality improvement through the Care Model program to improve health outcomes, reduce expenses, and ensure appropriate care. Expectations include participation in quality improvement activities such as quality audits and following preventive care standards.
2.17 A description of the provider web portal;	X					Comprehensive information about the provider portal is included in the Provider Manual. The information includes the URL for accessing the portal, tools, services available through the portal, etc.
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.			X			The required statement about non-exclusivity requirements was not found in the Provider Manual. This statement was noted in the provider contract templates provided for review. *Corrective Action Plan: Revise the Provider Manual to include the required non-exclusivity statement. Refer to the CAN Contract, Section 7 (H) (2) (s).*
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					During the onsite discussion, United staff provided an overview of ongoing provider education processes. However, no policy was found that addresses ongoing provider education. United staff confirmed this finding during the discussion. A document titled "2024 MS DOM EQRO Audit Provider Education Narrative" listed dates and related information for participation at Medical Association

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Events, DOM Managed Care Provider Workshops, mass virtual education events, and provider outreaches. The document also indicated that 1,715 provider interactions had occurred from Q3 2023 through Q2 2024. *Recommendation: Develop a policy, or revise an existing policy, to include processes undertaken for ongoing provider education.*
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 indicates United adopts CPGs and PHGs to ensure equitable and evidence-based care for all members. The guidelines are sourced from nationally recognized entities and are used for quality and health management programs, member education, and to identify safe and effective health services. The detailed process for initial review and adoption is included in the policy. Both internally/locally developed and nationally recognized CPGs and PHGs are reviewed every 12 months and as needed for updates.
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 CPGs and PHGs are disseminated to network practitioners through provider newsletters and the health plan's website. Members and potential members may also access the guidelines on the website. Providers are informed annually about the availability of guidelines via mail, fax, or email.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual indicates providers are encouraged to use the CPGs as a resource for clinical decision-making and it indicates providers are monitored for the use of the PHGs. A hyperlink is included that takes the user to the list of adopted CPGs as well as PHGs.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II D. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy NQM-025, Medical Record Review Process, lists the elements that must be included in medical records maintained for United's members. The list of medical record elements in the policy and the related audit tool is appropriate for assessing provider compliance with medical record documentation standards. Chapter 9 of the Provider Manual includes the specific elements that must be included in medical record documentation for United's members.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					Policy NQM-025, Medical Record Review Process, states United "conducts medical record review audits to assess compliance with its documentation standards and in accordance with state regulatory or contractual requirements." Review of the PAC minutes from November 29, 2023, and the QMC minutes from December 6, 2023, revealed United used a vendor, Episource, for the 2023 medical record reviews for PCPs and EPSDT providers. For each, 20 providers were randomly sampled. However, as has been noted in previous years, the number of records reviewed is small – six PCP records and 12 EPSDT provider records were reviewed. This is due to providers charging a fee/using copy service, unresponsiveness, provider terminations, etc. All the records reviewed received passing scores. *Recommendation: Consider increasing the sample size for the medical record review to get a better*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						representation of provider medical record documentation compliance.
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					Of the 2,524 sampled providers, only 30 responded, creating a response rate of 1.1%, which is a very slight increase over last year's rate of 1.0%. The percentage of providers rating the overall satisfaction with United as a "10" on a scale from 0 to 10 decreased from 2022 to 2023, although ratings of 8 or 9 increased. The service experience was scored as excellent or good by 67% of providers; the ease of the appeals process was scored as excellent or good by 56%; and the ease of matching patients' prescription drug needs to the treatment plan was scored as good/excellent by 72% of providers. Areas with the lowest ratings included Patient Support, Medical Records, Appeals, and Reimbursement. *Recommendation: Continued efforts should be made to enhance survey responses and advertise the importance of the survey to 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	X					Results were presented to the QMC in June 2023 and to the Provider Advisory Committee in February 2024.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
measures taken to address quality problems that were identified.						

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:						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As noted in Policy PS10, PCP Panel Notification, United makes member panel details available to all participating PCPs via the secure provider portal within five business days of receiving the Member Listing Report from DOM. Postcards are also sent to providers to remind them to check the portal for panel changes.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, states, "Participating and non-participating providers may access member enrollment information via the secure, password-protected online provider portal. Furthermore, member ID cards include a telephone number that all providers, including out-of-network providers, may call to verify member enrollment."

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Onsite discussion confirmed United monitors providers' panel status quarterly and can run ad hoc reports. Currently, only 215 PCPs (5%) have closed panels. This is a decrease from the previous year when the health plan reported 413 PCPs (>9%) with 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					Policy PS3, Geographic Access Standards, defines the CAN and CHIP geographic access standards United uses for PCP access for its network. The standards defined in the policy are compliant with the contractual requirements. The Quarterly Report on Accessibility of MississippiCHIP Members (July 1, 2024) confirms the use of correct urban and rural parameters to evaluate the geographic access of PCPs. The percentages of members with appropriate access are 99.3% (adult - urban) and 99.2% (child - urban) and 100% (adult and child - rural). This report also confirmed that United has contracts with FQHCs and RHCs. The document indicates 100% of urban members have the appropriate access to FQHCs and 99.7% of urban members have the appropriate access to RHCs. For rural access, 100% of members have the appropriate access to both FQHCs and RHCs. Onsite discussion confirmed that the Indian Health Care Providers within the state of Mississippi decline to participate in the CCO's network. However, United allows eligible members to use these providers as if they were in network and with no requirements for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						authorization. United's 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					Policy PS3, Geographic Access Standards, defines the geographic access standards United uses for non-PCP access for its network. The standards defined in the policy are compliant with contractual requirements. The Quarterly Report on Accessibility of MississippiCHIP Members (July 1, 2024) confirms the use of correct urban and rural parameters to evaluate the geographic access of non-PCP providers within the network.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					As noted in Policy PS3, geographic access reports are developed on a quarterly basis to assess network compliance with the stated contract 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." United submitted copies of quarterly Geo Access reports. The 2023 Quality Improvement & Population Health Management Annual Evaluation Report for CHIP states "Annually, Network Adequacy is monitored and reviewed using multiple data points to verify members have access for needed healthcare services. Performance against standards is evaluated based on goals, benchmarks, and any state specific requirements. Goals are established based on state contract requirements and historical trends. Analyses of the following network areas were performed:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Cultural, ethnic, racial, and linguistic needs of its membership. • Availability and Accessibility of Primary Care Physicians and High Volume/High Impact Specialists. • Member Experience, Complaints/Grievances, and Appeals. Opportunities for improvement are identified when goals are not met, and interventions are deployed for the high priority opportunities to improve network adequacy based on the summary of network accessibility, availability, and member experience." The assessment indicated goals were met for member-to-practitioner ratios and geographic access, except for 24-hour pharmacies. The report documented that "There are insufficient 24-hour pharmacies in the state to meet this goal. The Division of Medicaid has given a waiver for this contract requirement."
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					The 2024 QI Program Description for CHIP addresses United's Health Equity Program. As stated, the goal of the program is "to reduce health disparity and improve culturally and linguistically appropriate services." The QI Program Description lists activities conducted to monitor and evaluate the network's abilities to meet members' cultural and diversity needs. These activities include: • Assessing race, ethnicity, and languages by collecting race/ethnicity and language information from both practitioners and members. The language profile of the member population is assessed every three years to determine if changes are needed in language

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						services. United makes practitioner languages available to members via the Provider Directory. • Analyzing HEDIS data to identify trends and develop action plans, and evaluating CAHPS survey results to assess member satisfaction with health care experience, customer service, etc. • Identifying and prioritizing opportunities to reduce disparities and enhance culturally and linguistically appropriate services. United's website includes cultural competency resources, including training and education resources. The Provider Manual also provides an overview of cultural competence and provides information about the language interpretation line and member materials.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Policy PS3, Geographic Access Standards, describes the process followed when network gaps or inadequacies are discovered through routine monitoring. The process includes conducting an analysis to specify the geographic area with the inadequacy and the members who are impacted. This is followed by conducting research to determine if there are any non-participating providers in the area of the identified gaps. If providers are identified, United engages with them to encourage them to contract with the CCO. If no non-participating providers are identified, DOM is notified immediately. Case Management staff work with impacted members to ensure their access to needed medical services and to ensure continuity of care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 The CCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. United uses the Network Database and 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 (two times per month) for the paper-based directory; the online directory is refreshed according to a schedule with the most current provider data available at the time of data inquiry, based on a six-hour or overnight feed.
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 ID-5776, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions, outlines procedures for QOC investigations, implementation of resulting action plans, and disciplinary actions that may be taken against network practitioners. For imminent patient safety concerns, the case is referred to Quality Intervention Services. For other cases, medical records and other relevant information are requested and reviewed by a Clinical Reviewer. If no QOC issue is identified, the Clinical Reviewer may close the case. Case findings of potential moderate or serious QOC issues are referred to the Medical Director. The Medical Director will make a determination and may seek input from a Specialty Reviewer. Resulting action may include closing the case, implementing an Improvement Action Plan, referral to the Professional Review Committee, termination from network participation, etc. Policy PS13, Provider Terminations, addresses provider termination by United (for cause and not for cause).

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						DOM is notified in writing of the intent to terminate a provider 60 calendar days prior to the effective date. The provider is also notified in writing of the termination, including the reasons and effective date. For every provider termination, United identifies members who will be impacted and submits a provider termination work plan and supporting documentation to DOM.
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 network providers. The appointment availability standards defined in the policy comply with contractual requirements. The appointment access standards for PCPs, specialists, behavioral health providers, and dental providers are documented correctly in the Provider Manual. The 2023 Quality Improvement & Population Health Management Annual Evaluation Report for CHIP states "In order to monitor members' appropriate and timely access to care by primary care physicians and specialists, UnitedHealthcare has established standards for appointment access and after-hours care. Performance against appointment access standards is measured at least annually using a variety of methods." United conducts this monitoring by evaluating CAHPS survey results and complaints/grievances related to appointment access.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 The CCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					United contracts with Aucera, formerly DialAmerica, to conduct quarterly telephonic surveys to assess provider compliance with appointment access standards. United reported that goals are set at 80% for both successful contact rates and provider compliance with appointment access standards. Results for the Q2 2024 access study conducted by Aucera indicate: • The successful contact rate for PCPs was 20.26%, a decrease from last year's rate 23.47%. For pediatrics providers, the successful contact rate was 30.68%, an increase from the previous year's rate of 29.55%. Goals were met for all appointment access categories for PCPs and pediatrics providers. • For OB/GYN providers, the successful contact rate was 19.54%, a decrease from the previous year's rate of 24.14%. Goals were met for all appointment categories. • For behavioral health providers, the successful contact rate was 12.81%, a decrease from the previous year's rate of 18.93%. Goals were met for all appointment categories. When asked about interventions to address the low successful contact rates, United reported they are working with the Data Cleanse Team to get updated provider contact information. *Recommendation: Continue interventions to improve provider contact information.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 The CCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					The printed and online provider directories include all required elements.
2.4 The CCO conducts appropriate activities to validate Provider Directory information.	X					Last year, United submitted Policy NQM-052, Web-Based Directory Usability Testing, and a related MS Rider. Onsite discussion confirmed these policies have been retired and the CCO is using the Provider Directory Maintenance Schedule SOP. This SOP indicates printed Provider Directories are updated twice monthly and online directories are updated at least daily. Additionally, a document titled "2024 MS DOM EQRO Audit Provider Directory Validation Narrative" provided an overview of activities conducted to ensure Provider Directory information is current and correct. These activities include: • Conducting "ongoing quality reviews through provider data attestations, phone call campaigns to providers, and other methods." • Conducting a monthly comparison of a sample of provider records against the information collected through the data attestations, phone call campaigns, and other methods referenced above. • Using the results of the activities to update the Provider Directory as needed.
3. The CCO's provider network is adequate and is consistent with the requirements of	X					The State has time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the CMS protocol, "Validation of Network Adequacy."						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 can meet 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					New providers are identified through a monthly Network Notification report. These providers are contacted within 30 days of their contract effective date by a Provider Advocate to answer any immediate questions and to schedule the orientation. This process is detailed in Policy PS14, Provider Orientation Plan. As noted in the corresponding SOP, new provider orientation sessions are scheduled at the provider's earliest convenience. The orientation is conducted by Provider Advocates following the Provider Orientation Checklist. The full provider orientation session covers: • An overview of member benefits • Claims processes, including corrected claims and reconsiderations • Prior authorization processes • Provider roles and responsibilities • A discussion of provider's member panel

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Referral/collaboration with specialists and behavioral health providers • Appointment access standards • Accessing information/United's website/online portal • Call center phone number • The Provider Manual
2. Initial provider education includes:						
2.1 A description of the Care Management system and protocols, including transitional care management;	X					The Provider Manual provides an overview of Case Management, Disease Management, and Care Coordination/Health Education services provided by United for its members.
2.2 Billing and reimbursement practices;	X					The Provider Manual addresses claim processes, general billing guidelines, fee schedules, modifier codes, claim forms, clean claims and submission requirements, coding, etc.
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;	X					The Provider Manual directs the reader to the health plan's website to obtain detailed information about member benefits. Chapter 4: Medical Management provides an overview of specific member benefits, limitations, non-covered services, etc. The Provider Manual also provides copayment/out of pocket information and guidelines about appropriate use of emergency rooms. United addressed the recommendations from the previous EQR by including information in the Provider Manual that prior authorization is required for visits with out-of-network providers.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					Referral guidelines are addressed in the Provider Manual. Members may self-refer to certain services and providers without needing a referral from the PCP. However, out-of-network referrals require prior authorization. In cases of complex medical needs, specialists may serve as the member's PCP.
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					Appointment access standards are appropriately documented in the Provider Manual. PCPs are expected to follow up with members who miss appointments to ensure continuity of care, address potential barriers to accessing healthcare, reschedule necessary visits, provide guidance, and support adherence to treatment plans.
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					Chapter 5 of the Provider Manual provides information about EPSDT services, including associated member ages, elements included in EPSDT services, etc. The Provider Manual, page 51, states: • "Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant members." • "For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the EPSDT schedule." However, the Provider Manual does not instruct providers about where/how to access the EPSDT schedule.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the Provider Manual to include information about where/how providers can access the EPSDT schedule.
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;	X					The Provider Manual states PCPs and specialists serving as PCPs have a responsibility to "Follow up with members who are not compliant with the EPSDT screening requirement and EPSDT services."
2.8 Medical record handling, availability, retention, and confidentiality;		X				The Provider Manual addresses requirements for maintaining the confidentiality of member medical records, provision of medical records to members, medical record review by the CCO, record storage, and confidentiality requirements. The review revealed a discrepancy in the requirement for member medical record retention: • Page 74 states providers must retain member medical records for at least "10 years from the close of the Mississippi CHIP and MississippiCAN program agreement" between the State and United or other period as required by law. • Page 67 states, "Medical records are generally kept for a minimum of 5 years unless federal requirement mandates a longer time frame (i.e., immunization and tuberculosis records required for lifetime)." Onsite discussion confirmed providers are required to retain member medical records for 10 years, as stated on page 74 of the Provider Manual.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action Plan: Revise page 67 of the Provider Manual to document the correct timeframe for member medical record retention.
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
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 Provider Manual describes the roles and responsibilities of the PCP and indicates PCPs may request that a member be transferred to another PCP due to an "inability to start or maintain a professional relationship or if the member is noncompliant. The PCP must provide care for the member until a transfer is complete." Instructions are provided for PCPs who wish to request a member transfer.
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					The Provider Manual addresses available translation services and the availability of materials in various languages to support members. It provides specific contact numbers for interpreter services and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						emphasizes the importance of documenting language needs in medical records.
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					The Provider Manual provides information about the expectation for provider participation in quality improvement through the Care Model program to improve health outcomes, reduce expenses, and ensure appropriate care. Expectations include participation in quality improvement activities such as quality audits and following preventive care standards.
2.17 A description of the provider web portal;	X					Comprehensive information about the provider portal is included in the Provider Manual. The information includes the URL for accessing the portal, tools, services available through the portal, etc.
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.			X			The required statement about non-exclusivity requirements was not found in the Provider Manual. This statement was noted in the provider contract templates provided for review. *Corrective Action Plan: Revise the Provider Manual to include the required non-exclusivity statement. Refer to the CHIP Contract, Section 7 (H) (2) (s).*
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					During the onsite discussion, United staff provided an overview of ongoing provider education processes. However, no policy was found that addresses ongoing provider education. United staff confirmed this finding during the discussion. A document titled "2024 MS DOM EQRO Audit Provider Education Narrative" listed dates and related information for participation at Medical Association Events, DOM Managed Care Provider Workshops, mass

