The State of Mississippi

Division of Medicaid

UnitedHealthcare Community Plan - Mississippi

2013 External Quality Review

JUNE 2014

Table of Contents

Executive Summary

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The following report contains a description of the process and the results of the 2013 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid. The purpose of this review was to determine the level of performance demonstrated by UnitedHealthcare Community Plan - Mississippi (UHC) and to provide feedback for potential areas of further improvement.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review included a desk review of documents, a three-day onsite visit to the UnitedHealthcare Community Plan - Mississippi office, validation of performance improvement projects, validation of performance measures, validation of consumer and provider surveys, and a review of the health plans' Information System Capabilities Assessment.

Findings

The findings of the 2013 EQR indicate that UnitedHealthcare Community Plan - Mississippi improved their percentage of met scores in the area of Enrollee Services, Quality Improvement, and Utilization Management. Of concern was the health plan did not fully implement the corrective action plan that addresses the deficiencies identified during the previous EQR. As a result, several standards received a Not Met score.

STRENGTHS

Strengths of UnitedHealthcare's performance at the time of this review include the following:

- The Member Services Manager position has been filled and overall staffing levels appear to be sufficient to meet the needs of enrollees.
- UHC has detailed processes, policies, and procedures in place to ensure that claims are handled in a timely and accurate manner.
- UHC does an extensive analysis of the demographics and enrollment of their members.
- Systems, plans, and processes are in place to ensure that virtually any disaster scenario would be a fully recoverable event.
- CCME's review found UHC's information systems capabilities to fully meet the ISCA specifications.
- Physician Performance Profiles are supplied to practitioners so that they can review their quality performance and utilization data as compared to their peers within the state.
- The provider portal of the UHC website contains detailed information for providers including educational materials, forms, bulletins, newsletters and the Provider Manual.
- UHC has adopted a wide variety of preventive and clinical practice guidelines and they post the approved guidelines on their website for easy access.

- The Healthy First Steps program provides education and support during pregnancy, as well as assistance with finding community services such as WIC, behavioral health care and social services. This program is positively impacting babies born to enrollees who participate in the program.
- Committees are well attended and minutes document the discussions, recommendations, and any needed follow-up.
- Clinical Practice Consultants were hired to develop educational tools and complete provider visits to educate the physicians on the HEDIS measures and rates.
- The implementation of the Readmission Risk Assessment has had a positive impact on the number of hospital readmissions for UHC enrollees.
- Utilization files reviewed onsite were well organized and reflected that appropriate processes are in place, review determinations are timely, denial determinations are issued by appropriate physician reviewers, and that notifications are provided as required.
- All enrollees are screened for care management programs via a health risk assessment. Enrollees are identified for care management and other specialized programs to meet their needs. Appropriate re-screenings are done at the required intervals.

WEAKNESSES

Weaknesses identified included the following:

- The credentialing and recredentialing policies and program description does not address MS specific criteria. Many of the issues were identified in the previous EQR and not corrected.
- Credentialing and recredentialing files did not contain the disclosure of ownership forms, proof of primary/secondary source verification, signed attestations, proof of queries, proof of malpractice insurance and CLIA certificates/waivers, if applicable. In addition, office site visits for initial credentialing were not conducted and two files did not have hospital privileges appropriately verified.
- Errors noted in policies include:
    - Some enrollee responsibilities are missing from detailed in Attachment A of policy NQM-051, Members Rights and Responsibilities, and in its associated rider, NQM-051 Rider-MS 1.
    - Errors in the timeframe to notify enrollees of changes in covered services, benefits, or processes used to access benefits were noted.
    - The policy for enrollee disenrollment contains no distinction between mandatory and voluntary enrollees' ability to disenroll from a CCO.
- The printed Provider Directory does not include alternate languages spoken by providers.
- Errors were noted in the MS CAN Resource Guide which used for internal training and reference.
- Some information is missing from the Enrollee Handbook, including the timeframe for notifying members of a provider's termination and enrollee's right to obtain family planning services from any approved Medicaid provider.
- Multiple issues related to UHC's grievance process were identified.
- The number of grievances documented on the grievance log for 2013 was significantly different than the number of grievances reported in the 2013 Quality Improvement Program Evaluation.
- The *DOM Contract, Section 7.5*, indicates that enrollees may request a State Fair Hearing within 30 days of receiving a notice of action or within 30 days of the final decision by the Plan. The following issues were noted regarding requests for State Fair Hearings:

    - Policy MBR 13 incorrectly states that enrollees must request a Medicaid Fair Hearing within 90 calendar days of receipt of UHC's notice of resolution or within 90 calendar days of receipt of UHC's notice of action.
- The Utilization Management Program Description does not include all documentation required by the *DOM Contract, Section 6.4*.
- Several Utilization Management policies were not updated with the most recent review and approval dates.
- Errors in processing requests for which additional information is needed were noted in policy UCSMM.06.19, Information Based Clinical Review.
- Documents contained errors in the timeframe to request an appeal.
- The UHC website glossary defines an appeal but contains no definition of an action.
- Incomplete definitions of an action were noted in several documents.
- Incorrect timeframes for enrollee notification of the denial of an expedited appeal request were noted in policy MBR 14.
- Discrepancies were noted in the timeframe for resolution when an expedited appeal request is denied and the request is transferred to the standard appeal processing timeframe.
- Errors and incomplete information were noted in documentation of the timeliness of standard appeal resolutions.
- Errors were noted in the documentation of timeframes to request State Fair Hearings.
- Errors and discrepancies were noted in multiple documents regarding the timeframe to request continuation of benefits.
- The review of the annual delegation oversight tool used for oversight of appeals and grievances revealed that details of the standards and requirements which were evaluated were not included.
- No oversight tool was received for behavioral health. The Optumhealth Credentialing Program for 2013 received in the desk materials did not reflect any specific credentialing requirements for MS. Evidence of annual monitoring for credentialing/ recredentialing delegation was received but a review of the tools only showed NCQA requirements and no information specific to MS requirements.
- Many of the tools used for credentialing/recredentialing oversight did not list Medicaid in the Audit Findings tab, section "Product(s) supported by delegate".

Comparative Data

A comparison review of the scored standards by review category for the previous EQR conducted by CCME in 2012 with the current review results is shown in the table that follows.

TABLE 1

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Administration					
2012	25	0	0	0	25
2013	25	0	0	0	25

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Provider Services					
2012	54	11	4	0	69
2013	46	3	20	0	69
Enrollee Services					
2012	27	6	4	0	37
2013	30	6	1	0	37
Quality Improvement					
2012	14	1	0	0	15
2013	15	0	0	0	15
Utilization Management					
2012	24	15	0	0	39
2013	28	5	6	0	39
Delegation					
2012	1	1	0	0	2
2013	1	1	0	0	2
State-Mandated Services					
2012	3	0	0	1	4
2013	3	0	1	0	4

Recommendations for Improvement

CCME made the following recommendations that UnitedHealthcare Community Plan - Mississippi should implement to improve their processes and comply with state and federal requirements.

- When standard operating procedures define a process, they should be referenced in the applicable policy.
- The MS credentialing/recredentialing requirements should be included in the UnitedHealthcare Credentialing plan and any applicable policies.
- Proof of the following information should be included in the credentialing and recredentialing files.
    - Disclosure of ownership forms.
    - A copy of the license or proof of the license verification.
    - A copy of the Drug Enforcement Administration (DEA)/ Controlled Dangerous Substances (CDS) certificate or proof of the DEA/CDS verification.
    - If board certification is indicated by the provider, include proof of the board certification verification.
    - Copy of the malpractice insurance face sheet.

    - Files should contain a copy of the original attestation with signature. Electronic re-attestments from CAQH are acceptable as long as a copy of the original signature is in the file.
    - Proof of queries for the System for Award Management (SAM), National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), and Mississippi State Board for the specific discipline.
    - Hospital privileges should be verified for all practitioners. For practitioners without hospital privileges a plan for admitting patients should be included.
    - Proof of verification of Clinical Laboratory Improvement Amendments (CLIA) certificates/waivers should be in the files for all providers that indicate they perform laboratory services. If the Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services and include that documentation in the file.
    - Site assessments should be performed for initial credentialing of MS practitioners.
- Include any provider credentialing/recredentialing discussions in the PAC meeting minutes.
- Correct page five of policy NQM-056, Ongoing Monitoring of Office Site Quality, to reflect 45 days.
- Ensure the GEO Access reports reflect the two PCP criteria for measuring the network.
- Address Behavioral Health standards that comply with contract guidelines in a policy and include the guidelines in the Provider Manual.
- Review the web links for the practice guidelines to ensure they are actively working.
- Implement interventions to address the low results of the CCME conducted Provider Access and Availability Study.
- Improve documentation for the provider satisfaction survey and validity and reliability should also be demonstrated.
- Implement interventions to increase the response rate in both the provider satisfaction survey and the consumer satisfaction survey.
- Update policies, attachments, riders, and any other applicable documents to include all enrollee responsibilities found in the *DOM Contract, Section 4.10*.
- Correct the following errors in the MS Can Resource Guide:
    - Remove the limit on physician services for ER visits.
    - Correct the typographical error found on page 23 regarding an 11 Mississippian provider.
    - Correct the timeframe for urgent appointments found on page 16.
- The following corrections are needed in the Enrollee Handbook:
    - Add information to the Enrollee Handbook regarding the process for notifying enrollees of provider terminations.
    - Include information that family planning services can be obtained from any approved Medicaid provider, even if that provider is not part of the UHC network.
- Update the printed Provider Directory with alternate languages spoken by providers.
- Correct policies MBR 8a, page two, and MBR 17, page two, to reflect the correct requirement for member notification of significant changes to services, benefits, or processes used to access benefits.
- Update policy MBR 9 to contain complete language regarding disenrollment for both mandatory and voluntary enrollees. This language can be found in the *DOM Contract, Section 4.1 (a) and (b).*
- Regarding grievances, the following corrections are needed:

    - Add the definition of a grievance to policy MBR 13 and any other applicable documents.
    - Correct the timeframe for resolution and notification of a grievance in policy MBR 13.
    - Correct the timeframe for notification of an extension for a grievance when the extension is not requested by the enrollee in policies MBR 13 and MBR 13a.
- Correct the timeframe for requesting a State Fair Hearing in policy MBR 13, in the UHC appeal upheld resolution letter, and in the UBH appeal upheld resolution letter.
- Develop a process to ensure that grievances are accurately recorded on the grievance log.
- The following updates are needed in the UM Program Description:
    - A description of the mechanisms used to detect and document over- and underutilization.
    - Documentation of the process for making utilization review criteria available to providers.
    - Documentation of timeliness requirements for UM determinations and notifications.
    - A description of the processes used for both enrollee and provider appeals.
- Update policies COV 2a and COV 3a with the most current review and approval date.
- The following corrections are needed in policy UCSMM.06.19:
    - Correct the error regarding suspending cases when requested information is not received.
    - Correct the timeframe given for requested information to be provided on page two, item D (3) (ii).
    - Correct the reference to requesting information from the consumer or the consumer's representative.
- Correct the timeframe for requesting appeals in the document titled "Your Appeal Rights".
- Add the definition of an action to the UHC website glossary.
- Update the following documents with the full definition of an action found in the *DOM Contract, Section 7.3*:
    - Policies MBR 5a, MBR 13a, and MBR 14
    - The Enrollee Handbook
    - The MS CAN Resource Guide
- Correct the timeframe for notification of a denial of an expedited appeal request in policy MBR 14.
- Correct the discrepancies in the timeframes for resolution of an appeal when an expedited appeal request is transferred to the standard appeal process in policies MBR 14 and MBR 5a.
- Include both the pre-service and post-service timeframe for appeals resolutions in the following documents:
    - The MS CAN Resource Guide
    - The UBH policy titled "Member Appeals and Grievances of Non-Coverage Determinations
    - The notice of action letter attachment titled "Your Appeal Rights"
- Include both the pre-service and post-service appeal resolution timeframes in all documents, including:
    - The MS CAN Resource Guide
    - The UBH policy titled "Member Appeals and Grievances of Non-Coverage Determinations"
    - The initial denial letter attachment titled "Your Appeal Rights"
- Delete the paragraph on page 27 of the Enrollee Handbook that fails to include both the pre-service and post-service timeframe for resolution of appeals.

- Choose the timeframe that will be used for pharmacy appeals, and ensure that the chosen timeframe is documented accurately throughout policy RX-22.
- Correct the errors in the expedited appeal resolution timeframe in the following documents:
    - Policy MBR 5a
    - The Provider Manual, page 32
    - Policy RX-022
- Add information regarding the extension of appeal resolution timeframes to the MS CAN Resource Guide.
- Add the timeframe for notifying enrollees of an extension of an expedited appeal to policy MBR 5a.
- Correct the timeframe for notifying enrollees of plan-requested appeal extensions in policy MBR 13a.
- Correct the timeframe for requesting a State Fair Hearing in the UBH appeal uphold letter.
- Correct the timeframe to request continuation of benefits in the Enrollee Handbook, policy MBR 13a, the UBH policy titled “Member Appeals and Grievances of Non-coverage Determinations, the initial denial letter, the reduction in service letter, the document titled “Your Appeal Rights” that is attached to the UBH medical necessity denial letter, the UHC appeal upheld letter, and the UBH appeal uphold letter.
- The following documents should be corrected to indicate that all appeals can be requested before, at the same time as, or after a plan level appeal as required in the *DOM Contract, Section 7*:
    - The UBH policy titled “Member Appeals and Grievances of Non-Coverage Determinations
    - The UBH policy titled “Management of Behavioral Health Benefits”
- Update the delegation oversight tools to ensure they reflect the actual standards being evaluated and that those standards are the same requirements that UHC is being held to as an organization.
- Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which may include validation of encounter data, administration and validation of member and provider surveys, calculation of additional performance measures, and conduct performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; comparative information from previous reviews; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

Introduction

On January 1, 2011, the Mississippi Division of Medicaid (DOM) established the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Mississippi Medicaid beneficiaries. The goals of the program are to improve access to needed medical services, improve quality of care, and improve program efficiencies and cost effectiveness. The Mississippi Division of Medicaid has contracted with UnitedHealthcare Community Plan - Mississippi to provide services to individuals enrolled in the MississippiCAN Program.

In June 2012, DOM contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all Coordinated Care Organizations (CCO) participating in the MississippiCAN Program. The purpose of this review was to determine the level of performance demonstrated by UnitedHealthcare Community Plan - Mississippi (UHC) since the EQR was completed in 2012.
Goals of the review were:

1. To determine UnitedHealthcare's compliance with service delivery as mandated in the contract with DOM.
2. To evaluate the status of deficiencies identified during the 2012 annual review and any ongoing corrective action taken to remedy those deficiencies.
3. To provide feedback on potential areas for further improvement. The overriding goal of the annual EQR process is to ensure that contracted health care services are actually being delivered and are of good quality.

Process

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.
On February 3, 2014, CCME sent notification to UnitedHealthcare Community Plan - Mississippi that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow UnitedHealthcare to ask questions regarding the EQR process and the desk materials being requested. The teleconference was held on February 14, 2014 with UnitedHealthcare, CCME, and DOM in attendance.

The review consisted of two segments. The first was a desk review of materials and documents received from UnitedHealthcare on March 4, 2014 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs.

The second segment was an onsite review conducted on May 14th, 15th, and 16th at the UnitedHealthcare office located in Ridgeland, Mississippi. 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 UnitedHealthcare's administration and staff; and a file review of denials, appeals, utilization approvals, case management, credentialing, recredentialing and grievances. At the conclusion of the onsite review, an exit conference was held to discuss preliminary evaluation results and address areas of concern. All interested parties were invited to the entrance and exit conferences.

Findings

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between UnitedHealthcare and DOM. Strengths and weaknesses are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), or the standard was not evaluated (Not Evaluated) and are recorded on the tabular spreadsheet. (Attachment 4)

I. ADMINISTRATION

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance and confidentiality. An organizational chart received in the desk materials designates key personnel and the Member Services Manager position was showing as vacant. Onsite discussions confirmed the position has been filled and overall staffing levels appear to be sufficient to meet the needs for their enrollees. Jocelyn Chisholm Carter serves as chief executive officer and president for the Mississippi plan. Dr. Deirdre Phillips is licensed in Mississippi and serves as the medical director. Dr. Phillips provides the clinical oversight for health plan staff and chairs the Provider Advisory Committee (PAC) and the Healthcare Quality Utilization Management (HQUM) Committee.

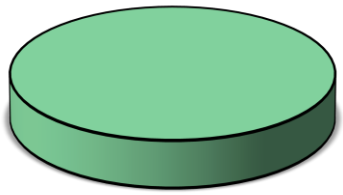
The majority of the policies utilized by UHC Community Plan - Mississippi are national policies that have been adopted by the plan. Many of the national policies discuss processes in general terms with

little information specific to the MS plan. Onsite discussion confirmed that UHC MS is in the process of reviewing all the policies and implementing local policies when the national ones do not address local guidelines. The plan uses standard operating procedures to define many of their processes and CCME suggested that the policies should reference the applicable standard operating procedure.

As part of the MS EQR activities, CCME performed an evaluation of the Information System Capabilities Assessment (ISCA) and other associated documentation provided by UnitedHealthcare (UHC). Based on the contents of the ISCA and the additional documentation submitted, we evaluated UHC's ability to handle and process claims appropriately and in a timely manner, meet the state guidelines for the delivery of health care services, collect health care data securely and accurately, and provide reports on those activities as required by DOM. UHC's systems function well for their intended purposes and appear to be capable of delivering the required performance. CCME's review found UHC's information systems capabilities to fully meet the ISCA specifications.

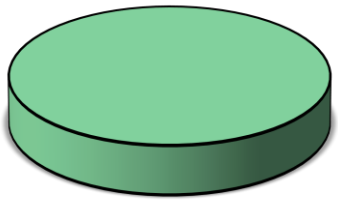
UnitedHealthcare continues to meet all the requirements in the Administration section of the EQR as shown in the charts that follow.

2012 RESULTS



Met – 100%

2013 RESULTS



Met – 100%

STRENGTHS

- The Member Services Manager position has been filled and overall staffing levels appear to be sufficient to meet the needs of enrollees.
- UHC has detailed processes, policies, and procedures in place to ensure that claims are handled in a timely and accurate manner.
- UHC does an extensive analysis of the demographics and enrollment of their members.
- Systems, plans, and processes are in place to ensure that virtually any disaster scenario would be a fully recoverable event.
- CCME's review found UHC's information systems capabilities to fully meet the ISCA specifications.

II. PROVIDER SERVICES

A review of all policies and procedures, the provider agreement, provider training and educational materials, the provider network information, credentialing and recredentialing files, and practice guidelines was conducted for Provider Services. Dr. Deirdre Phillips, medical director, locally reviews

all applications for credentialing and recredentialing. If the files are clean, they are approved and later presented to the local Provider Advisory Committee (PAC). If there are issues, Dr. Phillips renders a recommendation and the files are referred to the National Credentialing Committee (NCC) for review and discussion. The results are then presented to the local Provider Advisory Committee (PAC) which is chaired by Dr. Phillips. The NCC meets at least monthly and the PAC meets on a quarterly basis. A quorum is met for both committees with a minimum of 51 percent of voting members in attendance.