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						virtual education events, and provider outreaches. The document also indicates that 1,715 provider interactions had occurred from Q3 2023 through Q2 2024. *Recommendation: Develop a policy, or revise an existing policy, to include processes undertaken for ongoing provider education.*
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 indicates United adopts CPGs and PHGs to ensure equitable and evidence-based care for all members. The guidelines are sourced from nationally recognized entities and are used for quality and health management programs, member education, and to identify safe and effective health services. The detailed process for initial review and adoption is included in the policy. Both internally/locally developed and nationally recognized CPGs and PHGs are reviewed every 12 months and as needed for updates.
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 CPGs and PHGs are disseminated to network practitioners through provider newsletters and the health plan's website. Members and potential members may also access the guidelines on the website. Providers are informed annually about the availability of guidelines via mail, fax, or email.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual indicates providers are encouraged to use the CPGs as a resource for clinical decision-making and it indicates providers are monitored for the use of the PHGs. A hyperlink is included that takes the user to the list of adopted CPGs as well as PHGs.
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, Medical Record Review Process, lists the elements that must be included in medical records maintained for United's members. The list of medical record elements in the policy and the related audit tool is appropriate for assessing provider compliance with medical record documentation standards. Chapter 9 of the Provider Manual includes the specific elements that must be included in medical record documentation for United's members.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	X					Policy NQM-025, Medical Record Review Process, states United "conducts medical record review audits to assess compliance with its documentation standards and in accordance with state regulatory or contractual requirements." Review of the PAC minutes from November 29, 2023, and the QMC minutes from December 6, 2023, revealed United used a vendor, Episource, for the 2023 medical record reviews for PCPs and EPSDT providers. For each, 20 providers were randomly sampled. However, as has been noted in previous years, the number of records reviewed is small – six PCP records and 12 EPSDT provider records were reviewed. This is due to providers charging a fee/using copy service, unresponsiveness, provider terminations, etc. All the records reviewed received passing scores. *Recommendation: Consider increasing the sample size for the medical record review to get a better representation of provider medical record documentation compliance.*
II E. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					Of the 2,524 sampled providers, only 30 responded, creating a response rate of 1.1%, which is a slight increase over last year's rate of 1.0%. The percentage of providers rating the overall satisfaction with United as a "10" on a scale from 0 to 10 decreased from 2022 to 2023, although ratings of 8 or 9 increased.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The service experience was scored as excellent or good by 67% of providers; the ease of the appeals process was scored as excellent or good by 56%; and the ease of matching patients' prescription drug needs to the treatment plan was scored as good/excellent by 72% of providers. Areas with the lowest ratings included Patient Support, Medical Records, Appeals, and Reimbursement. *Recommendation: Continued efforts should be made to enhance survey responses and advertise the importance of the survey to 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					Results were presented to the QMC in June 2023 and to the PAC in February 2024.

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 Member Services review includes a review of all policies, procedures, member rights and responsibilities, member education, preventive health and chronic disease management, processes for handling grievances, and member enrollment and disenrollment.

Members are informed of their rights and responsibilities in new member materials and the CAN and CHIP Member Handbooks. The Provider Manual details member rights and responsibilities, which may be accessed on the website.

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. 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, the CAN and CHIP Member Handbooks, and instructions for accessing information in the Provider Directory.

The CAN and CHIP Member Handbooks include helpful information and resources for members to understand the health plan's processes, services, and requirements. Processes are in place to inform members of changes in benefits or services and to notify members of provider terminations from the network.

Member materials are written at an appropriate reading level to ensure they are easily understood by members. Members may request materials in alternate languages and formats and may access free translation and interpreter services.

Call center performance/call metric expectations are defined by DOM. United monitors call center performance by collecting and analyzing call data to identify opportunities for improvement and to develop action plans when needed. Training and education are provided to call center personnel to ensure target goals are met. The Service Quality Improvement Subcommittee monitors trends related to member and provider call center activities.

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.

United's CAN and CHIP Member Handbooks, the member portal, and the website provide information about steps for selecting a PCP, accessing 24-hour care, emergency assistance, and steps to disenroll from the health plan.

Grievances

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

Processes for managing member grievances are described in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN and CHIP Member Handbooks, Provider Manual, and on the website. The term "grievance" is defined, along with options for filing a grievance. Applicable timeframes for acknowledging and resolving grievances and extending the grievance resolution timeframe are clearly indicated in the member and provider materials. A sample of United's CAN and CHIP grievance files was reviewed. All reviewed files were processed timely with appropriate resolution notifications provided.

Member Satisfaction Survey Validation

UnitedHealthcare contracts with a vendor, Press Ganey, to conduct both the child and adult surveys. The surveys were fielded from February 2023 through May 2024.

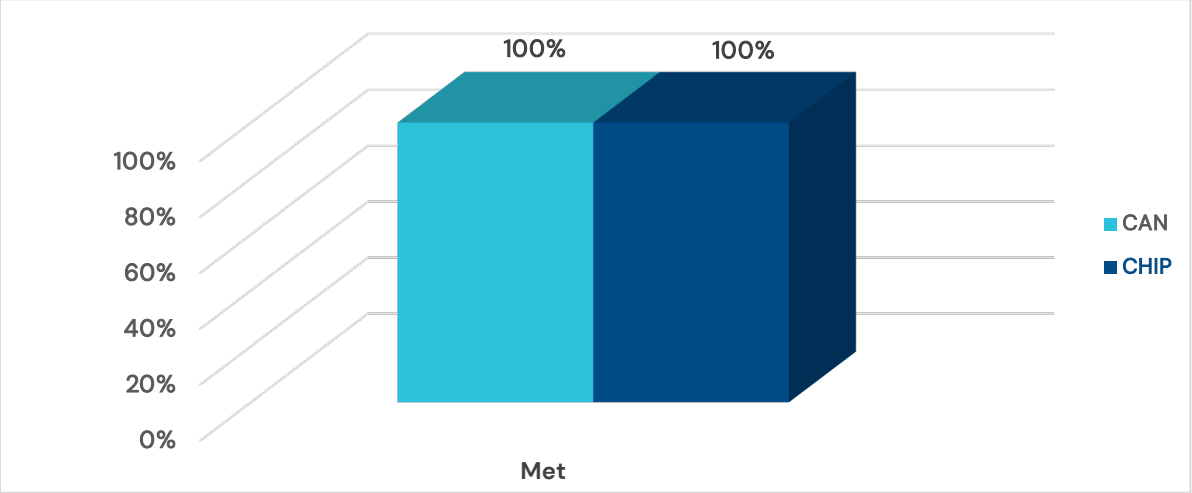
For Measure Year (MY) 2023, the adult response rate was 14.7%, a decline from last year's rate of 16.1%. For year over year trending, the findings showed the top three measures as rating of personal doctor, how well doctors communicated, and getting care quickly; the bottom three measures were getting needed care, rating of specialist, and customer service.

The CAN Children with Chronic Conditions (CCC) response rate was 10.2%, a slight decline from last year's rate of 10.8%. The top three measures were rating of personal doctor, rating of health care, and rating of specialist. The bottom three measures were coordination of care, how well doctors communicate, and getting care quickly.

The CHIP Child CCC response rate was 12.0%, a decline from last year's response rate of 14.4%. The top performing measures were getting needed care, rating of health care, and how well doctors communicate; the lowest three measures were getting care quickly, rating of personal doctor, and rating of health plan.

Each CAN and CHIP standard for the Member Service section for this EQR was scored as "Met." See *Figure 5*.

Figure 5: Member Services Findings



Strengths of the Member Services section are included in the table below.

Table 16: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
A sample of CAN and CHIP grievance files was reviewed for the 2024 EQR. All were acknowledged and resolved in a timely manner.	✓	✓	
Members are informed of their rights and responsibilities in many formats, including member and provider materials and United's website.			✓
Members are informed of preventive health and disease management resources through various mechanisms, including member newsletters, mailings, automated and live calls, e-mails, text messages, health fairs, and other health promotion events.			✓

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					Information about member rights and responsibilities is included in new member materials and the CAN Member Handbook. The Provider Manual and the website detail member rights and responsibilities
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					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.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
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;						

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

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;						
1.13 A description of EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.17 Instructions for reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						
1.20 Additional information as required by the contract and by federal regulation.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Members are informed at least 14 days prior to the implementation of changes to covered services, benefits, or to the provider network.
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					Member materials are written at the appropriate reading level and in 12-point font; large print materials are available in 18-point font if needed. 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					The CAN Member Handbook and website inform members of the 24-hour access to assistance. Interpreter services are available 24 hours per day, 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					
III C. Call Center						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					Member and provider materials, as well as United's website, clearly indicate the Call Center hours of operation and options for assistance.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Call Center staff utilize electronic scripts when interacting with members. The Division of Medicaid reviews these scripts at least annually and revises them as needed.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					The CAN Member Handbook indicates that disenrollment may be requested by members without cause during the initial 90 days of enrollment. The Handbook 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.
III E. Preventive Health and Chronic Disease Management Education						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks participation of pregnant members in recommended care, including participation in the WIC program.	X					
3. The CCO identifies children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					
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					United contracts with Press Ganey, a certified vendor, to conduct the adult and child surveys. Press Ganey acquired SPH analytics.
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from the adult and child surveys.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO reports results of the member satisfaction survey to providers.	X					A draft provider memo was submitted 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					QMC minutes for June showed the survey results are planned to be presented in the September meeting.
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					Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN Member Handbook, Provider Manual, and United's website describe processes for handling member grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance is provided in the CAN 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					Steps for filing a verbal or written grievance and options for needed assistance are outlined in policy POL2015-01, Member Appeal, State Fair Hearing, the CAN Member Handbook, the Provider Manual, and on the website.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					The appropriate timelines for the acknowledgement, extension if needed, and resolution of grievances are clearly outlined in policies, United's websites, and member and provider materials.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the grievance policy and procedure as formulated.	X					A review of a sample CAN grievance files found that all were resolved in a timely manner with the appropriate notifications to members.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					
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,	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
categorization, analysis, and reporting to the Quality Improvement Committee.						

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					Information about member rights and responsibilities is included in new member materials and the CHIP Member Handbook. The Provider Manual and the website detail member rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					
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;						

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member 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					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.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
applicable copayments and formulary restrictions;						
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						
1.13 A description of the Well-Baby and Well-Child services which include:						
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						
1.17 Instructions on reporting suspected cases of fraud and abuse;						
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						
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					Members are informed at least 14 days prior to the implementation of changes to covered services, benefits, or to the provider network.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language	X					Member materials are written in the appropriate reading level and in 12-point font; large print materials are available in 18-point font if needed. Member materials

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
translation for prevalent non-English languages.						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 vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					The CHIP Member Handbook and website inform members of the 24-hour access to assistance. Interpreter services are available 24 hours per day, 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					Member and provider materials, as well as United's website, clearly indicate the Call Center hours of operation and options for assistance.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					Call Center staff utilize electronic scripts when interacting with members. The Division of Medicaid reviews these scripts at least annually and revises them as needed.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					
III D. Member Enrollment and Disenrollment *42 CFR § 438.56*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					The CHIP Member Handbook indicates that disenrollment may be requested by members without cause during the initial 90 days of enrollment. The Handbook 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.
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					
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					
3. The CCO identifies children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					

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					United contracts with Press Ganey, a certified vendor, to conduct the child survey. Press Ganey acquired SPH analytics.
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Press Ganey summarizes and details all results from Child CCC 5.1H CAHPS survey.
3. The CCO reports the results of the member satisfaction survey to providers.	X					A draft provider memo was submitted 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					
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					Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, Provider Manual, and United's website describe processes for handling member grievances.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance is provided 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					Steps for filing a verbal or written grievance and options for assistance are outlined in policy POL2015-01, Member Appeal, State Fair Hearing, the CHIP Member Handbook, the Provider Manual, and on the website.
1.3 Timeliness guidelines for resolution of the grievance;	X					The appropriate timelines for the acknowledgement, extension if needed, and resolution of grievances are clearly outlined in policies, United's websites, and member and provider materials.
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					A review of a sample of CHIP grievance files found that all were resolved in a timely manner with the appropriate notifications to members. One file did not contain notes, which were provided following the onsite.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
improvement opportunities, and reported to the Quality Improvement Committee.						
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

United has developed a Quality Improvement program for CAN and CHIP to oversee the implementation and evaluation of quality improvement initiatives throughout the organization. Some of those initiatives are related to population health management, improving member experience, addressing any quality of care concerns, monitoring patient safety indicators, adhering to accreditation and regulatory requirements, serving culturally and linguistically diverse populations, engaging in evidence-based clinical guidelines, collaborating with community partners, reducing healthcare disparities, and collaborating with various functional areas within the organization to ensure a comprehensive approach to quality improvement. The 2024 Quality Improvement and Population Health Management Program Description for CAN and CHIP describes the program initiated by United. This document included a comprehensive scope of work for the QI program, detailing responsibilities, roles, and functions of various positions within the program.

The scope of the QI Program covers special health care needs through various programs, committees, and initiatives aimed at improving care coordination, improving health outcomes, and addressing disparities for members with complex and special health care needs. The goal for United's Health Equity program is to reduce health disparity and improve culturally and linguistically appropriate services.

Information regarding the QI Program was found in the Provider Manual and providers are informed that a copy of the QI Program is available upon request. However, the information found in the CAN Member Handbook, page 47, instructs the member to send their request for additional information in writing. There was no information found in the CHIP Member Handbook regarding the QI Program.

United's QI work plan is a detailed document outlining planned activities related to program priorities. The work plan includes specific interventions with target completion dates, responsible parties, and oversight committees. The QI work plan is reviewed and updated at least quarterly and approved by the Quality Management Committee.

The QMC is responsible for the QI Program. It oversees the implementation, coordination, and integration of all activities; provides program direction; and reviews and approves various QI program documents. The QMC is chaired by the Chief Medical Officer. The PAC evaluates and reviews clinical indicators, guidelines, quality of care complaints, appeals, grievances, inpatient quality issues, provider satisfaction survey results, and compliance with regulatory requirements. The PAC also conducts peer reviews, ensures care coordination between medical and behavioral health, recommends improvement actions, and provides input on quality improvement initiatives.

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 PAC meets at least four times per year.

United provides direct feedback to PCPs about their performance via the Provider Profile Report, the Patient Care Opportunity Report, and information provided by the clinical practice consultants. The Provider Profile Report offers direct feedback about key quality measures compared to a peer group within United's network. The Patient Care Opportunity Report helps identify gaps in care.

United monitors provider compliance with clinical and preventive health guidelines 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. For 2023, United selected Hemoglobin A1c Control for Patients with Diabetes, and Preventive Screenings for monitoring. For CHIP, United selected Childhood Immunization Status Combo 10 (CIS) and Immunization for Adolescents (IMA). The results of this monitoring are shared with providers and included in the QI Program Evaluation.

United provides coverage without limitations to CAN and CHIP members for EPSDT and Well-Baby and Well-Child services including periodic health screenings; appropriate, up-to- date immunizations; periodic examinations for vision, dental, and hearing; and all medically necessary services. Tracking systems are in place that provide information on compliance with these services, reporting of all screening results, and diagnosis, treatment, and/or referrals for members.

United conducts an evaluation to assess various aspects of the QI Program such as access to care, specialist appointment availability, medical records for providers, network adequacy, member satisfaction, prevention activities, quality improvement projects, and disparities monitoring. The 2023 Quality Improvement & Population Health Management Annual Evaluation Report for CAN and CHIP was comprehensive and covered all QI activities for United.

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 National Committee for Quality Assurance (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, 2023, through December 31, 2023.

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 2023.

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 process 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 — Documentation provided by United was used for validation of review findings. Supplementary information was provided via interviews and system demonstrations. 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 2023) to the previous year (MY 2022), and the changes from 2022 to 2023 are reported in *Table 17: CAN HEDIS Performance Measure Results*. Rate changes shown in green indicate substantial (>10%) improvement, and rates shown in red indicate substantial (>10%) decline.