UnitedHealthcare utilizes the national 2013-2014 Credentialing Plan to define the credentialing and recredentialing process and guidelines for licensed independent practitioners and facilities. A state specific rider addresses the requirements for MS; however, this rider has not been updated. In the previous EQR, recommendations were made to implement or update the state rider with MS specific requirements, and to date many of the recommendations were never corrected. A review of the credentialing and recredentaling files reflected issues that had been addressed in the previous EQR. Details of the deficiencies are explained in the weaknesses section that follows and in Attachment 4 of this report.

PROVIDER SATISFACTION SURVEY VALIDATION

UnitedHealthcare performed a provider satisfaction survey administered by the Center for the Study of Services (CSS), a survey vendor. As a part of this EQR, this survey was validated using the EQR Protocol 5, Validation and Implementation of Surveys (*version 2.0, September 2012*). The survey met the CMS protocol requirements and was found to be valid. In the table that follows we have identified areas that should be corrected to improve the survey documents and process.

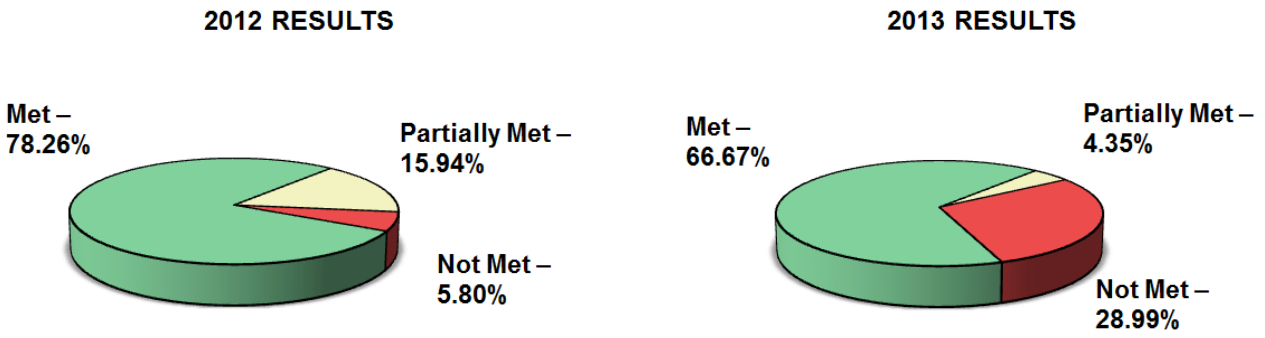
Section	Reasoning	Recommendation
Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	UnitedHealthcare used a survey that they developed. There is no documentation on how the survey was developed or if input from industry experts and/or focus groups was received. Also, there is no documentation for face validity, content validity, construct validity, or predictive validity.	Document the details of how the survey was developed and include the reliability of the survey instrument. Also, input from industry experts and/or focus groups should be considered.
Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	Survey reliability is considered each year through review of previous year results and trends to ensure consistency in the measurement and how results are being used. There is no documentation of test/re-test reliability studies.	Conduct and report test/re-test studies.

Section	Reasoning	Recommendation
Review whether the sample size is sufficient for the intended use of the survey. Include acceptable margin of error and level of certainty required.	A sample size of 1200 is standard approach for UnitedHealthcare provider survey processes. This sample size represents over 25 percent of targeted survey participants. The level of certainty and acceptable margin of error was not documented.	Document the level of certainty and acceptable margin of error.
Review that the procedures used to select the sample were appropriate and protected against bias.	Oversampling of PCPs is deliberately applied as a mechanism for promoting results that are representative of providers that regularly see UnitedHealthcare members.	Include details on the strata and how the strata are analyzed.
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	The 2013 response rates increased to 9.96 % from 6.06 % in 2012. Survey communication is directed to physicians, but actual respondents include a variety of provider entity roles: physicians (61%), office/practice managers (23%), and other practice support staff (16%). A total of 108 completed surveys were returned. The response rate was low. The documentation does not address the impact of the low response rate on the generalizeability of the survey findings. The documentation does not address the generalizeability of the survey findings and the impact of a variety of provider entity roles on generalizeability of the survey findings. Also, the documentation does not address the impact of oversampling of primary care physicians in the survey.	Include in the documentation a detailed assessment of the response rate and bias, and implications of the response rate for the generalizability of the survey findings. Include a discussion of the representativeness of the sample.

Section	Reasoning	Recommendation
Identify the technical weaknesses of the survey and its documentation.	UnitedHealthcare created their own survey instrument. They bear the responsibility to demonstrate that the survey instrument is valid and reliable. The documentation lacks a demonstration of validity and reliability. The survey had a poor response rate.	Document the validity and reliability of the survey instrument. Conduct tests to assess the validity and reliability of the survey instrument. Include input from survey experts and /or focus groups. Improve the response rate. In the survey solicitation consider providing feedback from previous surveys and how the plan addressed the concerns of providers. Use telephone follow-up of non-responders.
Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 9.96 %. This is lower than the CAHPS target response rate of 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample.	Focus on strategies that promote high response rates.

Details of the validation of the provider satisfaction survey can be found in the *CCME EQR Validation Worksheets,* Attachment 3.

The chart below shows an 11.59 percent reduction in Met scores for the standards in the Provider Services section.



Percents may not total 100% due to rounding

TABLE 2: PROVIDER SERVICES

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Partially Met	Not Met
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Not Met
	Current valid license to practice in each state where the practitioner will treat enrollees	Met	Not Met
	Valid DEA certificate and/or CDS Certificate	Met	Not Met
	Professional education and training, or board certification if claimed by the applicant	Met	Not Met
	Malpractice claims history	Partially Met	Not Met
	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Not Met
	Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)	Met	Not Met
	Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)	Met	Not Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Not Met	Partially Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Not Met
	Current valid license to practice in each state where the practitioner will treat enrollees	Met	Not Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Credentialing and Recredentialing	Valid DEA certificate and/or CDS Certificate	Met	Not Met
	Board certification if claimed by the applicant	Met	Not Met
	Malpractice claims since the previous credentialing event	Partially Met	Not Met
	Practitioner attestation statement	Met	Not Met
	Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Not Met
	Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)	Met	Not Met
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the enrollees assigned	Partially Met	Met
	Enrollees have a PCP located within a 30-mile radius or travel no more than 30-minutes of their residence. For rural regions, Enrollees have a PCP located within a 60-mile radius or travel no more than 60-minutes of their residence	Met	Partially Met
	The sufficiency of the provider network in meeting enrolleeship demand is formally assessed at least biennially	Partially Met	Met
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers.	Partially Met	Met
Primary and Secondary Preventive Health Guidelines	The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO enrollees to providers	Partially Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO develops clinical practice guidelines for disease and chronic illness management of its enrollees 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	Partially Met	Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Practitioner Medical Records	The CCO formulates policies and procedures outlining standards for acceptable documentation in the enrollee medical records maintained by primary care physicians	Partially Met	Met
	The CCO ensures that the enrollees' medical records or copies thereof are available within 14 business days from receipt of a request to change providers	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

PROVIDER ACCESS AND AVAILABILITY STUDY

As a part of the annual EQR process for UnitedHealthcare, a provider access study was performed focusing on primary care physicians. A list of current providers was given to CCME by the plan, from which a population of 1173 unique PCPs was found. A sample of 295 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that UnitedHealthcare members have with the contracted providers.

Calls were successfully answered 54 percent of the time by personnel at the correct practice which estimates to between 51 and 56 percent for the entire population. For those not answered successfully, 24 percent of the time (estimates to 22 to 26 percent for the entire population) the caller was informed that the physician was not at that phone number or was no longer at that practice. Out of the successful calls, 74 percent (71, 77) of the providers indicated they specifically accept UnitedHealthcare.

Of those that said they accept the plan, 90 percent (87, 92) of the providers responded they are accepting new Medicaid patients. When asked about any screening process for new patients, 31 percent (26, 36) indicated that an application or medical record prescreen was necessary. When the office was asked about the next available routine appointment, 75 percent (72, 79) of the appointment answers met within Mississippi contract requirements.

STRENGTHS

- Physician Performance Profiles are supplied to practitioners so that they can review their quality performance and utilization data as compared to their peers within the state.
- The provider portal of the UHC website contains detailed information for providers including educational materials, forms, bulletins, newsletters and the Provider Manual.
- UHC has adopted a wide variety of preventive and clinical practice guidelines and they post the approved guidelines on their website for easy access.

WEAKNESSES

- The following information was not included in the credentialing/recredentialing process and not addressed in the MS rider. Many of these issues were mentioned in the previous EQR and not corrected.
    - A copy of the malpractice insurance coverage face sheet and CLIA Certificates or Certificates of Waiver for practitioners that indicate they bill laboratory services on the application should be in the file. (A printed copy of a CLIA website search is acceptable.)
    - Office site visits should be conducted during the initial credentialing and evidence of the site review included in the credentialing file.
    - Follow-up site visits should be conducted of offices which received member complaints within 45 calendar days. Include evidence of the follow-up visit in the credentialing file.
    - For Nurse Practitioners (NP) that are acting as PCPs, confirm the plan for admitting patients. Also, under the new contract that will be implemented in 2014, the plan must verify that NPs acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.
    - Address Disclosure of Ownership forms in the credentialing/recredentialing process.
    - A copy of the signed attestation should be in the file. If using CAQH, a copy of the electronic re-attestation page is acceptable if a copy of the original signed attestation is included in the file.
    - Proof of primary/secondary source verifications (i.e. license, DEA/CDS, board certification, if applicable) and proof of queries (NPDB, SAM, OIG, State Sanctions) must be in the file. A printed copy of website searches is acceptable.
- Credentialing and recredentialing files reviewed onsite had the following issues:
    - Disclosure of ownership forms was not provided.
    - The files indicated electronic verification of the license but proof of the license verification was not in the files.
    - The files indicated electronic verification of the DEA but proof of the DEA verification was not in the majority of the files.
    - Electronic searches were performed when the provider indicated board certification or when the application section was not completed, but proof of the search was not included in the files.
    - Proof of the malpractice insurance was inconsistent. Several of the files reviewed had copies of the malpractice insurance in the file, but some files were checklist verified or used the attestation to meet the verification, and proof of the insurance was not in the files.
    - Files reflected current copies of the CAQH electronic signature attestation page, but only one file contained a copy of the original signed attestation showing what the provider originally attested to.
    - While all the files reviewed had proof of the NPDB queries in the file, proof of the other required queries were not in the files but only indicated on the checklist.
    - Proof of CLIA certificates/waivers was not in the recredentialing files for the providers that indicated on the application they perform laboratory services. Also, this information was not included as an item on the recredentialing checklist.

    - Hospital privileges were not appropriately verified in one credentialing file and one recredentialing file.
    - Office site visits were not conducted during the initial credentialing.
- Policy NQM-056, Ongoing Monitoring of Office Site Quality, states that the site visit vendor performs the site visit review within 45 calendar days of the receipt of a complaint on page three, but a 60 day timeframe is listed on page five.
- GEO Access reports reflected the standard of one provider within 30 miles for urban and one within 60 miles for rural areas. The required standard is two PCPs.
- Access standards for Behavioral Health are not addressed in a policy and are not mentioned in the Provider Manual.
- A few of the website links for the practice guidelines listed on the UHC website were not active.
- Results of the Provider Access and Availability Study conducted by CCME continued to be low in the areas of calls being answered successfully by personnel at the correct practice (54%) and the reason for unsuccessful calls was because the physician was not at the practice or phone number listed (24%).
- Documentation for provider satisfaction survey is not as extensive as the documentation for the CAHPS survey.
- The provider satisfaction survey has low response rates.
- Provider satisfaction survey lacks demonstrated validity and reliability.

III. ENROLLEE SERVICES

The review of Enrollee Services included policies and procedures, enrollee rights, enrollee orientation and educational materials, enrollee satisfaction, and the processes for handling grievances and practitioner changes. The Member Services department is available to enrollees Monday through Friday, 8:00 a.m. – 6:00 p.m. The NurseLine is also available 24 hours per day to assist enrollees. Within 14 days of enrollment, new enrollees receive a welcome packet that includes an introductory letter, ID card, Provider Directory, and Enrollee Handbook. Enrollees can also access a Provider Directory on the Plan's website which is updated weekly. The Enrollee Handbook is detailed and contains sufficient information for enrollees to navigate the plan.

Most of the issues identified during this review involved discrepancies in the policies and other program materials. Some of these issues involved the enrollee's responsibilities, how the enrollee is notified of Plan changes, alternate languages spoken by providers, the disenrollment process and grievances. Details are discussed in the weaknesses section below.

Even though several discrepancies were identified with the grievance policies, the health plan is handling grievances appropriately. Onsite review of grievance files confirmed that grievances are reviewed by appropriate staff and referred to the Quality Improvement department when there is a possible quality of care or quality of service issue. Grievances are appropriately monitored, tracked, trended, and analyzed for potential quality improvement opportunities. A review of the grievance log revealed that the number of grievances recorded on the log was significantly different than the number of grievances reported in the 2013 Quality Improvement Evaluation. CCME recommends that processes for documenting grievances be established to ensure that all grievances are captured on the log.

ENROLLEE SATISFACTION SURVEY VALIDATION

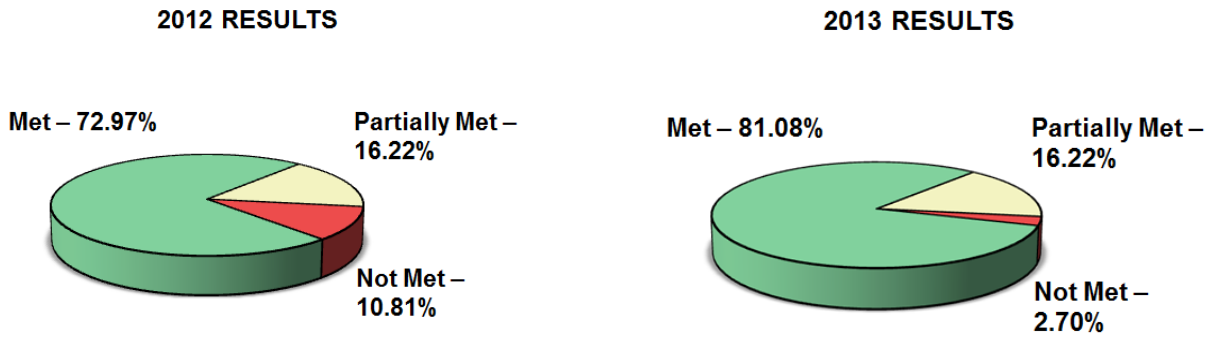
An enrollee satisfaction survey was performed on behalf of UnitedHealthcare by the Center for the Study of Services (CSS), an NCQA-certified CAHPS® vendor, using the CAHPS® 5.0H instrument. As a part of this EQR, the survey was validated using the CMS protocol for Administering or Validating Survey (*Final Protocol Version 2.0, September, 2012*).

The survey met the CMS protocol requirements and was found to be valid. In the table that follows we have identified areas that should be corrected to improve the survey documents and process.

Section	Reasoning	Recommendation
Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	Sample Size: Adult Survey: 1890 Child Survey: 2310 The acceptable margin of error and level of certainty were not included.	Include in the documentation the acceptable margin of error and the level of certainty required.
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	The overall response rate is 34.15% for the adult survey and 22.03% for the child survey. This is lower than the CAHPS target response rate of 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample.	Focus on strategies that promote high response rates. In the solicitation letter for the survey, include feedback to the consumer from previous surveys. Include the Plan's response to areas of dissatisfaction.
Identify the technical weaknesses of the survey and its documentation.	Documentation for the sample size does not include the acceptable margin of error or the level of certainty required. The response rate was lower than CMS's recommendation of between 40% and 50%.	Include in the documentation the acceptable margin of error and the level of certainty required. Focus on strategies that promote high response rates.
Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 34.15% for the adult survey and 22.03% for the children with chronic conditions survey. This is lower than the CAHPS target response rate of 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample.	Focus on strategies that promote high response rates.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets located in Attachment 3* of this report.

The chart below shows 81.08 percent of the standards in the Enrollee Services section were scored as Met. This is an improvement of 8.11 percent from the previous EQR. The percentage of standards scored as Not Met decreased from 10.81 to 2.70 percent.



Percents may not total 100% due to rounding

TABLE 3: ENROLLEE SERVICES

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Enrollee Rights and Responsibilities	The CCO formulates and implements policies outlining enrollee rights and responsibilities and procedures for informing enrollees of these rights and responsibilities	Partially Met	Met
	All Enrollee Responsibilities are included+	Met	Partially Met
Enrollee CCO Program Education	Enrollees are informed in writing within 14 days from CCO's receipt of enrollment data from the Division of all benefits to which they are entitled Limits of coverage, maximum allowable benefits and claim submission procedures; includes that no cost is passed on to the enrollee for OON services; Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services Policies and procedures for notifying enrollees affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers 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 Additional information as required by the contract and by federal regulation	Partially Met	Not Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Enrollee CCO Program Education	Enrollees are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Not Met	Partially Met
Enrollee Disenrollment	Enrollee disenrollment is conducted in a manner consistent with contract requirements	Met	Partially Met
Enrollee Satisfaction Survey	The CCO reports the results of the enrollee satisfaction survey to providers	Not Met	Met
Grievances	The procedure for filing and handling a grievance	Partially Met	Met
Grievances	Timeliness guidelines for resolution of the grievance as specified in the contract	Not Met	Partially Met
	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Partially Met	Met
	The CCO applies the grievance policy and procedure as formulated	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- The Healthy First Steps program provides education and support during pregnancy, as well as assistance with finding community services such as WIC, behavioral health care and social services. This program is positively impacting babies born to enrollees who participate in the program.

WEAKNESSES

- Enrollee responsibilities are detailed in Attachment A of policy NQM-051, Members Rights and Responsibilities, and in its associated rider, NQM-051 Rider-MS 1; however, all enrollee responsibilities specified in the *DOM Contract, Section 4.10,* are not included. The missing responsibilities include:
    - The responsibility to pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services.
    - The responsibility to show courtesy and respect to providers and staff.
- The MS CAN Resource Guide is used for internal training and reference. Several issues were identified with documentation in the MS CAN Resource Guide, including:

- A limit of six per calendar year for physician services for ER visits was documented on page 20. Onsite discussion confirmed that this is incorrect and there is no limit on physician services for ER visits.
- Page 23 contains the following typographical error, which could lead to confusion for staff: "If you cannot find an 11 Mississippian provider that meets your needs, call Member Services at 1.877.743.8731."
- Page 16 contains documentation that appointments for urgent (but not emergent) care are required within 48 hours. The *DOM Contract, Section 5.3*, requires appointments for urgent care within one day.