Table 17: CAN HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult Body Mass Index (BMI) Assessment (ABA)	51.38%	66.11%	14.73
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	69.10%	68.37%	-0.73
Counseling for Nutrition	51.09%	32.36%	-18.73
Counseling for Physical Activity	47.69%	30.41%	-17.28
Childhood Immunization Status (CIS)			
DTaP	77.13%	77.86%	0.73
IPV	92.94%	90.75%	-2.19
MMR	90.75%	89.29%	-1.46
HiB	89.54%	87.10%	-2.44
Hepatitis B	93.43%	92.94%	-0.49
VZV	90.27%	89.05%	-1.22
Pneumococcal Conjugate	77.62%	77.86%	0.24
Hepatitis A	80.29%	78.83%	-1.46
Rotavirus	74.70%	77.86%	3.16
Influenza	24.82%	19.22%	-5.6
Combination #3	70.07%	73.97%	3.9
Combination #7	57.91%	64.23%	6.32
Combination #10	19.22%	16.55%	-2.67
Immunizations for Adolescents (IMA)			
Meningococcal	51.58%	53.04%	1.46
Tdap/Td	76.16%	76.40%	0.24
HPV	23.36%	21.17%	-2.19
Combination #1	51.34%	52.80%	1.46
Combination #2	22.63%	20.68%	-1.95
Lead Screening in Children (LSC)	67.15%	68.86%	1.71
Breast Cancer Screening (BCS)	47.26%	45.93%	-1.33
Breast Cancer Screening (BCS-e)	-	45.93%	-
Cervical Cancer Screening (CCS)	54.99%	46.96%	-8.03
Chlamydia Screening in Women (CHL)			

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
16–20 Years	47.48%	49.13%	1.65
21–24 Years	58.96%	61.32%	2.36
Total	49.02%	50.84%	1.82
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
Appropriate Testing for Pharyngitis (3–17)	74.59%	83.24%	8.65
Appropriate Testing for Pharyngitis (18–64)	65.03%	73.14%	8.11
Appropriate Testing for Pharyngitis (65+)	NA	NA	NA
Appropriate Testing for Pharyngitis (Total)	73.31%	82.16%	8.85
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	19.95%	23.87%	3.92
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	50.76%	46.15%	-4.61
Bronchodilator	78.40%	80.77%	2.37
Asthma Medication Ratio (AMR)			
5–11 Years	82.22%	80.89%	-1.33
12–18 Years	78.52%	74.05%	-4.47
19–50 Years	61.42%	61.70%	0.28
51–64 Years	56.25%	61.70%	5.45
Total	75.79%	74.01%	-1.78
Plan All-Cause Readmissions (PCR-AD)			
Observed Readmission Rate	11.19	12.20	1.01
Expected Readmission Rate	10.92	10.77	-0.15
Observed/Expected (O/E) Ratio	1.0248	1.1329	0.1081
Outlier Rate	65.15	59.72	-5.43
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	60.34%	57.42%	-2.92
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	52.94%	52.00%	-0.94
Statin Therapy for Patients with Cardiovascular Disease (SPC)			
Received Statin Therapy - 21–75 years (Male)	79.83%	79.21%	-0.62
Statin Adherence 80% - 21–75 years (Male)	58.48%	57.45%	-1.03
Received Statin Therapy - 40–75 years (Female)	71.66%	72.80%	1.14
Statin Adherence 80% - 40–75 years (Female)	47.53%	52.92%	5.39
Received Statin Therapy - Total	75.72%	76.02%	0.3
Statin Adherence 80% - Total	53.26%	55.29%	2.03
Effectiveness of Care: Diabetes			
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
HbA1c Poor Control	45.01%	41.36%	-3.65
HbA1c Adequate Control	45.01%	50.12%	5.11
Eye Exam for Patients with Diabetes (EED)◊	59.61%	60.34%	0.73
Blood Pressure Control for Patients With Diabetes (BPD)	64.48%	58.39%	-6.09

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	21.99%	25.49%	3.50
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)	21.92%	25.48%	3.56
Statin Therapy for Patients with Diabetes (SPD)			
Received Statin Therapy	61.09%	62.30%	1.21
Statin Adherence 80%	52.05%	52.88%	0.83
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (AMM)			
Effective Acute Phase Treatment	49.07%	55.42%	6.35
Effective Continuation Phase Treatment	30.90%	34.24%	3.34
Follow-Up Care for Children Prescribed ADHD Medication (ADD)◊			
Initiation Phase	49.82%	51.77%	1.95
Continuation and Maintenance (C&M) Phase	66.57%	63.72%	-2.85
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	66.96%	66.97%	0.01
6-17 years - 7-Day Follow-Up	39.86%	41.24%	1.38
18-64 years - 30-Day Follow-Up	50.80%	53.69%	2.89
18-64 years - 7-Day Follow-Up	28.31%	33.29%	4.98
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
30-Day Follow-Up	59.84%	61.87%	2.03
7-Day Follow-Up	34.77%	38.19%	3.42
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
6-17 years - 30-Day Follow-Up	55.73%	61.21%	5.48
6-17 years - 7-Day Follow-Up	39.69%	41.21%	1.52
18-64 years - 30-Day Follow-Up	40.15%	38.08%	-2.07
18-64 years - 7-Day Follow-Up	24.91%	26.69%	1.78
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	45.25%	46.64%	1.39
Total- 7-Day Follow-Up	29.75%	32.06%	2.31
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)	41.63%	41.63%	0

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (18-64)	30.14%	24.05%	-6.09
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)	29.72%	36.14%	-4.9
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	41.07%	22.89%	-6.83
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)			
30-Day Follow-Up: 13-17 Years	28.30%	16.13%	-12.17
7-Day Follow-Up: 13-17 Years	24.53%	6.45%	-18.08
30-Day Follow-Up: 18+ Years	26.52%	22.34%	-4.18
7-Day Follow-Up: 18+ Years	15.65%	12.71%	-2.94
30-Day Follow-Up: Total	26.78%	21.74%	-5.04
7-Day Follow-Up: Total	16.94%	12.11%	-4.83
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	31.64%	25.15%	-6.49
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	31.28%	25.15%	-6.13
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	69.40%	71.75%	2.35
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	74.16%	72.07%	-2.09
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	77.08%	66.67%	-10.41
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	56.37%	59.55%	3.18
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose Testing (1-11)	35.45%	39.66%	4.21
Cholesterol Testing (1-11)	24.64%	25.84%	1.2
Blood Glucose and Cholesterol Testing (1-11)	21.90%	23.88%	1.98
Blood Glucose Testing (12-17)	47.12%	52.54%	5.42
Cholesterol Testing (12-17)	31.64%	34.39%	2.75
Blood Glucose and Cholesterol Testing (12-17)	28.85%	32.14%	3.29
Blood Glucose Testing (Total)	42.71%	47.73%	5.02
Cholesterol Testing (Total)	29.00%	31.19%	2.19
Blood Glucose and Cholesterol Testing (Total)	26.22%	29.06%	2.84
Effectiveness of Care: Overuse/Appropriateness			

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	1.22%	1.16%	-0.06
Appropriate Treatment for Upper Respiratory Infection (URI)			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)	73.42%	72.88%	-0.54
Appropriate Treatment for Upper Respiratory Infection (18-64)	56.30%	60.34%	4.04
Appropriate Treatment for Upper Respiratory Infection (65+)	NA	NA	NA
Appropriate Treatment for Upper Respiratory Infection (Total)	71.70%	71.59%	-0.11
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	50.85%	52.82%	1.97
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	40.10%	38.76%	-1.34
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	49.35%	51.10%	1.75
Use of Imaging Studies for Low Back Pain (LBP)	71.34%	68.91%	-2.43
Use of Opioids at High Dosage (HDO)	0.78%	0.96%	0.18
Use of Opioids from Multiple Providers (UOP)			
Multiple Prescribers	17.99%	14.73%	-3.26
Multiple Pharmacies	1.39%	2.16%	0.77
Multiple Prescribers and Multiple Pharmacies	0.76%	0.99%	0.23
Risk of Continued Opioid Use (COU)			
18-64 years - >=15 Days covered	5.67%	5.44%	-0.23
18-64 years - >=31 Days covered	3.65%	3.44%	-0.21
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	5.66%	5.48%	-0.18
Total - >=31 Days covered	3.65%	3.48%	-0.17
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
20-44 Years	82.95%	82.16%	-0.79
45-64 Years	88.95%	87.91%	-1.04
65+ Years	78.38%	70.00%	-8.38
Total	85.54%	84.51%	-1.03
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	-	19.64%	-
Oral Evaluation, Dental Services (3-5)	-	59.88%	-
Oral Evaluation, Dental Services (6-14)	-	64.75%	-
Oral Evaluation, Dental Services (15-20)	-	48.47%	-

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Oral Evaluation, Dental Services (Total)	-	53.33%	-
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	-	9.21%	-
Topical Fluoride for Children (3-4)	-	15.99%	-
Topical Fluoride for Children (Total)	-	12.16%	-
Initiation and Engagement of AOD Dependence Treatment (IET)◊			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	72.34%	67.35%	-4.99
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	4.26%	2.04%	-2.22
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	59.51%	60.67%	1.16
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	5.85%	3.77%	-2.08
Total: Initiation of AOD Treatment: 13-17 Years	61.54%	62.08%	0.54
Total: Engagement of AOD Treatment: 13-17 Years	6.54%	3.69%	-2.85
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	44.14%	44.59%	0.45
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	5.37%	8.88%	3.51
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	45.31%	49.36%	4.05
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	20%	27.90%	7.9
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	46.02%	42.22%	-3.8
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.19%	9.42%	1.23
Total: Initiation of AOD Treatment: 18+ Years	45.31%	44.00%	-1.31
Total: Engagement of AOD Treatment: 18+ Years	9.13%	11.89%	2.76
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	46.56%	46.65%	0.09
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	5.25%	8.27%	3.02
Opioid abuse or dependence: Initiation of AOD Treatment: Total	45.45%	50.41%	4.96
Opioid abuse or dependence:	20.55%	27.05%	6.5

Measure/Data Element	HEDIS MY 2022 CAN Rates	HEDIS MY 2023 CAN Rates	Change
Engagement of AOD Treatment: Total			
Other drug abuse or dependence: Initiation of AOD Treatment: Total	48.65%	46.21%	-2.44
Other drug abuse or dependence: Engagement of AOD Treatment: Total	7.72%	8.21%	0.49
Total: Initiation of AOD Treatment: Total	47.58%	46.87%	-0.71
Total: Engagement of AOD Treatment: Total	8.75%	10.61%	1.86
Prenatal and Postpartum Care (PPC)◊			
Timeliness of Prenatal Care Under 21 (Admin only rate)	-	80.45%	-
Postpartum Care Under 21 (Admin only rate)	-	54.45%	-
Timeliness of Prenatal Care Over 21(Admin only rate)	-	89.46%	-
Postpartum Care Over 21 (Admin only rate)	-	57.59%	-
Timeliness of Prenatal Care (Total per IDSS)	96.84%	92.94%	-3.9
Postpartum Care (Total per IDSS)	79.56%	80.05%	0.49
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1-11 years	57.10%	59.81%	2.71
12-17 years	61.27%	65.85%	4.58
Total	59.73%	63.68%	3.95
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	60.02%	57.65%	-2.37
15 Months-30 Months	66.10%	68.08%	1.98
Child and Adolescent Well-Care Visits (WCV)			
3-11 Years	43.95%	45.22%	1.27
12-17 Years	36.88%	39.00%	2.12
18-21 Years	21.9%	22.44%	0.54
Total	39.46%	41.02%	1.56

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.
◊ indicates that the measure has a "Trend with Caution" guidance note from NCQA for MY 2023.

As shown in the preceding table, Adult BMI Assessment (ABA) improved by 14.73 percentage points. There were several measures that showed a substantial decrease. Those included: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC).

All relevant CHIP HEDIS performance measures were compared for MY 2023 and the previous year (MY 2022), and the change from 2022 to 2023 is reported in the following table. Rate

changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 18: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	72.26%	66.67%	-5.59
Counseling for Nutrition	47.93%	36.98%	-10.95
Counseling for Physical Activity	48.66%	33.58%	-15.08
Childhood Immunization Status (CIS)			
DTaP	83.70%	85.16%	1.46
IPV	91.24%	92.21%	0.97
MMR	91.97%	92.21%	0.24
HiB	89.54%	90.02%	0.48
Hepatitis B	88.08%	91.73%	3.65
VZV	92.21%	91.73%	-0.48
Pneumococcal Conjugate	82.48%	85.16%	2.68
Hepatitis A	86.13%	84.43%	-1.7
Rotavirus	83.21%	82.48%	-0.73
Influenza	29.44%	22.38%	-7.06
Combination #3	76.40%	80.29%	3.89
Combination #7	68.13%	68.61%	0.48
Combination #10	26.28%	19.71%	-6.57
Immunizations for Adolescents (IMA)			
Meningococcal	51.82%	53.04%	1.22
Tdap/Td	87.83%	82.97%	-4.86
HPV	21.17%	18.98%	-2.19
Combination #1	51.82%	53.04%	1.22
Combination #2	19.95%	18.49%	-1.46
Lead Screening in Children (LSC)	64.72%	58.64%	-6.08
Chlamydia Screening in Women (CHL)			
16-20 Years	39.96%	43.25%	3.29
21-24 Years	NA	NA	NA
Total	39.96%	43.25%	3.29
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
3-17 years	76.20%	85.00%	8.8
18-64 years	74.05%	80.00%	5.95

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
65+ years	NA	NA	NA
Total	76.11%	84.84%	8.73
Asthma Medication Ratio (AMR)			
5–11 Years	83.77%	89.09%	5.32
12–18 Years	80.21%	83.84%	3.63
19–50 Years	NA	NA	NA
51–64 Years	NA	NA	NA
Total	81.9%	86.26%	4.36
Plan All-Cause Readmissions (PCR-AD)			
Observed Readmission Rate	NA	NA	NA
Expected Readmission Rate	NA	NA	NA
Observed/Expected (O/E) Ratio	NA	NA	NA
Outlier Rate	NA	NA	NA
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (CBP)	NA	NA	NA
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
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
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	54.05%	NA	NA
Effective Continuation Phase Treatment	24.32%	NA	NA
Follow-up care for children prescribed ADHD Medication (ADD) ◊			
Initiation Phase	49.83%	52.58%	2.75

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
Continuation and Maintenance (C&M) Phase	69.44%	60%	-9.44
Follow-Up After Hospitalization for Mental Illness (FUH)			
6-17 years - 30-Day Follow-Up	68.00%	63.98%	-4.02
6-17 years - 7-Day Follow-Up	42.00%	37.1%	-4.9
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	67.48%	63.21%	-4.27
Total-7-day Follow-Up	41.10%	36.79%	-4.31
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
6-17 years - 30-Day Follow-Up	72.97%	NA	NA
6-17 years - 7-Day Follow-Up	45.95%	NA	NA
18-64 years - 30-Day Follow-Up	NA	NA	NA
18-64 years - 7-Day Follow-Up	NA	NA	NA
65+ years – 30-Day Follow-Up	NA	NA	NA
65+ years – 7-Day Follow-Up	NA	NA	NA
Total-30-day Follow-Up	70.00%	66.67%	-3.33
Total-7-day Follow-Up	42.50%	40%	-2.5
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	NA	NA	NA
Follow-Up After High-Intensity Care for Substance Use 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

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (13-17)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (18+)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 days (Total)	NA	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 days (Total)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (16-64)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (65+)	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder (Total)	NA	NA	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	NA	NA	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NA	NA	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood Glucose Testing (1-11)	44.30%	36.78%	-7.52
Cholesterol Testing (1-11)	29.11%	35.63%	6.52
Blood Glucose and Cholesterol Testing (1-11)	29.11%	32.18%	3.07
Blood Glucose Testing (12-17)	54.27%	62.22%	7.95
Cholesterol Testing (12-17)	32.32%	36.67%	4.35
Blood Glucose and Cholesterol Testing (12-17)	28.66%	34.44%	5.78
Blood Glucose Testing (Total)	51.03%	53.93%	2.9
Cholesterol Testing (Total)	31.28%	36.33%	5.05
Blood Glucose and Cholesterol Testing (Total)	28.81%	33.71%	4.9
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	1.21%	1.34%	0.13
Appropriate Treatment or Children with URI (URI)			
3 months-17 Years	69.16%	69.57%	0.41

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
18-64 Years	52.04%	59.24%	7.2
65+ Years	NA	NA	NA
Total	68.66%	69.21%	0.55
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)	35.13%	38.26%	3.13
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)	NA	0	0
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	35.09%	37.97%	2.88
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	0.00%	0.00%	0.00
18-64 years - >=31 Days covered	0.00%	0.00%	0.00
65+ - >=15 Days covered	NA	NA	NA
65+ - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	0.00%	0.00%	0.00
Total - >=31 Days covered	0.00%	0.00%	0.00
Access/Availability of Care			
Oral Evaluation, Dental Services (OED)			
Oral Evaluation, Dental Services (0-2)	-	30.28%	-
Oral Evaluation, Dental Services (3-5)	-	65.08%	-
Oral Evaluation, Dental Services (6-14)	-	69.01%	-
Oral Evaluation, Dental Services (15-20)	-	54.75%	-
Oral Evaluation, Dental Services (Total)	-	62.49%	-
Topical Fluoride for Children (TFC)			
Topical Fluoride for Children (1-2)	-	14.06%	-
Topical Fluoride for Children (3-4)	-	22.60%	-
Topical Fluoride for Children (Total)	-	19.18%	-
Initiation and Engagement of AOD Dependence Treatment (IET) ◊			

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
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	50.00%	43.59%	-6.41
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	12.50%	10.26%	-2.24
Total Initiation of AOD Treatment: 13–17 years	48.89%	47.73%	-1.16
Total Engagement of AOD Treatment: 13–17 years	11.11%	9.09%	-2.02
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+Years	NA	NA	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+Years	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+Years	NA	NA	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	NA	NA	NA
Total Initiation of AOD Treatment: 18+ years	NA	NA	NA
Total Engagement of AOD Treatment: 18+ years	NA	NA	NA
Alcohol Abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA
Alcohol Abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA
Opioid Abuse or dependence: Initiation of AOD Treatment: Total	NA	NA	NA
Opioid Abuse or dependence: Engagement of AOD Treatment: Total	NA	NA	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	46.15%	38.30%	-7.85
Other drug abuse or dependence: Engagement of AOD Treatment: Total	9.62%	8.51%	-1.11
Initiation of AOD Treatment: Total	43.33%	40.00%	-3.33
Engagement of AOD Treatment: Total	8.33%	7.27%	-1.06
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care Under 21 (Admin only rate)	NA	NA	NA
Postpartum Care Under 21 (Admin only rate)	NA	NA	NA

Measure/Data Element	HEDIS MY 2022 CHIP Rates	HEDIS MY 2023 CHIP Rates	Change
Timeliness of Prenatal Care (Total per IDSS)	NA	NA	NA
Postpartum Care (Total per IDSS)	NA	NA	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
1–11 Years	41.03%	57.14%	16.11
12–17 Years	74.16%	63.00%	-11.16
Total	64.06%	61.48%	-2.58
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	71.83%	63.90%	-7.93
15 Months–30 Months	74.38%	80.90%	6.52
Child and Adolescent Well-Care Visits (WCV)			
3–11 Years	44.81%	44.94%	0.13
12–17 Years	39.96%	41.12%	1.16
18–21 Years	24.93%	25.03%	0.1
Total	41.18%	41.72%	0.54

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.
◊ indicates that the measure has a "Trend with Caution" guidance note from NCQA for MY 2023.

The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), 1-11 Years CHIP HEDIS measure showed an increase of 16.11 percentage points.

The measures for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), 12-17 Years showed a substantial decrease.

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 2023 and the previous year (MY 2022). The change from 2022 to 2023 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 19: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2022 CAN Rates	MY 2023 CAN Rates	Change
Adult Core Set Measures			
Primary Care Access and Preventative Care			
Colorectal Cancer Screening (COL-AD)◊			

Measure	MY 2022 CAN Rates	MY 2023 CAN Rates	Change
Ages 46 - 50	-	23.99%	-
Ages 50 - 64	42.69%		-
Ages 51- 65	-	44.36%	-
Ages 65 - 75	32.84%		-
Ages 66 - 75	-	29.17%	-
Total (Ages 46 – 75)	38.76%	39.81%	1.05
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)			
Ages 18 - 64	0.67%	0.71%	0.04
Ages 65+	0.00%	0.00%	0.00
Total	0.66%	0.71%	0.05
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)			
Most or moderately effective contraception – 3 days	13.44%	13.18%	-0.26
Most or moderately effective contraception – 90 days	54.35%	54.29%	-0.06
LARC - 3 Days	0.92%	0.98%	0.06
LARC - 90 Days Reported	11.37%	11.26%	-0.11
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)			
Most or moderately effective contraception rate	23.63%	25.26%	1.63
LARC rate	2.43%	2.55%	0.12
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	24.43	25.01	0.58
Ages 65+	NA	0.00	0.00
Total	24.38	24.96	0.58
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)			
Ages 40 - 64	54.12	63.35	9.23
Ages 65+	230.41	0	-230.41
Total	54.94	63.03	8.09
HEART FAILURE ADMISSION RATE (PQI-08)			
Ages 18 - 64	54.46	53.09	-1.37
Ages 65+	0	216.45	216.45
Total	54.35	53.42	-0.93
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)			
Ages 18 - 39	3.06	1.11	-1.95
HIV VIRAL LOAD SUPPRESSION (HVL - AD)			

Measure	MY 2022 CAN Rates	MY 2023 CAN Rates	Change
Ages 18 - 64	19.61%	22.25%	2.64
Ages 65+	NA	NA	NA
Total	20.75%	22.03%	1.28
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)			
Ages 18 - 64	-	66.67%	-
Ages 65+	-	NA	-
Total	69.82%	66.85%	-2.97
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	0.83%	1.03%	0.20
Ages 65+	NA	NA	NA
Total	0.83%	1.02%	0.19
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	4.36%	4.04%	-0.32
Ages 65+	NA	NA	NA
Total	4.35%	4.07%	-0.28
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)			
Overall	37.32%	38.94%	1.62
Prescription for Buprenorphine	34.60%	37.55%	2.95
Prescription for Oral Naltrexone	2.01%	0.88%	-1.13
Prescription for Long-acting, Injectable Naltrexone	0.24%	0.25%	0.01
Prescription for Methadone	1.54%	1.01%	-0.53
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	-	36.02%	-
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	-	26.82%	-
Discussed or Recommended Cessation Medications: Ages 18 to 64	-	20.31%	-
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	-	16.86%	-
Percentage of Current Smokers and Tobacco Users: Age 65 and Older	-	NA	-
Advising Users to Quit: Age 65 and Older	-	NA	-
Discussing Cessation Medications: Age 65 and Older	-	NA	-
Discussing Cessation Strategies: Age 65 and Older	-	NA	-
Percentage of Current Smokers and Tobacco Users: Total	-	35.47%	-
Advising Users to Quit: Total	-	26.42%	-

Measure	MY 2022 CAN Rates	MY 2023 CAN Rates	Change
Discussing Cessation Medications: Total	-	20.00%	-
Discussing Cessation Strategies: Total	-	16.60%	-
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	1.24%	1.42%	0.18
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	40.15%	36.71%	-3.44
Age 2 Screening	48.91%	47.09%	-1.82
Age 3 Screening	50.36%	46.70%	-3.66
Total Screening	46.47%	42.24%	-4.23
Maternal and Perinatal Health			
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)			
Most or moderately effective contraception – 3 days	1.68%	2.92%	1.24
Most or moderately effective contraception – 90 days	61.76%	62.66%	0.90
LARC - 3 Days	1.26%	1.30%	0.04
LARC - 90 Days Reported	15.97%	14.61%	-1.36
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	29.03%	28.86%	-0.17
LARC Rate	2.68%	2.41%	-0.27
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	50.73%	46.68%	-4.05
Numerator 2 All Four Molars Sealed	35.24%	30.92%	-4.32
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	0.63%	1.07%	0.44
Ages 1-2	22.28%	23.27%	0.99
Ages 3-5	59.05%	57.13%	-1.92
Ages 6-7	64.66%	64.93%	0.27
Ages 8-9	65.46%	65.37%	-0.09
Ages 10-11	63.66%	63.97%	0.31
Ages 12-14	58.42%	58.28%	-0.14
Ages 15-18	48.36%	47.44%	-0.92
Ages 19-20	28.58%	29.77%	1.19
Total Ages <1-20	50.98%	50.34%	-0.64

Measure	MY 2022 CAN Rates	MY 2023 CAN Rates	Change
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TFL-CH) (Rate 1)			
Ages 1-2	9.59%	11.16%	1.57
Ages 3-5	27.03%	27.00%	-0.03
Ages 6-7	31.47%	32.54%	1.07
Ages 8-9	31.62%	32.42%	0.80
Ages 10-11	30.71%	29.37%	-1.34
Ages 12-14	26.51%	27.48%	0.97
Ages 15-18	19.01%	19.38%	0.37
Ages 19-20	8.14%	9.65%	1.51
Total Ages 1-20	24.11%	24.53%	0.42
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TFL-CH) (Rate 2)			
Ages 1-2	5.52%	6.53%	1.01
Ages 3-5	25.44%	25.01%	-0.43
Ages 6-7	30.94%	31.60%	0.66
Ages 8-9	31.27%	31.94%	0.67
Ages 10-11	30.41%	28.74%	-1.67
Ages 12-14	26.32%	26.85%	0.53
Ages 15-18	18.85%	18.91%	0.06
Ages 19-20	8.14%	9.49%	1.35
Total Ages 1-20	23.21%	23.24%	0.03
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TFL-CH) (Rate 3)			
Ages 1-2	2.95%	3.27%	0.32
Ages 3-5	0.38%	0.38%	0.00
Ages 6-7	0.00%	0.03%	0.03
Ages 8-9	0.00%	0.02%	0.02
Ages 10-11	0.00%	0.01%	0.01
Ages 12-14	0.00%	0.03%	0.03
Ages 15-18	0.00%	0.01%	0.01
Ages 19-20	0.00%	0.00%	0.00
Total Ages 1-20	0.40%	0.46%	0.06

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.

As noted in the preceding table and in *Table 20*, there were no CAN or CHIP Non-HEDIS measures that showed a substantial increase or decrease.

Table 20: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2022 CHIP Rates	MY 2023 CHIP Rates	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	0.29%	0.60%	0.31%
Ages 65+	NA	NA	NA
Total	0.29%	0.60%	0.31%
Care of Acute and Chronic Conditions			
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)			
Ages 18 - 64	0.00	0.00	0.00
Total	0.00	0.00	0.00
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
Ages 65+	NA	NA	NA
Total	NA	NA	NA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)			
Ages 18 - 64	-	NA	NA
Ages 65+	-	NA	NA
Total	-	NA	NA
Behavioral Health Care			
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	NA	NA	NA
Total	NA	NA	NA
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)			
Ages 18 - 64	NA	NA	NA
Ages 65+	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
Prescription for Long-acting, Injectable Naltrexone	NA	NA	NA
Prescription for Methadone	NA	NA	NA

Measure	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)			
Percentage of Current Smokers and Tobacco Users: Ages 18 to 64	-	NA	NA
Advised Smokers and Tobacco Users to Quit: Ages 18 to 64	-	NA	NA
Discussed or Recommended Cessation Medications: Ages 18 to 64	-	NA	NA
Discussed or Provided Other Cessation Strategies: Ages 18 to 64	-	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	1.34%	1.44%	0.10
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)			
Age 1 Screening	51.61%	41.67%	-9.94
Age 2 Screening	54.01%	53.45%	-0.56
Age 3 Screening	48.18%	52.52%	4.34
Total Screening	51.15%	52.87%	1.72
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 – 90 days	NA	NA	NA
LARC - 3 Days	NA	NA	NA
LARC - 90 Days	NA	NA	NA
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)			
Most or moderately effective contraception rate	27.51%	27.46%	-0.05
LARC Rate	1.72%	2.28%	0.56
Dental and Oral Health Services			
SEALANT RECEIPT ON PERMANENT FIRST MOLARS (SFM-CH)			
Numerator 1 At Least One Sealant	47.09%	45.04%	-2.05
Numerator 2 All Four Molars Sealed	32.89%	31.29%	-1.60
ORAL EVALUATION, DENTAL SERVICES (OEV-CH)			
Age <1	NA	NA	NA
Ages 1-2	32.91%	30.09%	-2.82
Ages 3-5	61.65%	62.86%	1.21
Ages 6-7	69.39%	69.27%	-0.12
Ages 8-9	72.30%	69.92%	-2.38
Ages 10-11	69.90%	69.51%	-0.39
Ages 12-14	64.70%	65.28%	0.58
Ages 15-18	54.04%	53.26%	-0.78
Ages 19-20	43.51%	38.71%	-4.80

Measure	MY 2022 CHIP Rates	MY 2023 CHIP Rates	Change
Total Ages <1-20	61.17%	60.51%	-0.66
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TFL-CH) (Rate 1)			
Ages 1-2	16.42%	16.94%	0.52
Ages 3-5	32.20%	32.00%	-0.20
Ages 6-7	38.29%	36.08%	-2.21
Ages 8-9	39.33%	37.28%	-2.05
Ages 10-11	37.08%	36.57%	-0.51
Ages 12-14	31.39%	30.68%	-0.71
Ages 15-18	21.68%	21.23%	-0.45
Ages 19-20	14.22%	15.35%	1.13
Total Ages 1-20	30.27%	29.38%	-0.89
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TFL-CH) (Rate 2)			
Ages 1-2	11.27%	11.66%	0.39
Ages 3-5	30.51%	30.71%	0.20
Ages 6-7	37.75%	35.28%	-2.47
Ages 8-9	39.15%	36.88%	-2.27
Ages 10-11	36.92%	36.28%	-0.64
Ages 12-14	31.32%	30.34%	-0.98
Ages 15-18	21.63%	20.84%	-0.79
Ages 19-20	14.22%	14.94%	0.72
Total Ages 1-20	30.27%	28.67%	-1.60
PREVENTION: TOPICAL FLUORIDE FOR CHILDREN (TFL-CH) (Rate 3)			
Ages 1-2	3.31%	3.30%	-0.01
Ages 3-5	0.43%	0.34%	-0.09
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%	0.02%	0.02
Ages 19-20	0.00%	0.00%	0.00
Total Ages 1-20	0.19%	0.18%	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*. 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 Sickle Cell Disease Management Decreasing Emergency Room (ER) Utilization. All the CAN PIPs scored in the "High Confidence in Reported Results" range as noted in the tables below. A summary of each PIP's status and interventions is also included.