- Issues identified with information in the Enrollee Handbook include:
  - The *DOM Contract, Section 4.3*, specifies that within 14 days of enrollment, enrollees must be notified that they will be given written notice of a provider termination within 15 days. There is no mention in the Enrollee Handbook that members will be notified of provider termination from the network or the timeframe and method of notification.
  - There is no documentation in the Enrollee Handbook of enrollees' right to obtain family planning services from any approved Medicaid provider, regardless of whether they are part of the UHC network of providers. This is a requirement of the *DOM Contract, Section 4.6 (f) (i).*
- Although both the Enrollee Handbook, page six, and the MS CAN Resource Guide, page 15, indicate that alternate languages spoken by providers would be included in the Provider Directory, the printed Provider Directory does not include alternate languages spoken by providers.
- *Federal Regulation §438.10 (f) (4)* and the *DOM Contract, Section 4.3,* require written notice of significant changes to be given to enrollees at least 30 days before the intended effective date of the change. However, Policy MBR 8a, page two, and policy MBR 17, page two, state that enrollees will be notified at least 14 days before implementation of changes to covered services, benefits, or processes used to access benefits.
- Policy MBR 9 details the policy for enrollee disenrollment, but contains no distinction between mandatory and voluntary enrollees' ability to disenroll from a CCO. The policy doesn't document that the mandatory member population will be able to change plans one time only within 90 days and after the 90 day period ends, they are not able to disenroll to regular Medicaid.
- Multiple issues related to UHC's grievance process were identified, including:
  - Policy MBR 13, Plan Enrollees are Informed about Complaint and Grievance procedure, fails to define a grievance.
  - The grievance resolution timeframes documented in policy MBR 13 is incorrect:
    - Page four, item seven, indicates that the timeframe for resolution and notification of a grievance is 90 calendar days from the date of receipt.
    - Page four, item eight, lists a timeframe of 45 calendar days, but does not indicate specifically what this timeframe is for.
  - Policies MBR 13 and MBR 13a both incorrectly state that members will be notified within five business days for an extension of a grievance resolution that was not requested by the enrollee. The *DOM Contract, Section 7.2*, requires enrollee notification of the reason for an extension within two working days when the extension was not requested by the enrollee.
- The *DOM Contract, Section 7.5*, indicates that enrollees may request a State Fair Hearing within 30 days of receiving a notice of action or within 30 days of the final decision by the Plan. The following issues were noted regarding requests for State Fair Hearings:

    - Policy MBR 13 incorrectly states that enrollees must request a Medicaid Fair Hearing within 90 calendar days of receipt of UHC's notice of resolution or within 90 calendar days of receipt of UHC's notice of action.
- The number of grievances documented on the grievance log for 2013 was significantly different than the number of grievances reported in the 2013 QI Program Evaluation document.
- The response rates for both the adult and child CAHPS surveys were low, at 34.15% and 22.03% respectively.

IV. QUALITY IMPROVEMENT

The quality improvement program for UnitedHealthcare is outlined in three key documents, the Quality Improvement Program description, the work plan, and their annual evaluation. Each document demonstrates the program UnitedHealthcare has designed to evaluate, monitor, and enhance the quality of care and quality outcomes for the services and health care provided to members. The work plan identifies planned activities related to program priorities that address the quality and safety of clinical care and services. The work plan lists the tasks or topics, objectives, measures, actions, target completion, and date of committee review. The responsible owner(s) of the tasks or topics was not included on the 2013 work plan. This was discussed during the onsite and a copy of the 2014 work plan was provided which included the responsible party for each activity.

The Quality Management Committee has been established and promotes the goals and objectives of the program through oversight and approval of all quality improvement activities. The Quality Improvement Program description provided a brief overview of this committee's responsibilities, membership, and the quorum of voting members needed for each meeting. The minutes demonstrated that this committee meets at regular intervals and is well attended. The attendance, guests that attend each meeting, discussions, recommendations, and any needed follow-up are included in the minutes. Several of the guests listed as attending the meetings were noted as non-voting members on the 2013 Mississippi Committee Matrix. It was recommended that when recording committee attendance, the non-voting members should not be listed as guests. UnitedHealthcare's QI staff revised the format of the meeting minutes during the onsite visit and is now listing the non-voting members of the committee as non-voting participants.

UnitedHealthcare recognized that their results of the Healthcare Effectiveness Data and Information Set (HEDIS®) were not meeting some of the goals set by the health plan and the Division of Medicaid. Clinical Practice Consultants were hired to develop educational tools and complete provider visits to educate the physicians on the HEDIS® measures and rates.

CCME conducted a validation review of the performance measures following the protocols developed by CMS. UHC uses MedMeasures™ by ViPS®, an NCQA-certified HEDIS® software vendor, for their performance measures. The plan was found to be fully compliant and met all the CMS validation requirements for the performance measures.

The quality improvement projects included topics for Reducing Adult, Adolescent and Childhood Obesity; Use of Appropriate Medications for People with Asthma, Annual Monitoring for Patients on ACE/ARB Inhibitors, and Comprehensive Diabetes Care. CCME conducted a validation of these projects following the CMS protocols and the results are summarized in the table that follows.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION SCORES

PROJECT	VALIDATION SCORE
Reducing Adult, Adolescent and Childhood Obesity	119 / 124 = 96% HIGH CONFIDENCE
Use of Appropriate Medications for People with Asthma	99 / 99 = 100% HIGH CONFIDENCE
Annual Monitoring for Patients on ACE/ARB Inhibitors	105 / 106 = 99% HIGH CONFIDENCE
Comprehensive Diabetes Care	114 / 124 = 92% HIGH CONFIDENCE

All of the projects scored within the *High Confidence* range and met the CMS validation protocol. In the table that follows we have identified areas that should be corrected to improve the project documentation.

REDUCING ADULT, ADOLESCENT AND CHILDHOOD OBESITY		
Section	Reasoning	Recommendation
Methodology used for the re-measurement	The Plan switched to the hybrid methodology. The major purpose of the hybrid methodology is to increase the accuracy of the reported rates; however, it is not valid to compare those rates with the rates received through the administrative method.	Re-Measurement one should be established as the baseline so future measurements will be comparable.
ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS		
Section	Reasoning	Recommendation
Statistical evidence that any observed performance improvement is true improvement	Improvement noted from the previous measurement period was not statistically significant.	Consider revising the interventions to help boost improvement rates.
COMPREHENSIVE DIABETES CARE		
Section	Reasoning	Recommendation
Accurately and clearly presented PIP results	The reported results for measure number six, re-measurement one is not correct. The reported numerator and denominator values do not match the reported rate.	Revise the reported results for this measure to ensure they are correctly reported in the documentation.

Methodology used for the re-measurement	The Plan switched to the hybrid methodology. The major purpose of the hybrid methodology is to increase the accuracy of the reported rates; however, it is not valid to compare those rates with the rates received through the administrative method.	Re-Measurement one should be established as the baseline so future measurements will be comparable.

Details of the validation of the performance measures and focused studies may be found in the *CCME EQR Validation Worksheets,* Attachment 3.

In the Quality Improvement section 100 percent of the standards were scored as Met as illustrated in the chart that follows.

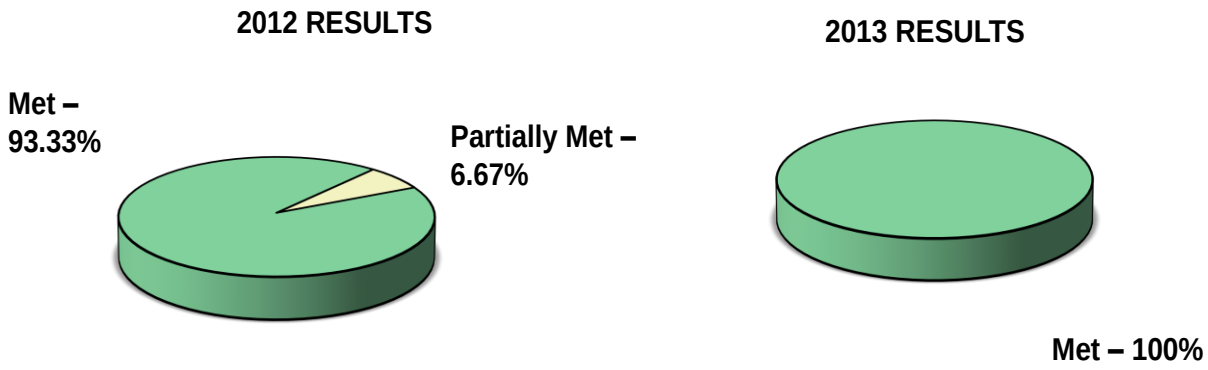


TABLE 4: QUALITY IMPROVEMENT

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Quality Improvement Projects/Focused Studies	The study design meets the requirements of the CMS protocol	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- Committees are well attended and minutes document the discussions, recommendations, and any needed follow-up.
- Clinical Practice Consultants were hired to develop educational tools and complete provider visits to educate the physicians on the HEDIS measures and rates.

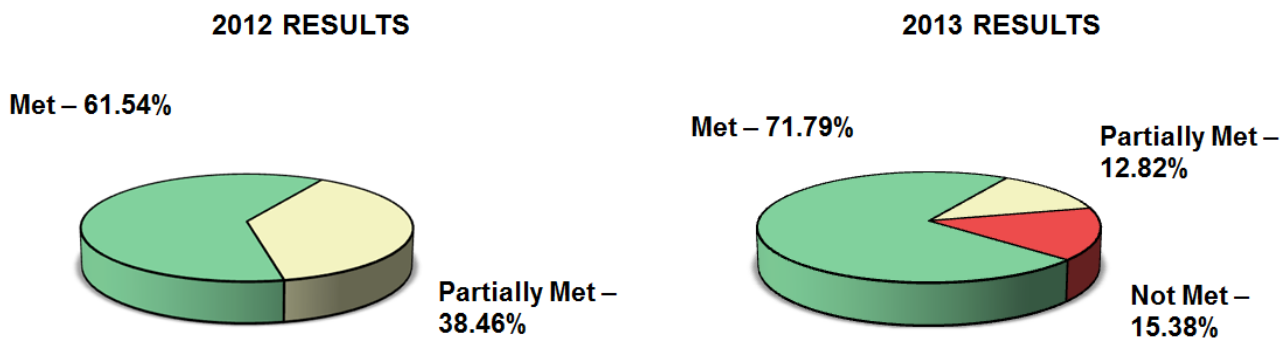
V. UTILIZATION MANAGEMENT

The Utilization Management (UM) review included a review of policies, the program description, and approval, denial, appeal, and case management files.