Table 21: Reducing 30-Day Psychiatric Inpatient Readmission Rates PIP

Reducing 30-Day Psychiatric Inpatient Readmission Rates	
The Behavioral Health (BH) 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 to determine if the interventions help decrease psychiatric readmissions. The BH readmissions PIP was retired at the end of 2023. The readmission rate slightly increased from baseline 18% to 18.7% in 2022, and then the final rate increased very slightly to 18.8%. However, there were several barriers to this project as noted in the lessons learned report. Interventions were provider, system, and member-related, and COVID did have an impact on outpatient follow-up after discharge, which likely increased readmission rates. At the completion of the PIP, several action steps were in place to continue working to decrease readmissions including hiring staff to allow face to face opportunities, improving collaboration with facilities, and enhancing provider engagement.	
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 rate. • 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 22: Improving Pregnancy Outcomes PIP

Improving Pregnancy Outcomes	
The goal of the Improved Pregnancy Outcomes PIP is to reduce the total number of preterm deliveries by monitoring the percentage of women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment. The Improved Pregnancy Outcomes 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 four rate was 92.94% which was a decline from the previous year's hybrid rate of 96.84%. The PIP was retired. The lessons learned document noted several challenges that had to be considered. The Healthy First Step program, face to face visits for unable to reach members, and all digital online interventions will continue to maintain the current prenatal care visit rate.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	94/95=99% High Confidence in Reported Results
Interventions	
• Home visit care management services in seven underserved communities in MS. • Care management for high-risk pregnant members and their babies less than a year old. • The Optum Whole Person Care Program provides telephonic and/or face-to-face outreach to high-risk members to educate the member and help with establishing an obstetric practice. • Dedicated maternity Member Services Team for telephonic outreach to low-risk members or to members whose risk is unknown to identify any barriers such as transportation/childcare and to 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 23: Respiratory Illness Management PIP

Respiratory Illness Management	
Respiratory Illness Management 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%, increasing to 80.77% at remeasurement four (2023), an increase from the 2022 rate of 78.40%. This demonstrates improvement and exceeds the comparison goal. Corticosteroids improved from 42.24% at baseline to 46.15% in 2023 (decline from 50.76% in 2022) which demonstrated improvement although it remained below the comparison goal rate of 52.28%. The AMR baseline was 70.7% and increased to 74.01% in 2023 (a decline from the 2022 the rate of 75.79%), indicating improvement although below the comparison goal of 78.06%. This PIP was retired in 2024. The lessons learned document noted asthma and COPD RetroDur and Medication Adherence Program will continue, and the focus will remain on improving care coordination and discharge planning.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results

Respiratory Illness Management
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 24: 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 persistent super users of emergency room services for sickle cell disease complications. The baseline rate of 36.28% declined to 24.78% in 2023 (the rate was 28.91% in 2022, so the 2023 rate improved) which exceeded the comparison goal (lower is better). Thus, this PIP showed improvement overall with an 11.5% reduction in ER utilized by members with sickle cell disease. The report did not specify that the PIP was retired, but the lessons learned document noted that the PIP was retiring. The lessons learned also noted that limited access remains a barrier that United is addressing, and health workers are resuming face to face field visits which might be a valuable resource to improve members' self-management.	
Previous Validation Score	**Current Validation Score**
74/75=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Outreach to providers encouraging the use of hydroxyurea for patients who do not have a pharmacy claim for hydroxyurea. • Quarterly meetings with FQHCs to address emergency room utilization and high-risk cohort patients. • Member outreach for scheduling appointments, transportation, pharmacy concerns, enrollment in case management, and assisting with follow-up appointments. • Telehealth campaigns and after-hour care newsletters. • Weekly interdisciplinary rounds for Case Management. • Provider education with the After Hour Care newsletter.	

There are no corrective actions and no recommendations for the CAN PIPs as they have been retired.

CHIP PIP Validation Results: United submitted the same PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Follow Up After Hospitalization, Obesity, and Member Satisfaction (Getting Needed Care). All the CHIP PIPs scored in the "High

Confidence in Reported Results" range as noted in tables below. Summaries of each project's status and the interventions are also included.

Table 25: 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 WCV showed the rate for 12–17-year-olds increased to 41.12% from 39.96% in 2022; the 18–21-year-old rate increased to 25.03% in 2023 from 24.93% in 2022 for the administrative rates. Hybrid rates were also presented for the total (12-21 years of age) for all measurement periods. Challenges were reported to be age related discomfort with talking about health and appointment difficulty based on work and school. After-hours and weekend appointments, as well as school-based clinics, are now being developed to address the timing concerns.	
Previous Validation Score	**Current Validation Score**
74/75 = 99% High Confidence in Reported Results	75/75=100% High Confidence in Reported Results
Interventions	
• Phone calls to noncompliant members and after-hours and weekend clinic days. Staff collaborated with participating clinics to close care gaps. • Clinical practice consultants and clinical transformation consultants conduct educational sessions with providers on HEDIS requirements. • Resumption of the Farm to Fork activities for members to receive educational materials regarding wellness visits and immunizations.	

Table 26: 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. This PIP report showed that the 30-day follow up rate declined from 67.48% in 2022 to 63.21% in 2023 which represented a decline from the previous two years. The 7-day follow up rate declined from 41.1% in 2022 to 36.79% in 2023. Overall, both indicators showed substantial improvement from the baseline rates. The lessons learned report noted collaboration increases, case management benefits, and consideration of value-based contracting to sustain the improvement.	
Previous Validation Score	**Current Validation Score**
80/80 = 100% High Confidence in Reported Results	74/75 = 99% High Confidence in Reported Results
Interventions	

Follow Up After Hospitalization for Mental Illness
• Reviewing current audit tools to ensure discharge planning is started at the beginning of the inpatient stay. • Continue demographic workflow to improve capture of current contact numbers for enrollees. • Fax blasts sent to practitioners and clinical staff sharing the requirement for behavioral health practitioners and PCPs to communicate relevant treatment information involving member care. • Case management initiate calls to schedule follow-up appointments.

Table 27: 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: BMI percentile, counseling for nutrition, and counseling for physical activity. Rates were computed using hybrid methodology. BMI percentile documentation declined from 72.28% in 2022 and to 66.67% in 2023. Counseling on nutrition declined from 47.93% in 2022 to 36.98% in 2023. Counseling for physical activity declined from 48.66% in 2022 to 33.58% in 2023. The lessons learned report noted that interventions will continue and several resources to ensure access to exams and healthy lifestyle education for members.	
Previous Validation Score	**Current Validation Score**
94/95 = 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 28: Getting Needed Care CAHPS PIP

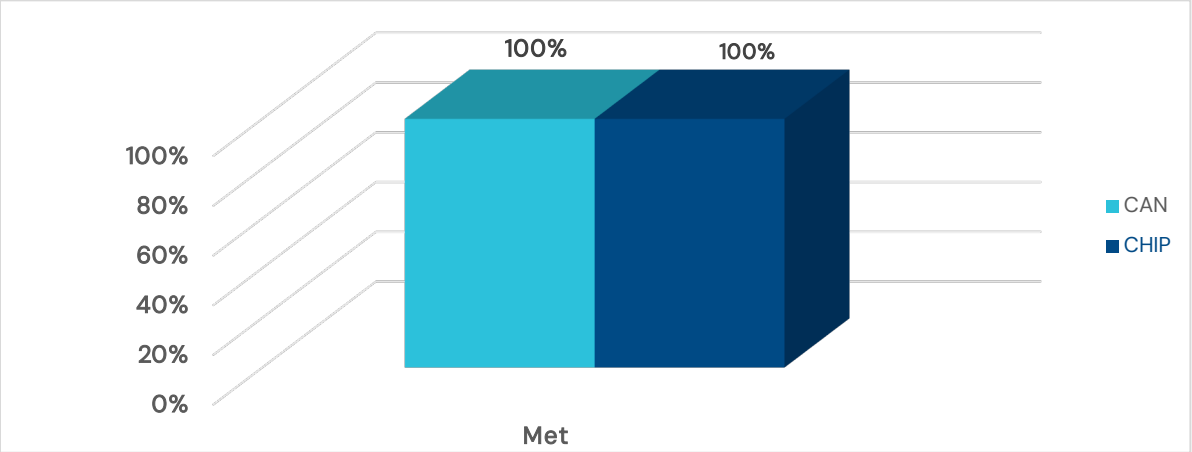
Getting Needed Care CAHPS	
For the member satisfaction PIP, Getting Needed Care, the goal is to increase the percentage of members who answer the CAHPS Child Survey question regarding the ease of seeing a specialist and improve the rate to meet the NCQA quality compass percentile rate. The rate declined from 87%, with the final rate of 84.7%. Overall, the rate improved from baseline rate of 80.92%. The lessons learned document noted the CAHPS Task Force team will continue. The document also noted the lack of reliability of the data due to the low response rates, which will be addressed using oversampling and member reminders.	
Previous Validation Score	**Current Validation Score**
94/95=100% High Confidence in Reported Results	94/95=100% High Confidence in Reported Results

Getting Needed Care CAHPS
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.

There are no corrective actions or recommendations for the submitted CHIP PIPs as they have been retired. 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



Strengths, weaknesses, and recommendations for the Quality Improvement section are included in the tables below.

Table 29: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
United's Quality Improvement Program is structured and comprehensive with well-defined committees.	✓		
Utilization of data from various sources is used for quality monitoring.	✓		

Strengths	Quality	Timeliness	Access to Care
The PIPs were based on analysis of comprehensive aspects of enrollee needs and services, and the rationale for each topic was documented.	✓		
All PIPs received validation scores in the High Confidence Range.	✓		
United was fully compliant with all the Information Systems Standards and submitted valid and reportable rates for all HEDIS measures in the scope of the audit.	✓		
No concerns were identified with United's data processing, integration, and measure production for the reported CMS Adult and Child Core Set measures. United followed the measure specifications and produced reportable rates for the measures in the scope of the validation.	✓		
The Adult BMI Assessment (ABA) measure for CAN and the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), 1-11 Years for CHIP rates improved more than 10 percentage points.	✓		

Table 30: Quality Improvement Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Information regarding the QI Program was found in the Provider Manual. However, the information found in the CAN Member Handbook, page 47, instructs the member to send their request for additional information in writing. There was no information found in the CHIP Member Handbook regarding the QI Program.	*Recommendation: Update the Member Handbook to include information regarding the QI Program and provide a phone number for members to call instead of requiring them to submit a written request for additional information. Also, include information in the CHIP Member Handbook regarding the QI Program.*	✓		
The following HEDIS MY 2023 measure rates were determined to be areas of opportunity for United since their rates had a greater than 10 percentage point decline: • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) declined more than 17% for the CAN population and more than 10% for the CHIP population in the Counseling for Nutrition and Counseling for Physical Activity indicators. • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) declined by more than 12% in the 30-Day Follow-Up and 7-Day Follow-Up indicators for the CAN	*Recommendation: Seek opportunities to improve the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure rate for the CAN and CHIP populations.*	✓		

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
population aged 13–17 years. This measure, however, should be treated with caution due to the change in the measure criteria and the relatively small denominators. • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) declined more than 10% for the CAN population. • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) - declined by 11.16% for the CHIP population aged 12–17 Years.				

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 Quality Improvement program to oversee the implementation and evaluation of quality improvement initiatives throughout the organization. Some of those initiatives are related to population health management, improving the member experience, addressing quality of care concerns, monitoring patient safety indicators, adhering to accreditation and regulatory requirements, serving culturally and linguistically diverse populations, engaging in evidence-based clinical guidelines, collaborating with community partners, reducing healthcare disparities, and collaborating with various functional areas within the organization to ensure a comprehensive approach to quality improvement. The 2024 Quality Improvement and Population Health Management Program Description for CAN describes the program initiated by United. This document included a comprehensive scope of work for the QI program, detailing responsibilities, roles, and functions of various positions within the program. Information regarding the QI Program was found in the Provider Manual and providers are informed that a copy of the QI Program is available upon request. However, the information found in the Member Handbook, page 47, instructs the member to send their request for additional information in writing. *Recommendation: Update the Member Handbook to include information regarding the QI Program and*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provide a phone number for members to call instead of requiring them to submit a written request for additional information.
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 scope of the QI Program covers special health care needs through various programs, committees, and initiatives aimed at improving care coordination, health outcomes, and addressing disparities for members with complex and special health care needs. The goal for United's Health Equity program is to reduce health disparity and improve culturally and linguistically appropriate services.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					United's QI work plan is a detailed document outlining planned activities related to program priorities. The work plan includes specific interventions with target completion dates, responsible parties, and oversight committees. The QI work plan is reviewed and updated at least quarterly and approved by the QMC.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QMC is responsible for the QI program. It oversees the implementation, coordination, and integration of all QI activities; provides program direction; and reviews and approves various QI program documents. The PAC evaluates and reviews clinical indicators, guidelines, quality of care complaints, appeals, grievances, inpatient quality issues, provider satisfaction survey results, and compliance with regulatory requirements. The PAC also conducts peer reviews, ensures care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						coordination between medical and behavioral health, recommends improvement actions, and provides input on quality improvement initiatives.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Chief Medical Officer chairs the QMC and the PAC. Network providers specializing in OB/GYN, Internal Medicine, Psychiatry, Dentistry, Pediatrics, and Family Medicine are included as voting members on the PAC.
3. The QI Committee meets at regular intervals.	X					The QMC and PAC meet at least four times per year.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures identified by DOM to evaluate their accuracy as reported by United for the CAN populations. United met all the requirements for the validation.
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 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.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					Constellation conducted a validation of each project following the protocol developed by CMS titled *EQR Protocol 1: Validating Performance Improvement*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Projects. All the CAN PIPs scored in the "High Confidence in Reported Results" range.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					United provides direct feedback to PCPs about their performance via the Provider Profile Report, the Patient Care Opportunity Report, and information provided by the clinical practice consultants. The Provider Profile Report offers direct feedback on key quality measures compared to a peer group within United's network. The Patient Care Opportunity Report helps identify gaps in care.
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 guidelines 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. For 2023, United selected Hemoglobin A1c Control for Patients with Diabetes, and Preventive Screenings for monitoring.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					United provides coverage without limitations to members for EPSDT services including periodic health screenings; appropriate, up-to- date immunizations; periodic examinations for vision, dental, and hearing; and all medically necessary services. Several standard

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						operating procedures include the process followed by United for tracking member compliance with EPSDT services. 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					United conducts an evaluation to assess various aspects of the QI Program such as access to care, specialist appointment availability, medical records for providers, network adequacy, member satisfaction, prevention activities, quality improvement projects, and disparities monitoring. The 2023 Quality Improvement & Population Health Management Annual Evaluation Report was comprehensive and covered all QI areas for United.
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					The 2024 Quality Improvement and Population Health Management Program Description for CHIP was provided for review. This document included a comprehensive scope of work for the QI program, detailing responsibilities, roles, and functions of various positions within the program. Some of those responsibilities included overseeing quality improvement initiatives related to population health management, member experience, accreditation requirements, patient safety, and reducing healthcare disparities. The document also outlines the activities, responsibilities, and functions of different areas and committees involved in the QI activities. Information regarding the QI Program was found in the Provider Manual and providers are informed that a copy of the QI Program is available upon request. However, there was no information found in the CHIP Member Handbook regarding the QI Program. *Recommendation: Include information in the CHIP Member Handbook regarding the QI Program.*
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The scope of the QI Program covers special health care needs through various programs, committees, and initiatives aimed at improving care coordination, health outcomes, and addressing disparities for members with complex and special health care needs. The goal for United's Health Equity program is to reduce health disparity and improve culturally and linguistically appropriate services.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
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					The 2023 and 2024 QI Work Plans were submitted for review. Both work plans focused on activities and initiatives related to population health management, HEDIS improvement activities, quality documents and reports, patient safety initiatives, member experience metrics, grievances, and appeals. The QI work plan is reviewed and approved by the Quality Management Committee.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QMC is responsible for the QI program. It oversees the implementation, coordination, and integration of all QI activities; provides program direction; and reviews and approves various QI program documents. The PAC evaluates and reviews clinical indicators, guidelines, quality of care complaints, appeals, grievances, inpatient quality issues, provider satisfaction survey results, and compliance with regulatory requirements. The PAC also conducts peer reviews, ensures care coordination between medical and behavioral health, recommends improvement actions, and provides input on quality improvement initiatives.
2. The composition of the QI Committee reflects the membership required by the contract.	X					
3. The QI Committee meets at regular intervals.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures identified by DOM to evaluate their accuracy as reported by United for the CHIP populations. United met all the requirements for the validation.
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 PIPs this year for validation that were submitted last year. The topics included Adolescent Well Care, Member Satisfaction (Getting Needed Care), 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 all the validation requirements.
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. For CHIP, United selected Childhood Immunization Status Combo 10 (CIS) and Immunization for Adolescents (IMA). The result of this monitoring is shared with providers and included in the QI Program Evaluation.
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, 002, Well-Child Services, United provides coverage without limitations to members in the CHIP program for Well-Baby and Well-Child services including periodic health screenings and appropriate and up-to- date immunization as well as periodic examinations for vision, dental, and hearing and all medically necessary services. Tracking systems are in place that provide information on compliance with Well-Baby and Well-Child service provision requirements.
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 conducts an evaluation to assess various aspects of the QI Program. The CHIP 2023 Quality Improvement & Population Health Management Annual Evaluation Report was comprehensive and covered all QI areas for United.
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)

United's CAN and CHIP program objectives, scope of activities, and program structure are outlined in various policies and the UM Program Description. Optum's Behavioral Utilization Management Program Description outlines the structure of the behavioral health program that is offered by Optum Behavioral Health. The Pharmacy Program Description outlines the pharmacy program.

Responsibilities of the Chief Medical Officer include conducting second level reviews, clinical consultations, policy development, etc. The Behavioral Health Medical Director provides clinical oversight of the behavioral health program, including consultation, conducting second level reviews, and managing the medical expense initiatives. The Pharmacy Director oversees the clinical operations of the pharmacy program, including conducting second level pharmacy reviews, policy implementation, and consultation.

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

Initial clinical reviews are conducted by licensed health professionals using clinical criteria such as InterQual, Medical Policy, Coverage Determination Guidelines, American Society for Addiction Medicine, Optum Clinical Policies, Level of Care Utilization System, etc. to make medical necessity determinations. Nonclinical staff members may issue administrative benefit coverage approvals and supervision is provided by the licensed health professionals.

Annually, United conducts Inter-Rater Reliability (IRR) testing for physicians and clinical reviewers. The IRR results exceeded the target goal. Additionally, Optum Behavioral Health conducted an audit of physicians and doctoral level psychologists to ensure consistency in clinical application. Based upon the audit, all received a passing score.

United's current Pharmacy Benefit Manager is Gainwell. However, the Provider Manual still lists Optum Rx as the Pharmacy Benefit Manager. During the onsite discussion, it was clarified by United that Gainwell is the current Pharmacy Benefit Manager, with the change occurring on July 1, 2024. The Provider Manual should be updated to reflect the change in the Pharmacy Benefit Manager.

Constellation's review of a sample of approval files reflected that the reviews of the authorization requests were completed timely by appropriate healthcare professionals. The review of a sample of denial files found that the determinations were made in a timely manner, second level reviews were conducted appropriately, and the reasons for the adverse benefit determinations were

communicated correctly. However, it was noted that five CAN and five CHIP denial files incorrectly informed members that an oral request for an appeal must be followed by a written request within 30 days.

Appeals

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

United documents the process for managing member appeals in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, in the CAN and CHIP Member Handbooks, in the Provider Manual, and on the website. The definition of an appeal and steps for filing verbally or in writing by the member, legal guardian, authorized representative, or service provider, are consistent throughout member and provider information. The timeframes for appeal acknowledgment, resolution, and extension if needed are consistently outlined in United's materials. The UM Program Evaluation indicates that appeals are analyzed quarterly to evaluate and address trends. During onsite discussion, it was reported that training and education are provided to address identified trends.

A sample of CAN and CHIP appeal files was reviewed for the 2024 EQR, and it was found that most of the appeals were acknowledged and resolved in a timely manner. One CAN resolution notice was addressed to the provider rather than the member. Two CAN files were not resolved within the required timeframe.

Care Management, Coordination and Continuity of Care

42 CFR § 208, 42 CFR § 457.1230 (c)

United's 2024 Care Management Model Program Description and Addendum, Optum's Behavioral Health Case Management Program Description, and various policies outline the health plan's approach and guidelines for physical health and behavioral health care management services for the CAN and CHIP members. The 2023 Quality Improvement and Population Health Management Program Description provides an outline of United's population health management program.

Members are identified for care management through various resources such as pharmacy claims, UM referrals, practitioner referrals, self-referrals, hospital discharge referrals, etc. Additionally, predictive modeling data tools aid in identifying high risk members for referral to the care management program.

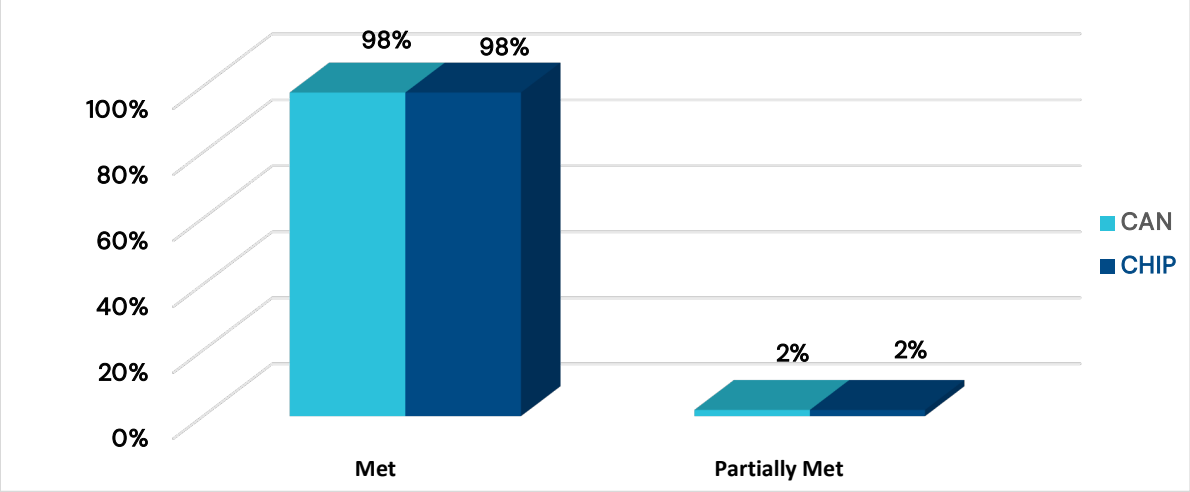
Once a member is referred for care management services, a health risk assessment is conducted within 30 calendar days for members newly assigned to the high or medium risk levels. After the assessment, the member risk level is adjusted as needed and a treatment plan is developed with the member, guardian (if required), and any additional interdisciplinary team members.

Disease management programs are also offered to members to address specific healthcare needs. The Provider Manual refers to the program as the Whole Person Model. During the onsite discussion, United clarified that while the concept of whole person care remains relevant, the program's name has recently been changed to Care Model Program. Additionally, specialty programs, such as the Pediatric Specialty Program, are available to pediatric patients to address the specific needs of pediatric members and their families.

Transition of care management services are also offered to members. United's interdisciplinary transition of care team provides transition of care plans for members to ensure a successful transition to the identified level of care.

As noted in *Figure 7*, 98% of the Utilization Management standards for CAN and CHIP were scored as "Met."

Figure 7: Utilization Management Findings



Strengths, weaknesses, recommendations, and corrective actions for the Utilization Management section are included in the tables below.

Table 31: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Constellation Quality Health's review of sample CAN and CHIP files indicated that they were completed in a timely manner.		✓	✓
United's Behavioral Health timeliness goal of 95% for processing behavioral health prior authorization requests was maintained throughout the year.		✓	✓
Health programs are available to address the specific needs of pediatric members and their families, including Pediatric Specialty Programs for patients in the Neonatal Intensive Care Unit.	✓		

Table 32: Utilization Management Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
United's current Pharmacy Benefit Manager is Gainwell. However, the Provider Manual still lists Optum Rx as the Pharmacy Benefit Manager. During the onsite discussion, it was clarified by United that Gainwell is the current Pharmacy Benefit Manager, with the change occurring on July 1, 2024.	*Recommendation: Update the Provider Manual to reflect the current pharmacy benefit manager.*	✓		
Constellation's review of the sample CAN and CHIP denial files found that five CAN files and five CHIP files incorrectly informed members that a written appeal request is required within 30 days of an oral appeal request.	*Corrective Action Plan: Update the adverse benefit determination letters to accurately reflect that a written appeal request is not required to follow oral appeal requests, in accordance with the CAN Contract, Exhibit D and CHIP Contract, Exhibit E.*	✓		
United recently changed their disease management program name to Care Model Program; however, the Provider Manual references Whole Person Model as the name of the program. During the onsite discussion, United clarified that the program's name has recently been changed to Care Model Program.	*Recommendation: Update the Provider Manual to reflect the updated name of the disease management program as Care Model Program.*	✓		

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 CAN program objectives, scope of activities, and program structure are outlined in various policies and the UM Program Description. Optum's Behavioral Utilization Management Program Description outlines the structure of the behavioral health program that is offered by Optum Behavioral Health. The Pharmacy Program Description outlines the pharmacy program that is managed by Gainwell.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					United's CAN 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, supervision, and quality assurance mechanisms to ensure optimal staff performance.
1.3 Guidelines/standards to be used in making utilization management decisions;	X					As outlined in various policies, initial clinical reviews are conducted by licensed clinical staff using clinical criteria such as InterQual and State Benefit Guidelines. Non-clinical staff members may issue administrative benefit coverage approvals and supervision is provided by licensed health professionals.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 Consideration of new technology;	X					The Medical Technology Assessment Committee reviews new or existing medical policies to be used when performing medical necessity reviews, as applicable.
1.6 The appeal process, including a mechanism for expedited appeal;	X					The Member Handbook, Adverse Benefit Determination Letter Template, and various policies outline the appeal process for members. The documents describe that an appeal may be submitted within 60 days of an Adverse Benefit Decision.
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The Chief Medical Officer's responsibilities include conducting second level reviews, clinical consultations, policy development, etc. The Behavioral Health Medical Director provides clinical oversight of the behavioral health program, including consultation, conducting second level reviews, and managing the medical expense initiatives. The Pharmacy Director oversees the clinical operations of the pharmacy program, including conducting second level pharmacy reviews, policy implementation, and consultation.
3. The CCO periodically reevaluates medical necessity determination guidelines and/or criteria.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					As outlined in Policy UCSMM.06.10, Clinical Review Criteria, and United's UM Program Description, review staff use criteria such as InterQual, Medical Policy, Coverage Determination Guidelines, etc. to make medical necessity determinations. The Behavioral Health UM Program Description indicates that clinical criteria, such as American Society for Addiction Medicine, Optum Clinical Policies, Level of Care Utilization System, etc., are used to conduct behavioral health reviews.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The review of a sample of approval files found that there is consistency in using appropriate clinical criteria in to make medical necessity 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					Annually, United conducts Inter-Rater Reliability (IRR) testing for physicians and clinical reviewers. The IRR results exceeded the target goal. Additionally, Optum Behavioral Health conducts an audit of physicians and doctoral level psychologists to ensure consistency in clinical application. Based upon the audit, all received a passing score.
5. Pharmacy Requirements						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					United's current Pharmacy Benefit Manager is Gainwell. However, the Provider Manual lists Optum Rx as the Pharmacy Benefit Manager. During the onsite discussion, it was clarified by United that Gainwell is the current Pharmacy Benefit Manager, with the change occurring on July 1, 2024. *Recommendation: Update the Provider Manual to reflect the current pharmacy benefit manager.*
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					A descriptive outline of the emergency care and post-stabilization requirements is included in Policy UCSMM.04.11, Consumer Safety, and in the Member Handbook. Emergency and post-stabilization services are provided at no cost to members without prior authorization .
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of a sample of CAN files found that approval determinations were completed timely and were promptly communicated.
10. Denials						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					The review of a sample of CAN denial files found that appropriate physicians conducted second level reviews.
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				Constellation's review of the sample CAN denial files found that the files were completed in a timely manner, second level reviews were conducted appropriately, and the reasons for the adverse benefit decisions were clearly communicated. However, it was noted that five files incorrectly informed members that a written appeal request is required within 30 days of an oral appeal request. *Corrective Action Plan: Update the adverse benefit letters to accurately reflect that a written appeal request is not required to follow an oral appeal request, in accordance with the CAN Contract, Exhibit D.*
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	X					Processes for managing member appeals are described in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
determination by the CCO in a manner consistent with contract requirements, including:						CAN Member Handbook, the Provider Manual, and on United's website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					Documentation of the steps for processing appeals are outlined in United's policies and in member and provider materials. It was discussed during the onsite that corrections from the previous EQR were made to CAN member and provider materials.
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					Timeframes for appeal resolution are consistently documented in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN Member Handbook, the Provider Manual, appeal letter templates, and on United's website.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.	X					A sample of CAN appeal files was reviewed for the 2024 EQR, and it was found that most were acknowledged and resolved in a timely manner. One CAN resolution notice was addressed to the provider rather than the member. Two CAN files were not resolved within the required timeframe.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					The UM Program Evaluation indicates that appeals are analyzed quarterly to evaluate and address trends.
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					United's 2024 Care Management Model Program Description and Addendum, Optum's CAN Behavioral Health Case Management Program Description, and various policies outline the health plan's approach and guidelines for physical and behavioral health care management services. The 2023 Quality Improvement and Population Health Management Program Description provides an outline of United's population health management program that aims to improve

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						population health, improve care experiences, and reduce healthcare costs.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					As described in the Behavioral Health Complex Case Management Program Description and Care Management Model Program Description and Addendum, members are identified for care management through various resources such as pharmacy claims, UM referrals, practitioner referrals, self-referrals, hospital discharge referrals, etc. Also, as outlined in the Care Management Program Description, the Community and Care 2.0 Care Management program utilizes specific criteria such as frequent hospitalization, high risk hospitalization, catastrophic diagnoses, etc. to identify members for care management referral. Additionally, predictive modeling data tools such as the Hotspotting Tool, Emerging, Risk Model, IPRO Risk Scoring Tool, etc., aid in identifying high risk members for referral to the care management program.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					As outlined in Policy NCM 002, Care Management Process, Policy MS 002 Rider, Care Management Process, and United's Care Management Program Description and Addendum, health risk assessments are conducted within 30 calendar days for members newly assigned to the high or medium risk levels.
4. The detailed health risk assessment includes all required elements:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					As described in the Care Management Program Description and Addendum and Policy NCM 002, Care Management Process, a thorough assessment of the member's current and past medical history is conducted.
4.3 Demographic information;	X					Within the Health Risk Assessment, an evaluation of the member's environmental needs, current living arrangement, and social determinants 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					Detailed health risk assessments are conducted by health professionals. After the assessment is completed, a detailed person-centered plan is developed. The treatment plan is developed with the member, guardian (if required), and any additional interdisciplinary team members.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					
7. The CCO utilizes care management techniques to ensure comprehensive,	X					United provides care management activities including scheduling assistance, documentation of services provided, discharge planning, and coordination with

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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					Members assigned to the medium risk level receive targeted services, including those provided to low-risk members. These services encompass health education, appointment coordination, and relapse prevention. This is detailed in United's Care Management Program Description and Addendum, as well as Policy MS 002, Rider Care Management Process. Additionally, health programs and specialty programs such as the Pediatric Specialty Program are available to address the specific needs of pediatric members and their families, including patients in the Neonatal Intensive Care Unit.
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					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost including, but not limited to, diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					The disease management program is described in Policy NCM 006 Integration of Physical and Behavioral Health Through Whole Person Care, the Care Management Program Description and Addendum, the Member Handbook, and the Provider Manual. The Provider Manual refers to the program as the Whole Person Model. During the onsite discussion, United clarified that while the concept of whole person care

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						remains relevant, the program's name has recently been changed to Care Model Program. *Recommendation: Update the Provider Manual to reflect the updated name of the disease management program as Care Model Program.*
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					The Care Management Program Description and Addendum, policies, Member Handbook, and Provider Manual outline the transitional care management process. As described in Policy MS 021, Management of Care Transitions, United tracks, reviews, and analyzes data at least monthly to identify any unplanned transition trends to ensure timeliness and appropriateness of services with the ultimate goal of reducing unplanned transitions.
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					As described in the Care Management Program Description and Addendum and Policy MS 021, Management of Care Transitions, United's interdisciplinary transition of care team designs and implements the transition of care plan for members to ensure a successful transition to the identified level of care.
4. The CCO meets other Transition of Care requirements.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					A written summary of the effectiveness of the UM program is prepared annually and was approved by the Health Quality Utilization Management Committee on 5/15/24 and Quality Management Committee 6/5/24.