UHC has new strategies in an effort to decrease the number of readmissions, including use of a readmission risk assessment along with increased member outreach and referrals to case management. In late 2012, UHC began working with Health Connect to develop a pilot program with a goal of reducing readmissions for UHC members. Major components of the program include multidisciplinary care teams that provide a four week post-discharge program for hospitalized patients nearing discharge. Prior to discharge, an assessment is completed including medication reconciliation, the member's ability to self-manage their disease, and the member's access to a primary care medical home. After discharge, members are provided with a disease management plan and encouraged to visit their primary care medical home. Three weeks after discharge, members are contacted either by phone or in person and an additional face-to-face visit is made at four weeks post-discharge to assess adherence to their disease management plan. The initial evaluation of the program in the first quarter of 2013 indicated that readmission rates were reduced significantly.

Although there was an overall increase in the number of standards scored as Met from the previous EQR, deficiencies noted in this review are primarily related to errors in policies and procedures. Also, several items that were listed as deficiencies during the previous EQR have not been corrected. Specifically, items that are required to be included in the UM Program Description by the *DOM Contract, Section 6.4*, were listed as deficiencies during the previous EQR. UHC responded to the previous EQR results with a corrective action plan and indicated that those items would be added to the 2013 UM Program Description; however, the items were not included. Also, many weaknesses were found in the appeals process, particularly in the definitions of actions and appeals, timeframes for resolution of appeals, and processes for requesting State Fair Hearings and continuation of benefits. Details of these and other issues can be found in the weaknesses section that follows.

Overall 71.79 percent of the Utilization Management standards received a Met score as shown in the pie chart below. This represents an increase in Met scores of 10.25 percent from the 2012 results.



Percents may not total 100% due to rounding

TABLE 5: UTILIZATION MANAGEMENT

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Utilization Management (UM) Program	The CCO formulates and acts within policies and procedures that describe its utilization management program	Partially Met	Not Met
	Guidelines / standards to be used in making utilization management decisions	Partially Met	Not Met
	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Not Met
	The appeal process, including a mechanism for expedited appeal	Partially Met	Not Met
The Utilization Management (UM) Program	The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Partially Met	Met
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all enrollees across all reviewers	Partially Met	Met
	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Partially Met	Met
	If the CCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Partially Met	Met
	Initial utilization decisions are made promptly after all necessary information is received	Partially Met	Not Met
	Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denial of service and the procedure for appeal	Met	Partially Met
Appeals	The definitions of an action and an appeal and who may file an appeal	Met	Partially Met
	The procedure for filing an appeal	Partially Met	Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Appeals	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Not Met
	The CCO applies the appeal policies and procedures as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- The implementation of the Readmission Risk Assessment has had a positive impact on the number of hospital readmissions for UHC enrollees.
- Utilization files reviewed onsite were well organized and reflected that appropriate processes are in place, review determinations are timely, denial determinations are issued by appropriate physician reviewers, and that notifications are provided as required.
- All enrollees are screened for care management programs via a health risk assessment. Enrollees are identified for care management and other specialized programs to meet their needs. Appropriate re-screenings are done at the required intervals.

WEAKNESSES

- The UM Program Description does not include several items that are required in the *DOM Contract, Section 6.4*, including:
  - A description of mechanisms used to detect and document overutilization or underutilization of medical services,
  - Processes for making utilization criteria available to providers,
  - Documentation of timeliness requirements of UM determinations and notifications, and
  - A description of the appeals process for Mississippi enrollees and providers.
- Policies COV 2a and COV 3a were reviewed and approved in the June 2013 Health Quality and Utilization Committee meeting but the review dates on the policies were not updated.
- The following errors were noted in policy UCSMM.06.19, Information Based Clinical Review:
  - Page two, item D (iii), incorrectly states that if information has been requested but is not forthcoming within the timeframe allotted, the case may be suspended. Onsite discussion confirmed that this is an error in the policy.
  - Page two, item D (3) (ii), states that if the request is for a standard pre- or post-service review, the consumer or consumer's representative is notified of the specific information required and is given 45 days to provide the information.
- The *DOM Contract, Section 7.3 (C)*, allows appeals to be requested within 30 calendar days of receiving the notice of action. Errors in the timeframe to request an appeal were noted in the following documents:
  - The attachment to the initial notice of action letters, titled "Your Appeal Rights", indicates that appeals may be requested within 30 days from the date of the letter or action to file an appeal.
- The UHC website glossary defines an appeal but contains no definition of an action.

- The following documents do not include information that the definition of an action includes the denial for a resident of a rural area with only one CCO to obtain services outside the network:
    - Policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures
    - Policy MBR 13a, Plan Enrollees Are Informed About Complaint and Grievance Procedure
    - Policy MBR 14, Expedited Review Process
    - Enrollee Handbook, page 26
    - MS CAN Resource Guide, page 21.
- The *DOM Contract, Section 7.4 (G) (2)*, requires plans to make reasonable efforts to give the Enrollee prompt oral notice of the denial of an expedited appeal request and to follow up with a written notice within two (2) calendar days. However, Policy MBR 14, page 6, says that this written notice must be provided within 3 calendar days.
- Discrepancies were noted in the timeframe for resolution when an expedited appeal request is denied and the request is transferred to the standard appeal processing timeframe:
    - Policy MBR 14, Expedited Review Process, page six, indicates that they will be transferred to a 30-day timeframe for resolution.
    - Policy MBR 5a, page 13, indicates they will be transferred to a 45-day resolution timeframe.
- Other issues identified with the timeliness of standard appeal resolutions include:
    - UHC uses different timeframes for resolution of pre-service and post-service appeals; however, some documents don't include the pre-service resolution timeframe.
        - The MS CAN Resource Guide, page 22, lists only a 45 day timeframe for appeals.
        - The United Behavioral Health policy titled "Member Appeals and Grievances of Non-Coverage Determinations" lists only a 45 calendar day resolution requirement for appeals.
        - The initial denial letter attachment titled "Your Appeal Rights" includes only the 45 day timeframe.
    - The Enrollee Handbook, page 27, contains one paragraph that documents one resolution timeframe for appeals-45 days. The next paragraph on page 27 documents different timeframes for pre-service appeals (30 days) and standard appeals (45 days).
    - Policy RX-22, Pharmacy Grievances and Appeals, page 1, states that pharmacy appeals should follow the UHC policies and procedures; however, a reference chart on page 5 of the policy indicates that standard appeals response time is 15 calendar days and expedited appeals response time is 72 hours.
    - Although some documents correctly list the expedited appeal resolution timeframe as 3 business days, incorrect information was noted in other documents, including:
        - Policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures (page 13), does not state the timeframe for notifying enrollees of the extension when the extension is not requested by the enrollee.
        - The Provider Manual, page 32, states UHC will make reasonable efforts to give the enrollee prompt verbal notice of an expedited appeal not wholly resolved in their favor and will follow-up with a written notice of action within two calendar days.
        - Policy RX-022, Pharmacy Grievances and Appeals, contains a table on page 5 that specifies turnaround times for expedited pharmacy appeals as 72 hours. Policy MBR 5a indicates the timeframe as 3 business days for expedited appeals.

    - Regarding extensions of appeal resolution timeframes, the following issues were identified:
        - The MS CAN Resource Guide contains no information regarding extension of appeal resolution timeframes.
        - Policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures, does not state the timeframe requirement for notifying enrollees of a plan-requested extension for an expedited appeal. The policy states that written notification is required, but does not document the timeframe (page 13).
        - Policy MBR 13a, Plan Enrollees Are Informed about Complaint and Grievance Procedure, states on page 5 that enrollees will be notified of a plan-requested appeal extension within 5 business days. The *DOM Contract, Section 7.2*, requires this notification within 2 business days.
- The *DOM Contract, Section 7.5*, allows enrollees to request a State Fair Hearing up to 30 days from the date of receipt of a notice of the Action or within 30 days of the final decision by the Contractor. The United Behavioral Health appeal uphold letter states that enrollees unhappy with the decision to uphold the original denial determination may request a State Fair Hearing "within 30 days from the original notice of denial from UBH".
- Requirements for continuation of benefits pending the outcome of an appeal can be found in *Federal Regulation §438.420* and in the *DOM Contract, Section 7.3 (L)*. Errors and discrepancies were noted in multiple documents regarding the timeframe to request continuation of benefits:
    - The Enrollee Handbook, page 28, says that benefits must be requested within 10 days of the date on the Notice of Action.
    - Policy MBR 13a, page 6, states that benefit continuation must be requested within 10 business days after the notice of action is mailed.
    - United Behavioral Healthcare policy, "Member Appeals and Grievances of Non-coverage Determinations" states on page 9 that continuation of benefits must be requested within 30 days from the date on the Notice of Action.
    - The initial denial letter, the reduction in service letter, and the United Behavioral Health medical necessity denial letter state in their attachment titled "Your Appeal Rights" that continuation of benefits must be requested within 10 days of the date on the letter.
    - The UnitedHealthcare and United Behavioral Health Appeal Uphold Letters state benefits must be requested within 10 days from the date the enrollee receives the decision.
- The *DOM Contract, Section 7*, specifies that enrollees have the right to file a request for a State Fair Hearing with the Division of Medicaid upon notification of a contractor action, or concurrent with, subsequent to, or in lieu of an appeal of the contractor action. The following issues related to requests for State Fair Hearings were noted in the United Behavioral Health (UBH) policies:
    - The UBH policy titled "Member Appeals and Grievances of Non-Coverage Determinations":
        - Documents that expedited appeals may be requested for services not yet rendered at the same time as an urgent appeal to the MS DOM. The policy contains no documentation that all appeals to MS DOM (standard and expedited) may be requested, before, at the same time as, or after a plan level appeal.