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					United's CHIP program objectives, scope of activities, and program structure are outlined in various policies and the Utilization Management Program Description. Optum's Behavioral Utilization Management Program Description outlines the structure of the behavioral health program offered by Optum Behavioral Health. The Pharmacy Program outlines the pharmacy program. United also has care management and disease management programs to address health and care management needs for the CHIP Mississippi members as outlined in the Care Management Model Program Description.
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					As outlined in various policies, standard authorizations are processed within three calendar days or two business days. Expedited and pharmacy requests are processed within 24 hours. Initial reviews of service authorization requests may be extended 14 calendar days if it is in the best interest of the member.
1.5 Consideration of new technology;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					If a member receives an adverse benefit decision, a member or representative can file an appeal within 60 days of the decision as described in the Member Handbook, Policy UCSMM.07.11 Appeal Timeframes, Policy UCSMM.07.12 Appeal Process and Record Documentation, and Letter Template.
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					As described in Policy UCSMM.02.12 Performance Assessment and Incentives, UM Program Description Addendum, and Provider Manual, United staff do not receive any incentives for performing adverse benefit decisions.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The Chief Medical Officer's responsibilities include conducting second level reviews, clinical consultations, policy development, etc. The Behavioral Health Medical Director provides clinical oversight of the behavioral health program; this entails consultation, conducting second level reviews, and managing the medical expense initiatives.
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					As outlined in Policy UCSMM.06.10, Clinical Review Criteria, and United's UM Program Description, review staff use criteria such as InterQual, Medical Policy, Coverage Determination Guidelines, American Society for Addiction Medicine, Optum Clinical Policies, Level

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of Care Utilization System, Child and Adolescent Level of Care/Service Intensity Utilization System, etc. to make clinical determinations.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation's review of a sample of approval files reflected consistency in using appropriate clinical criteria in performing medical necessity 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					Annually, United conducts IRR testing for physicians and clinical reviewers. The results exceeded the target goal. Additionally, Optum Behavioral Health conducted an audit of physicians and doctoral level psychologists to ensure consistency in clinical application. Based upon the audit, all received a passing score.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					United's current Pharmacy Benefit Manager is Gainwell. However, the Provider Manual lists Optum Rx as the Pharmacy Benefit Manager. During the onsite discussion, it was clarified by United that Gainwell is the current Pharmacy Benefit Manager, with the change occurring on July 1, 2024. *Recommendation: Update the Provider Manual to reflect the current pharmacy benefit manager.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					An outline of emergency care and post-stabilization requirements is included in Policy UCSMM.04.11, Consumer Safety and Member Handbook. Emergency and post-stabilization services are provided at no cost to members without prior authorization .
7. Utilization management standards/criteria are available to providers.	X					
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					
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Constellation's review of a sample of CHIP files found that appropriate physicians made adverse benefit determinations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Constellation's review of the sample CHIP denial files found that the determinations were completed in a timely manner, second level reviews were conducted appropriately, and the reasons for the adverse benefit decisions were clearly communicated. However, it was noted that five files incorrectly informed members that a written appeal request is required within 30 days of an oral appeal request. *Corrective Action Plan: Update the adverse benefit determination letters to accurately reflect that a written request is not required to follow oral appeal requests, in accordance with the CHIP Contract, Exhibit E.*
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					Processes for managing member appeals are described in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, the Provider Manual, and on the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeal terminology is defined consistently in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, and in member and provider materials.
1.2 The procedure for filing an appeal;	X					The steps for processing appeals are outlined in United's policies, CHIP member materials, and provider

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						materials. It was discussed during the onsite that corrections from the previous EQR were made to CHIP member and provider materials.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal;	X					Timeframes for appeal resolutions are consistently documented in Policy POL2015-01, MS Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, the Provider Manual, appeal letter templates, 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 review of a sample of CHIP appeal files found that all were acknowledged and resolved in a timely manner.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					The UM Program Evaluation indicates that appeals are analyzed quarterly to evaluate and address trends.
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					United's 2024 Care Management Model Program Description and Addendum, Optum's CHIP Behavioral Health Case Management Program Description, and various policies outline the health plan's approach and guidelines for physical and behavioral health care management services. The 2023 Quality Improvement and Population Health Management Program Description provides an outline of United's population health management program that aims to improve population health, improve care experiences, and reduce healthcare costs.
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					The health risk assessment for newly referred members is completed within 30 calendar days as outlined in Policy NCM 002, Care Management Process, Policy MS 002 Rider, Care Management

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Process, and United's Care Management Program Description and Addendum.
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					Upon completion of the health risk assessment, a detailed person-centered plan is developed within 30 days. The treatment plan is developed with the member, guardian (if required), and any additional interdisciplinary team members.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Members are assigned a risk level upon assessment and the member's risk level is reassessed at least annually or if there is a major shift in the member's health or service needs.
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and Child Health Program, and the Department of Human Services;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					Members that are assigned to the medium risk level receive specific services, including those provided at the low risk level. Services include member health education, appointment coordination, relapse prevention, etc. Health programs and specialty programs such as the Pediatric Specialty Program are available to address the specific needs of pediatric members and their families, including patients in the Neonatal Intensive Care Units.
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					Members that are assigned to the high risk level receive specific services, including those provided at the low and medium risk levels. Also, the Perinatal High Risk Management/Infant Services System provides

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						perinatal services to high risk pregnant women as described in the Program Description and Addendum and Policy NCM 047, High Risk Members For Maternity Case Management.
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					The disease management program is described in Policy NCM 006, Integration of Physical and Behavioral Health Through Whole Person Care, the Care Management Program Description and Addendum, the Member Handbook, and the Provider Manual. The Provider Manual refers to the program as the Whole Person Model. During onsite discussion, United clarified that while the concept of whole person care remains relevant, the program's name has recently been changed to Care Model Program. *Recommendation: Update the Provider Manual to reflect the updated name of the disease management program as Care Model Program*
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or	X					Review of the sample of care management files indicated that comprehensive assessments were conducted to identify the treatment needs for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
inpatient setting back to home or other community setting.						member and to ensure coordinated care for the members receiving transition of care 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						
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					A written summary of the effectiveness of the UM program is prepared annually and was approved by the Health Quality Utilization Management Committee on 5/15/24 and Quality Management Committee 6/5/24.

F. Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. For this review, United reported six delegation agreements for CAN and five delegation agreements for CHIP, as shown in *Table 33: Delegated Entities and Services*.

Table 33: Delegated Entities and Services

Delegated Entities	Delegated Services
Optum Behavioral Health	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 *(CAN Only)*	Non-Emergency Transportation (NET) benefit services broker, NET provider network, NET claims processing, NET quality management, NET call center operations
eviCore National	Radiology and Cardiology utilization management services, prior authorization handling, call center services
MARCH Vision Care	Vision and eye care benefit administration services, vision network contract management, call center operations, claims processing
OptumRX	Pharmacy benefit administration services, network adequacy, call center services, claims processing timeliness, prior authorization handling

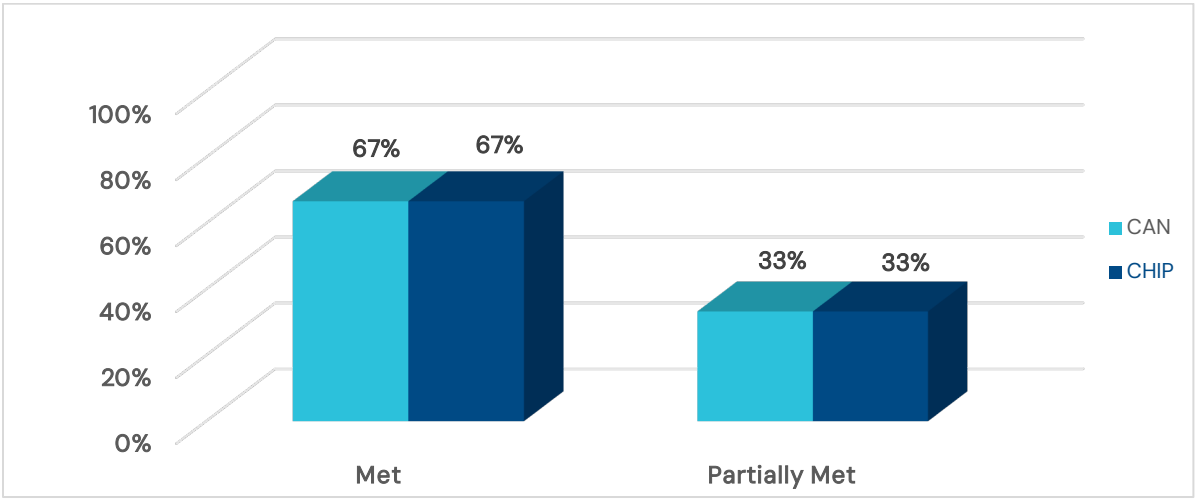
Policy DVO-01, Delegated Vendor Oversight Strategy, establishes United's policy and process for ensuring that oversight of delegated vendors occurs as required by United's contract with DOM. This policy outlines the responsibilities of the Delegated Services Manager and Vendor Oversight Coordinator. The policy indicates United monitors each delegated vendor's performance on an ongoing basis and conducts a formal review at least once per year.

United monitors each subcontractor's performance on an ongoing basis. Copies of each subcontractor's scorecards were provided for review. Results of these scorecards are reported to the Delegated Vendor Joint Oversight Committee, Service Quality Improvement Subcommittee, and the Compliance Committee. If there are performance issues, these committees recommend the next steps to remedy the identified issues.

Policy DVO-01, Operations / Delegated Vendor Oversight, mentions annual reviews or annual audits several times. The policy states, "Perform yearly targeted audits of delegated vendor assignments to include items such as member and provider correspondence/material, notification timeliness, handbooks, portals and websites." The policy also indicates the results will be included in the Annual Quality Management Program Evaluation. However, the results of the formal annual audit were not provided. This was discussed onsite and additional information was requested. United responded, "monitoring of the delegated entities and the activities assigned to them are accomplished through several ongoing activities. All subcontractors submit monthly/quarterly reports to demonstrate compliance with Service Level Agreements and program effectiveness. The evaluations of these performance measures are reviewed annually and documented within the MSCAN & CHIP Subcontractor Annual Evaluation report. Evaluations pertaining to utilization, clinical, and quality are measured separately within those perspective program evaluations." The Subcontractor Annual Evaluation report referenced in United's response and provided for review was a summary that included a description of the delegated entities, scorecard assessment results, and interventions or action plans where applicable. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation as required by the *CAN Contract, Section 15* and the *CHIP Contract, Section 14*.

United met 67% of the standards for the Delegation Section as noted in *Figure 8: Delegation Findings*. The Partially Met score was related to annual monitoring of the subcontractor's performance.

Figure 8: Delegation Findings



Strengths, weaknesses, and corrective actions for the Delegation section are included in the tables below.

Table 34: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
United has policies and procedures in place for monitoring each subcontractor's performance. Copies of each subcontractor's scorecards are reviewed during the Delegated Vendor Joint Oversight Committee meetings.	✓		

Table 35: Delegation Weaknesses, Corrective Actions, and Recommendations

Weakness	Recommendation or Corrective Action	Quality	Timeliness	Access to Care
Policy DVO-01, Operations / Delegated Vendor Oversight, the *DOM CAN Contract, Section 15* and *CHIP Contract, Section 14* requires United to monitor each subcontractor's performance on an ongoing basis and subject it to a formal review at least once per year. The results of this monitoring are required to be included in the Annual Quality Management Program Evaluation. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation.	*Corrective Action Plan: Conduct a formal annual audit of all subcontractors and include the results of this oversight monitoring in the Annual Quality Management Program Evaluation as required by the DOM CAN Contract, Section 15 and CHIP Contract, Section 14.*	✓		

DELEGATION—CAN

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 FR § 438.230 and 42 CFR § 457.1233(b)*						
1. The CCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Policy DVO-01, Delegated Vendor Oversight Strategy, establishes United's policy and process for ensuring that oversight of delegated vendors occurs as required by United's contract with DOM. This policy outlines the responsibilities of the Delegated Services Manager and the Vendor Oversight Coordinator. This policy indicates that United monitors each delegated vendor's performance on an ongoing basis and conducts a formal review at least once per year.
2. 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 for CAN.
3. 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				United monitors each subcontractor's performance on an ongoing basis. Copies of each subcontractor's scorecards were provided for review. Results of these scorecards are reported in the Delegated Vendor Joint Oversight Committee, Service Quality Improvement Subcommittee, and the Compliance Committee. If there are performance issues, these committees recommend the next steps to remedy any issues. Policy DVO-01, Operations / Delegated Vendor Oversight, mentions annual review or annual audits several times. The policy states, "perform yearly targeted audits of delegated vendor assignments to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include items such as member and provider correspondence/material, notification timeliness, handbooks, portals and websites." The policy also indicates the results will be included in the Annual Quality Management Program Evaluation. However, the results of the formal annual audit were not provided. This was discussed onsite and additional information was requested. United responded, "monitoring of the delegated entities and the activities assigned to them are accomplished through several ongoing activities. All subcontractors submit monthly/quarterly reports to demonstrate compliance with Service Level Agreements and program effectiveness. The evaluations of these performance measures are reviewed annually and documented within the MSCAN & CHIP Subcontractor Annual Evaluation report. Evaluations pertaining to utilization, clinical, and quality are measured separately within those perspective program evaluations." The Subcontractor Annual Evaluation report referenced in United's response was a summary that included a description of the delegated entities, scorecard assessment results, and interventions or action plans where applicable. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual Quality Management Program Evaluation as required by the *CAN Contract, Section 15*. *Corrective Action Plan: Conduct a formal annual audit of all subcontractors and include the results of this*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						oversight monitoring in the Annual Quality Management Program Evaluation as required by the CAN Contract, Section 15.

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)*						
1. The CCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					
2. 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 five delegation agreements for CHIP.
3. 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				United monitors each subcontractor's performance on an ongoing basis. Copies of each subcontractor's scorecards were provided for review. Results of these scorecards are reported in the Delegated Vendor Joint Oversight Committee, Service Quality Improvement Subcommittee, and the Compliance Committee. If there are performance issues, these committees recommend the next steps to remedy any issues.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy DVO-01, Operations / Delegated Vendor Oversight, mentions annual review or annual audits several times. The policy states, "perform yearly targeted audits of delegated vendor assignments to include items such as member and provider correspondence/material, notification timeliness, handbooks, portals and websites." The policy also indicates the results will be included in the Annual Quality Management Program Evaluation. However, the results of the formal annual audit were not provided. This was discussed onsite and additional information was requested. United responded, "monitoring of the delegated entities and the activities assigned to them are accomplished through several ongoing activities. All subcontractors submit monthly/quarterly reports to demonstrate compliance with Service Level Agreements and program effectiveness. The evaluations of these performance measures are reviewed annually and documented within the MSCAN & CHIP Subcontractor Annual Evaluation report. Evaluations pertaining to utilization, clinical, and quality are measured separately within those perspective program evaluations." The Subcontractor Annual Evaluation report referenced in United's response was a summary that included a description of the delegated entities, scorecard assessment results, and interventions or action plans where applicable. There was no documentation of the annual audits conducted by United. Also, the results of the ongoing monitoring and the annual audits were not included in the Annual

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Management Program Evaluation as required by the *CHIP Contract, Section 14.* *Corrective Action Plan: Conduct a formal annual audit of all subcontractors and include the results of this oversight monitoring in the Annual Quality Management Program Evaluation as required by the CHIP Contract, Section 14.*

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Assessment of Corrective Action Plans from Previous EQR

Attachment 1: Initial Notice and Materials Requested for Desk Review

June 3, 2024

J. Michael Parnell
President & CEO
UnitedHealthcare Community Plan – Mississippi
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Mr. Parnell:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2024 External Quality Review (EQR) of UnitedHealthcare Community Plan – Mississippi is being initiated. The review will include the MississippiCAN (MSCAN) and Mississippi CHIP (MS CHIP) Programs and will be conducted by Constellation Quality Health, formerly The Carolinas Center for Medical Excellence.

The methodology used 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 Constellation Quality Health) and a virtual onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The virtual onsite visit will be conducted on **September 4, 2024**, and **September 5, 2024**, for the MississippiCAN and Mississippi CHIP Programs.

In preparation for the desk review, the items on the enclosed MississippiCAN Materials Request for Desk Review and Mississippi CHIP Materials Request for Desk Review lists should be provided to Constellation Quality Health no later than **July 3, 2024**.

Please upload all the desk materials electronically to Constellation Quality Health 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, Constellation Quality Health 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 Constellation Quality Health 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

MississippiCAN 2024 External Quality Review

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 positions 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. Please include all of the following:
    a. A list of all contracted providers. This list should be submitted as an excel spreadsheet and include county, specialty, panel limitations, and a description of any codes used in the spreadsheet.
    b. Geographic access assessments
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios
    f. Analysis of in-network and out-of-network utilization data
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 2023 and 2024.

11. The most recent reports that summarize 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 all committee meetings within the past year for committees reviewing or taking action on MSCAN related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.
14. Membership lists and a committee matrix for all MSCAN committees, including the professional specialties of any non-staff members. Please indicate which members are voting members and include committee charters if available.
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 2023 and 2024 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 2023 through June 2024. 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 2023 to June 2024. 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 2023 through June 2024.
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.
    a. Copies of the EPSDT tracking reports and follow-up activities from August 2023 through June 2024.
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 with updated data for MY 2023. *(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 2023 through June 2024.

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 2023 (MY 2023) Record of Administration, Data Management and	• Please submit the same Roadmap your CCO completed for the MY 2023 [1]NCQA HEDIS Compliance Audit™, that was

Folder	Requested Document	Description
	Processes (Roadmap)	conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for all supplemental data sources that are utilized for all measures included under PMV review. If the CCO did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) CSV and Excel workbooks for MSCAN for MY 2023.
c.	HEDIS MY 2023 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 2023. NOTE: Constellation understands CCOs may not receive the FARs from the HEDIS auditors until 7/15/24. Please submit this item by 7/17/24.
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℠, 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, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health's portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. Constellation Quality Health 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, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health 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. Constellation Quality Health 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	Constellation Quality Health 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 2023 through June 2024. 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 2023 through June 2024, 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 Constellation Quality Health.

These materials:

- should be organized and uploaded to the secure Constellation Quality Health EQR File Transfer site at https://eqro.thecarolinascenter.org.
- should be submitted in the categories listed.

UnitedHealthcare Community Plan – Mississippi

Mississippi CHIP 2024 External Quality Review

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 positions 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. Please include all of the following:
    a. A list of all contracted providers. This list should be submitted as an excel spreadsheet and include county, specialty, panel limitations, and a description of any codes used in the spreadsheet.
    b. Geographic access assessments
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios
    f. Analysis of in-network and out-of-network utilization data
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 2023 and 2024.

11. The most recent reports that summarize 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 2023 and 2024 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 2023 through June 2024. 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 2023 to June 2024. 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 2023 through June 2024.
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.
    a. Copies of the Well-Baby Well-Child tracking reports and follow-up activities from August 2023 through June 2024.
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 with updated data for MY 2023. *(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 2023 through June 2024.

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 2023 (MY 2023) Record of Administration, Data Management and Processes (Roadmap)	• Please submit the same Roadmap your CCO completed for the MY 2023 [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

Folder	Requested Document	Description
		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 2023.
c.	HEDIS MY 2023 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 2023. NOTE: Constellation understands CCOs may not receive the FARs from the HEDIS auditors until 7/15/24. Please submit this item by 7/17/24.
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, Constellation Quality Health will send a second request with selected measures and request the CCO upload (via Constellation Quality Health portal, folder 36 f) a list of the first 100 numerator compliant records that are identified through claims data. Constellation Quality Health 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, Constellation Quality Health will send a second request with selected measures and request the CCO to upload (via Constellation Quality Health 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. Constellation Quality Health will select a random sample to conduct the medical record review validation.
h.	Rate Reporting template populated with data for non-HEDIS measure rates	Constellation Quality Health 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 2023 through June 2024. 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 2023 through June 2024, 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 Constellation Quality Health.

These materials:

- should be organized and uploaded to the secure Constellation Quality Health 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 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. CAHPS Survey reports for MY2023 for Child with CCC and Adult surveys (CAN) and Child with CCC (CHIP)

3. A Mississippi-specific policy for the Pharmacy Lock-in Program.

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
- Performance Measure Validation CAN
- Performance Measure Validation CHIP
- Performance Improvement Project Validation CAN
- Performance Improvement Project Validation CHIP
- Network Validation CAN
- Network Validation CHIP

EQR Survey Validation Worksheet

Plan Name	United CAN
Survey Validated	CAHPS MEMBER SATISFACTION – ADULT
Validation Period	2023
Review Performed	2024

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 MY2023
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective was documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience was identified in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023

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 MY2023
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 MY2023

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 MY2023
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 MY2023
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 MY2023
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 MY2023
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 MY2023

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 MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2023

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 MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult CAHPS Report MY2023
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 MY2023

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 MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult CAHPS Report MY2023
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 MY2023

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 MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child with CCC response rate was 14.7% which is a decline from the previous year's rate of 16.1%. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult CAHPS Report MY2023

Results Elements		Validation Comments and Conclusions
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 MY2023
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 MY2023

EQR Survey Validation Worksheet

Plan Name	United CAN
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD WITH CCC
Validation Period	2023
Review Performed	2024

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability is documented. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child with CCC response rate was 10.2% which is a slight decline from the previous year's rate of 10.8%. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

EQR Survey Validation Worksheet

Plan Name	United CHIP
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD WITH CCC
Validation Period	2023
Review Performed	2024

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability is documented. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

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:* Press Ganey Child with CCC CAHPS Report MY2023.

Survey Element		Element Met / Not Met	Comments and Documentation
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

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 with CCC CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child with CCC response rate was 12% which is a decline from the previous year's rate. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023
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 with CCC CAHPS Report MY2023

EQR PM Validation Worksheet

Plan Name:	United Healthcare - MSCAN
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2024
Review Performed:	9/4/2024

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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:	ALL ADULT AND CHILD CMS CORE MEASURES – CAN
Reporting Year:	2024
Review Performed:	9/4/2024

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS ADULT AND CHILD CORE SET MEASURES SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	

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:	ALL HEDIS MEASURES
Reporting Year:	2024
Review Performed:	9/4/2024

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**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
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 – MS CHIP**
Name of PM:	**All ADULT AND CHILD CMS CORE MEASURES – CHIP**
Reporting Year:	**2024**
Review Performed:	**9/4/2024**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS ADULT AND CHILD CORE SET MEASURES SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Met**	

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV,	**Met**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
	member months' calculation, member years' calculation, and adherence to specified time parameters).		
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 PIP Validation Worksheet

Plan Name:	United CAN
Name of PIP:	Behavioral Health Readmissions
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Hinds County has a high rate of readmissions.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The readmission rate slightly increased from baseline 18% to 18.7% in 2022, and then the final rate increased very slightly to 18.8%. **Recommendation**: *Not applicable now that PIP is retired.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement in primary indicator did not occur.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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:	2023
Review Performed:	2024

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
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling method is sound.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling methodology was appropriated.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	HEDIS sample size was applied.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and processes of care.
Step 6: Review Data Collection Procedures		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The baseline rate was 92.21% and the remeasurement #4 rate was 92.94% which was a decline from the previous year's hybrid rate of 96.84%. **Recommendation**: *Not applicable as PIP is retired.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance	**NA**	Improvement in primary indicator did not occur.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
appear to be the result of the planned quality improvement intervention)? **(5)**		
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 CAN
Name of PIP:	Respiratory Illness
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Childhood asthma is a major concern in MS. COPD is the fourth leading cause of death.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
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 measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Two measures showed a decline, and one measure showed improvement. For bronchodilators, the baseline was 74.96% increasing to 80.77% at remeasurement four (2023) an increase from 2022 rate of 78.40%, which demonstrates improvement and exceeded the comparison goal. Corticosteroids improved from 42.24% at baseline to 46.15% in 2023 (decline from 50.76% in 2022) which

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
		demonstrated improvement although remained below the comparison goal rate of 52.28%. The AMR baseline was 70.7% and increased to 74.01% in 2023 (a decline from the 2022 the rate of 75.79%), indicating improvement although below the comparison goal of 78.06%. **Recommendation**: *Not applicable as PIP is retired.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement was not demonstrated across all indicators.
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	**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 CAN
Name of PIP:	Sickle Cell Disease
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	In 2018, a low percentage of members were compliant with taking their Hydroxyurea.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The rate was 36.28% a baseline and declined to 24.78% in 2023 (the rate was 28.91% in 2022, so the 2023 rate improved), which exceeded the comparison goal (lower is better). Thus, this PIP showed improvement overall with an 11.5% reduction in ER utilized by SCD members.
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 not demonstrated across all indicators.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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 as final rate not sustained over time.

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	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:	Follow Up after Hospitalization for Mental Illness
Reporting Year:	2023
Review Performed:	2024

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**	UnitedHealthcare Community Plan of Mississippi (UHC) chose this topic because of its importance to the State Department of Medicaid, but also to UHC with the intent of improving overall follow-up after hospitalizations for mental illness.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.

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 measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	30-day rate declined from 2022 to 2023; 7-day rate declined from 2022 to 2023. **Recommendation**: *Not applicable as PIP is retired.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance	**NA**	No improvement to assess.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
appear to be the result of the planned quality improvement intervention)? **(5)**		
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:	2023
Review Performed:	2024

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**	Data show a need to improve the rate to the NCQA quality compass percentile rate regarding getting needed care – easy to see a specialist
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS specifications for sampling was utilized
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	A systematic sampling method is used for the CAHPS® survey
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	A systematic sampling method is used for the CAHPS® survey to ensure appropriate sample size.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate declined from 2022 to 2023. **Recommendation**: *Not applicable as PIP is retired.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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:	Reducing Childhood and Adolescent Obesity
Reporting Year:	2023
Review Performed:	2024

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**	Mississippi's obesity rate is 33.8% and is considered the most obese state in the country. Mississippi youth are at risk as well with an obesity rate of 18% and children at 21.9%
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS specifications for sampling was utilized
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	A systematic sampling method is used for the CAHPS® survey
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	A systematic sampling method is used for the CAHPS® survey to ensure appropriate sample size.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rates for BMI documentation, counseling for nutrition, and counseling for physical activity declined from 2022 to 2023. **Recommendation**: *Not applicable as PIP is retired.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
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
Reporting Year:	2023
Review Performed:	2024

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**	Well child visits were below goal rates.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study are stated clearly.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addresses aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project includes all relevant populations.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected are clearly specified.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	**Score**	**Comments**
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data are noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods are documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provide consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel are listed.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data are reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report includes analysis of change in rate between measurement periods and qualitative analysis of the results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers are documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Ages 12-17 rate improved from 2022 to 2023; Ages 18 to 21 rate improved from 2022 to 2023.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be due to several interventions for members and providers.
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 Network Adequacy Validation Worksheet

Plan Name:	United CAN
Reporting Year:	2023
Review Performed:	2024

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)**	**N/A**	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		
Component / Standard (Total Points)	**Score**	**Comments**
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.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	**Score**	**Comments**
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		
Component / Standard (Total Points)	**Score**	**Comments**
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 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	99	99

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:	2023
Review Performed:	2024

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)**	N/A	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		
Component / Standard (Total Points)	**Score**	**Comments**
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.

ACTIVITY 2: ASSESSMENT OF CCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	**Score**	**Comments**
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		
Component / Standard (Total Points)	**Score**	**Comments**
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.

ACTIVITY 3: ASSESSMENT OF CCO NETWORK ADEQUACY RESULTS		
Component / Standard (Total Points)	**Score**	**Comments**
3.4 Did the CCO accurately interpret its results? **(10)**	**MET**	Findings were interpreted and analyzed by CCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION 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	**99**	**99**

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.*

Attachment 4: Assessment of Corrective Action Plans from Previous EQR

Constellation Quality Health

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

UnitedHealthcare Community Plan of Mississippi 2023 Corrective Action Plan – CAN

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II C. Provider Education			
2. Initial provider education includes: 2.8 Medical record handling, availability, retention, and confidentiality;			
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.*	UHCs' template agreements with providers, including the regulatory appendices that are part of those agreements, include the required document retention requirements. Standard Contract Language: Maintenance. Medical Group will maintain Medical Group Records for at least 10 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law. The language can be found in the following sections of the base agreements and the Regulatory Appendix. Supporting Documentation: -Finding1_MSCAN_MS MGA Agreement_pg11sec5.9 -Finding1_MSCAN_MS Ancillary Agreement_pg9sec4.10 -Finding1_MSCAN_MS Facility Agreement_pg8sec4.10 -Finding1_MSCAN_MS FQHC_RHC Agreement_pg8sec4.10 -Finding1_MSCAN_MS Medicaid CAN Regulatory Appendix_pg7sec3.9 UHC's response – 1/22/2024 The Provider Manual has been updated to include the required timeframe for medical record retention. Supporting Documentation:	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	-Finding1_PMG 20231121-125415 CAN CLEAN_Final_pg 49 -Finding1_PMG 20231121-125415_Final_MSCAN REDLINE		
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;			
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.*	This information can be found on page 57 in the Responsibility of the PCP section 2023 Care Provider Manual MississippiCAN. Language in the manual Pg 57: For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify us by regular mail: UnitedHealthcare Community Plan c/o Medical Director 795 Woodlands Parkway-Suite 301 Ridgeland, MS 39157 Supporting Documentation: -Finding2_MSCAN_Care Prov Manual_pg57	✓	
Utilization Management			
V. C. Appeals			
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;			
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*	Policy USCMM 0712, Appeals Process and Record Documentation has been updated to remove expedited requirement for filing an appeal verbally. Supporting Documentation: -Finding3_CAN_UCSMM 07 12 Appeal Process and Record Documentation_RevisedCAP_pg2 Policy USCMM.07.11, Appeal Review Timeframes, has been updated to remove the written attestation requirement following a verbal appeal. Supporting Documentation: -Finding3_CAN_UCSMM 07 11 Appeal Review Timeframes_RevisedCAP_pg3 The CHIP PDF download, MS-Appeals-Grievances, has been updated to remove the written attestation requirement following a verbal appeal. Supporting Documentation: -Finding3&6_MS-Appeals-Grievance_pg3	✓	

2023 EQR Findings – CAN	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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.			
2. The CCO applies the appeal policies and procedures as formulated.			
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. *Corrective Action Plan: Ensure that processes are in place to ensure that Written Consent or Appointment of Representative Forms are in place as needed.*	A separate section of the letter has been created to specifically address the provider in addition to the member response section. Continuation of quarterly meetings with the appeals and grievance team to review and identify any errors within the resolution letters. Supporting Documentation: -Finding4&7_MS Provider Facing Letter Proposal The current process follows the National Committee for Quality Assurance (NCQA) guidance on utilization management (UM) review on expedited appeal requests and ensures that written consent or appointment of representative forms are in place as needed. Supporting Documentation: -Finding4&7_MS AOR Job Aid	✓	

Constellation Quality Health

ASSESSMENT OF CORRECTIVE ACTION PLANS FROM PREVIOUS EQR

UnitedHealthcare Community Plan of Mississippi 2023 Corrective Action Plan – CHIP

2023 EQR Findings – CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II C. Provider Education			
2. Initial provider education includes: 2.12 A description of the role of a PCP and the reassignment of a member to another PCP;			
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.*	This information can be found on page 55 in the PCP Responsibilities section 2023 Care Provider Manual Mississippi Children's Health Insurance Program (CHIP). Language in the manual Pg 55: For any reason, including panel size, if the PCP is unable to assume care for assigned member(s), the PCP should notify us through the Provider Portal, calling, or by regular mail: UnitedHealthcare Community Plan c/o Medical Director 795 Woodlands Parkway-Suite 301 Ridgeland, MS 39157 Supporting Documentation: -Finding5_MSCHIP_Provider Manual_DRAFT_pg55	✓	
Utilization Management			
V. C. Appeals			
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;			

2023 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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."* 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."*	Policy USCMM 0712, Appeals Process and Record Documentation has been updated to remove expedited requirement for filing an appeal verbally. Supporting Documentation: -Finding3_CAN_UCSMM 07 12 Appeal Process and Record Documentation_RevisedCAP_pg2 Policy USCMM.07.11, Appeal Review Timeframes, has been updated to remove the written attestation requirement following a verbal appeal. Supporting Documentation: -Finding3_CAN_UCSMM 07 11 Appeal Review Timeframes_RevisedCAP_pg3 The CHIP PDF download, MS-Appeals-Grievances, has been updated to remove the written attestation requirement following a verbal appeal. Supporting Documentation: -Finding3&6_MS-Appeals-Grievance_pg3	✓	
2. The CCO applies the appeal policies and procedures as formulated.			

2023 EQR Findings - CHIP	Actions Taken by CCO To Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
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.* 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.*	A separate section of the letter has been created to specifically address the provider in addition to the member response section. Continuation of quarterly meetings with the appeals and grievance team to review and identify any errors within the resolution letters. Supporting Documentation: -Finding4&7_MS Provider Facing Letter Proposal The current process follows the National Committee for Quality Assurance (NCQA) guidance on utilization management (UM) review on expedited appeal requests and ensures that written consent or appointment of representative forms are in place as needed. Supporting Documentation: -Finding4&7_MS AOR Job Aid	✓	
V E. Transitional Care Management			
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.			
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.*	The process for the C&S Behavioral Health Care Coordination & Advocacy (BH CCA) outlines the process for care management services. Refresher training and staff coaching sessions were held in December 2023 and January 2024. Supporting Documentation: -Finding8_KB0054407_Redacted_pgs4-8	✓	