- Page 6 documents that if UBH fails to make a determination and issue a notice within the timeframe requirements, an enrollee may be permitted to bypass the UBH internal appeal process and have the case reviewed by MS DOM.

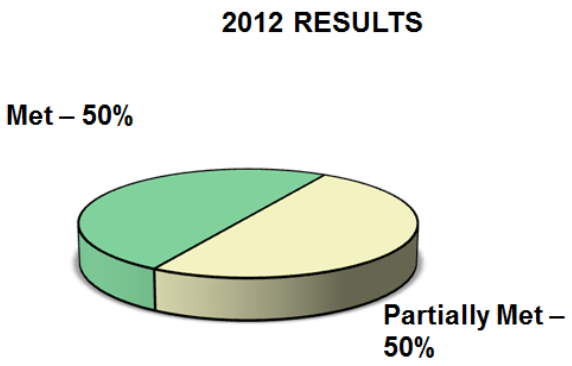
- The UBH policy titled "Management of Behavioral Health Benefits" states on page 13 that notices of action for non-coverage determinations will include information about the enrollee's right to request a State Fair Hearing through the MS DOM when the internal appeal review process has been completed."

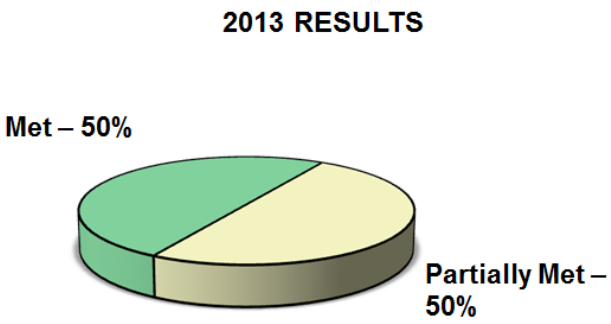
VI. DELEGATION

UnitedHealthcare has delegated contracts with the following entities: Vision Service Plan, United Dental, Optum, United C&S Prior Authorization, United Clinical Services, MHG & Physicians Corporation, Hattiesburg Clinic, Mississippi Health Partners, River Region, HubHealth, and University Physicians. The vendor list received in the desk materials also listed Appeals & Grievances and Pharmacy as delegated. A sample agreement was received in the desk materials.

Evidence of annual oversight was presented in the desk materials for the delegated entities. However, issues were identified in the oversight tools and are discussed in the weaknesses section below.

Of the two standards scored in the Delegation section, one standard received a Partially Met score as represented in the charts below.





WEAKNESSES

- A review of the oversight tools showed the following issues:
  - The review of the annual delegation oversight tool used for oversight of appeals and grievances revealed that details of the standards and requirements which were evaluated were not included. The tool includes only general statements such as "decision time standard" and "written time standard", but does not define what those standards are.
  - No oversight tool was received for behavioral health. The Optumhealth Credentialing Program for 2013 received in the desk materials did not reflect any specific credentialing

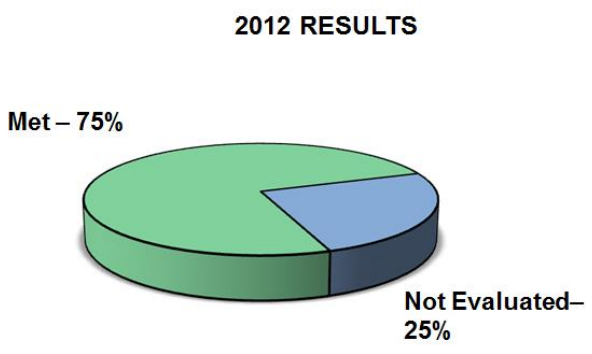
requirements for MS. In fact, Attachment B (State Specific Requirements) did not include MS.

- Evidence of annual monitoring for credentialing/ recredentialing delegation was received but a review of the tools only showed NCQA requirements and no information specific to MS requirements. The tool should include requirements for the following: proof of primary/secondary source verifications (i.e. license, DEA/CDS, board certification, if applicable, etc.) and proof of queries (NPDB, SAM, OIG, State Sanctions) must be in the file; site reviews for initial credentialing; site reviews for member complaints within 45 days instead of the 60 days listed in the tool; proof of malpractice insurance; signed attestation and current re-attestment if using CAQH; copy of CLIA certificate/waiver; hospital privileges should be addressed for nurse practitioners acting as PCPs; and delegates should be collecting ownership disclosure forms for credentialing and recredentialing.
- Many of the tools used for credentialing/recredentialing oversight did not list “Medicaid” in the Audit Findings tab, section “Product(s) supported by delegate”.

VII. STATE-MANDATED SERVICES

UnitedHealthcare provides enrollees all of the benefits specified in the contract and ensures that providers are compliant with providing required immunizations and EPSDT services.

The standard in this section that was scored as Not Met is related to deficiencies from the previous EQR not being corrected. There were six deficiencies in the area of credentialing and recredentialing processes, policies, and files that were not corrected; one deficiency was not corrected related to information in the Provider Directory; and six deficiencies were not corrected in the information documented in the Utilization Management Program Description, the timeframe for submission of additional information in policy UCSMM.06.19, and in the documentation of pre-service and post-service appeals resolution timeframes in several documents.



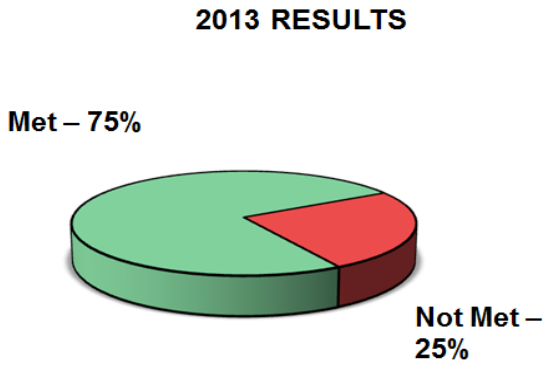


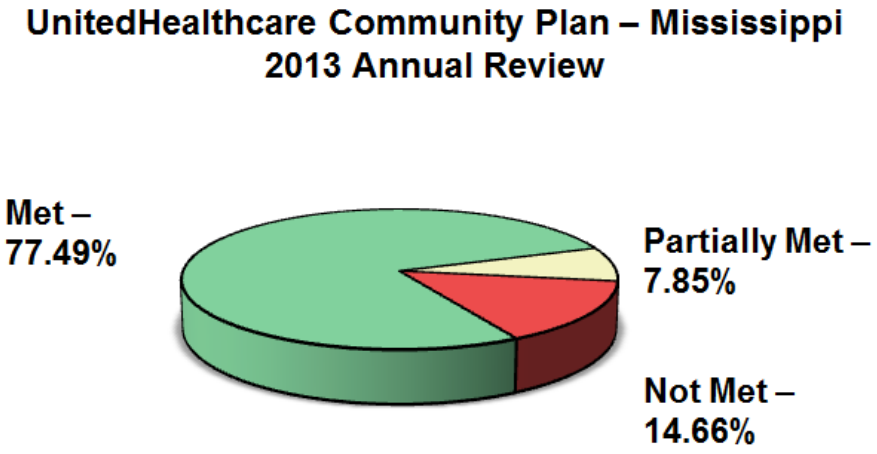
TABLE 6: STATE-MANDATED SERVICES

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
State-Mandated Services	The CCO addresses deficiencies identified in previous independent external quality reviews	Not Evaluated	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

Summary and Recommendations

The findings of the 2013 EQR indicate that UnitedHealthcare Community Plan - Mississippi improved their percentage of met scores in the area of Enrollee Services, Quality Improvement, and Utilization Management. Of concern was the health plan did not fully implement the corrective action plan that addresses the deficiencies identified during the previous EQR. As a result, several standards received a Not Met score. Overall, UHC received a Met score for 77.49 percent of the standards for the 2013 External Quality Review. Not Met scores increased by 10.47 percent from the prior EQR.



CCME recommends that UnitedHealthcare implement the following to improve their processes and comply with all federal regulations and contract requirements.

1. When standard operating procedures define a process, they should be referenced in the applicable policy.

2. The MS credentialing/recredentialing requirements should be included in the UnitedHealthcare Credentialing plan and any applicable policies.

3. Proof of the following information should be included in the credentialing and recredentialing files.

a. Disclosure of ownership forms.
b. A copy of the license or proof of the license verification.
c. A copy of the Drug Enforcement Administration (DEA)/ Controlled Dangerous Substances (CDS) certificate or proof of the DEA/CDS verification.
d. If board certification is indicated by the provider, include proof of the board certification verification.
e. Copy of the malpractice insurance face sheet.
f. Files should contain a copy of the original attestation with signature. Electronic re-attestments from CAQH are acceptable as long as a copy of the original signature is in the file.
g. Proof of queries for the System for Award Management (SAM), National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), and Mississippi State Board for the specific discipline.
h. Hospital privileges should be verified for all practitioners. For practitioners without hospital privileges a plan for admitting patients should be included.
i. Proof of verification of Clinical Laboratory Improvement Amendments (CLIA) certificates/waivers should be in the files for all providers that indicate they perform laboratory services. If the Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services and include that documentation in the file.
j. Site assessments should be performed for initial credentialing of MS practitioners.

4. Include any provider credentialing/recredentialing discussions in the PAC meeting minutes.

5. Correct page five of policy NQM-056, Ongoing Monitoring of Office Site Quality, to reflect 45 days.

6. Ensure the GEO Access reports reflect the two PCP criteria for measuring the network.

7. Address Behavioral Health standards that comply with contract guidelines in a policy and include the guidelines in the Provider Manual.

8. Review the web links for the practice guidelines to ensure they are actively working.

9. Implement interventions to address the low results of the CCME conducted Provider Access and Availability Study.

10. Improve documentation for the provider satisfaction survey and validity and reliability should also be demonstrated.

11. Implement interventions to increase the response rate in both the provider satisfaction survey and the consumer satisfaction survey.

12. Update policies, attachments, riders, and any other applicable documents to include all enrollee responsibilities found in the *DOM Contract, Section 4.10*.

13. Correct the following errors in the MS Can Resource Guide:
    a. Remove the limit on physician services for ER visits.

b. Correct the typographical error found on page 23 regarding an 11 Mississippian provider.
c. Correct the timeframe for urgent appointments found on page 16.

14. The following corrections are needed in the Enrollee Handbook:
    a. Add information to the Enrollee Handbook regarding the process for notifying enrollees of provider terminations.
    b. Include information that family planning services can be obtained from any approved Medicaid provider, even if that provider is not part of the UHC network.

15. Update the printed Provider Directory with alternate languages spoken by providers.

16. Correct policies MBR 8a, page two, and MBR 17, page two, to reflect the correct requirement for member notification of significant changes to services, benefits, or processes used to access benefits.

17. Update policy MBR 9 to contain complete language regarding disenrollment for both mandatory and voluntary enrollees. This language can be found in the *DOM Contract, Section 4.1 (a) and (b).*

18. Regarding grievances, the following corrections are needed:
    a. Add the definition of a grievance to policy MBR 13 and any other applicable documents.
    b. Correct the timeframe for resolution and notification of a grievance in policy MBR 13.
    c. Correct the timeframe for notification of an extension for a grievance when the extension is not requested by the enrollee in policies MBR 13 and MBR 13a.

19. Correct the timeframe for requesting a State Fair Hearing in policy MBR 13, in the UHC appeal upheld resolution letter, and in the UBH appeal upheld resolution letter.

20. Develop a process to ensure that grievances are accurately recorded on the grievance log.

21. The following updates are needed in the UM Program Description:
    a. A description of the mechanisms used to detect and document over- and underutilization.
    b. Documentation of the process for making utilization review criteria available to providers.
    c. Documentation of timeliness requirements for UM determinations and notifications.
    d. A description of the processes used for both enrollee and provider appeals.

22. Update policies COV 2a and COV 3a with the most current review and approval date.

23. The following corrections are needed in policy UCSMM.06.19:
    a. Correct the error regarding suspending cases when requested information is not received.
    b. Correct the timeframe given for requested information to be provided on page two, item D (3) (ii).
    c. Correct the reference to requesting information from the consumer or the consumer's representative.

24. Correct the timeframe for requesting appeals in the document titled "Your Appeal Rights".

25. Add the definition of an action to the UHC website glossary.

26. Update the following documents with the full definition of an action found in the *DOM Contract, Section 7.3*:
    a. Policies MBR 5a, MBR 13a, and MBR 14.
    b. The Enrollee Handbook.
    c. The MS CAN Resource Guide.

27. Correct the timeframe for notification of a denial of an expedited appeal request in policy MBR 14.

28. Correct the discrepancies in the timeframes for resolution of an appeal when an expedited appeal request is transferred to the standard appeal process in policies MBR 14 and MBR 5a.

29. Include both the pre-service and post-service timeframe for appeals resolutions in the following documents:
    a. The MS CAN Resource Guide
    b. The UBH policy titled “Member Appeals and Grievances of Non-Coverage Determinations
    c. The notice of action letter attachment titled “Your Appeal Rights”

30. Include both the pre-service and post-service appeal resolution timeframes in all documents, including:
    a. The MS CAN Resource Guide
    b. The UBH policy titled "Member Appeals and Grievances of Non-Coverage Determinations"
    c. The initial denial letter attachment titled "Your Appeal Rights"

31. Delete the paragraph on page 27 of the Enrollee Handbook that fails to include both the pre-service and post-service timeframe for resolution of appeals.

32. Choose the timeframe that will be used for pharmacy appeals, and ensure that the chosen timeframe is documented accurately throughout policy RX-22.

33. Correct the errors in the expedited appeal resolution timeframe in the following documents:
    a. Policy MBR 5a
    b. The Provider Manual, page 32
    c. Policy RX-022

34. Add information regarding the extension of appeal resolution timeframes to the MS CAN Resource Guide.

35. Add the timeframe for notifying enrollees of an extension of an expedited appeal to policy MBR 5a.

36. Correct the timeframe for notifying enrollees of plan-requested appeal extensions in policy MBR 13a.

37. Correct the timeframe for requesting a State Fair Hearing in the UBH appeal uphold letter.

38. Correct the timeframe to request continuation of benefits in the Enrollee Handbook, policy MBR 13a, the UBH policy titled “Member Appeals and Grievances of Non-coverage Determinations, the initial denial letter, the reduction in service letter, the document titled “Your Appeal Rights” that is attached to the UBH medical necessity denial letter, the UHC appeal upheld letter, and the UBH appeal uphold letter.

39. The following documents should be corrected to indicate that all appeals can be requested before, at the same time as, or after a plan level appeal as required in the *DOM Contract, Section 7*:
    a. The UBH policy titled “Member Appeals and Grievances of Non-Coverage Determinations
    b. The UBH policy titled “Management of Behavioral Health Benefits”

40. Update the delegation oversight tools to ensure they reflect the actual standards being evaluated and that those standards are the same requirements that UHC is being held to as an organization.

41. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

UnitedHealthcare Community Plan - Mississippi

2013 External Quality Review

Attachment 1

Initial Notice

The Carolinas Center *for* Medical Excellence
100 Regency Forest Drive, Suite 200, Cary, NC 27518-8598 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

February 3, 2014

Jocelyn Chisolm Carter, Esq., Plan President
UnitedHealthcare Community Plan- Mississippi
795 Woodland Parkway, Suite 301
Ridgeland, MS 39157

Dear Ms. Carter:

This letter serves as your notification that the 2013 External Quality Review (EQR) Compliance review of UnitedHealthcare Community Plan is being initiated at this time at the request of the Mississippi Division of Medicaid (DOM). An external quality review conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with the DOM. It will include both a desk review at CCME and a multi-day onsite review at UnitedHealthcare Community Plan's office in Ridgeland, and will address all contractually required services. Please note that CCME's review methodology will include the protocols required by the Centers for Medicare and Medicaid Services for the external quality review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans.

In preparation for the desk review, the items on the enclosed list are due at CCME no later than **March 5, 2014**. The CCME EQR team plans to conduct the onsite visit at UnitedHealthcare Community Plan on **May 14, 2014 through May 16, 2014**. To prepare your organization for the upcoming review, we would like to schedule a conference call with your management staff, in conjunction with DOM, to describe our process and answer any questions you may have. Please contact me at 800-682-2650, ext. 5588 or 919-461-5588 with dates your staff will be available for this conference call.

Sincerely,

Karen Smith

Karen Smith
Project Manager

Enclosure

cc: DOM

UnitedHealthcare Community Plan - Mississippi

2013 External Quality Review

Attachment 1

Materials Requested for Desk Review

EXTERNAL QUALITY REVIEW 2013

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.
2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.
3. Current membership demographics including total enrollment, category of eligibility and distribution by age ranges, sex, and county of residence.
4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current enrollee-to-PCP ratios and enrollee-to-specialist ratios.
5. A complete list of network providers for the MississippiCAN enrollees. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.
6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.
7. A current provider list/directory as supplied to enrollees.
8. A copy of the current Compliance plan.
9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.
10. The Quality Improvement work plans for 2013 and 2014.
11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.
12. Documentation of all Performance Improvement Projects (PIPs) completed or planned as required by DOM, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc…).

    For any project using NON-HEDIS measures include the following items with your PIP documentation:
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plans IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 record sample from those abstracted charts.

c. For projects measures derived from administrative electronic systems:
    - full source code documentation of how the measure was processed and calculated for the PIP, and
    - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

13. Minutes of all committee meetings for the past twelve months for all committees reviewing or taking action on Health Plan 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 committees in #13 above, including the professional specialty of any non-staff members. Please indicate which members are voting members.
15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.
16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.
17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.
18. A complete list of all enrollees enrolled in the case management program from January 1, 2013 – December 31, 2013. Please include open and closed case management files, the enrollee's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.
19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Enrollee Services Representatives and/or Call Center personnel.
20. A copy of the enrollee handbook and any statement of the enrollee bill of rights and responsibilities if not included in the handbook.
21. A report of findings from the most recent enrollee and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.
22. A copy of any enrollee and provider newsletters, educational materials and/or other mailings.
23. A copy of the Grievance, Complaint and Appeal logs for the months of January 1, 2013 – December 31, 2013.
24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.
25. Service appointment availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards.
26. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other CCO services and covered benefits is assessed.
27. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other CCO services and covered benefits is assessed.
28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

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

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

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

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., enrollee ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);
    d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

These materials:

- **should be organized and submitted on a CD or thumb drive (any material not available electronically may be submitted hardcopy);**
- **should be submitted in the categories listed.**

UnitedHealthcare Community Plan - Mississippi

2013 External Quality Review

Attachment 2

Materials Requested for Onsite Review

External Quality Review 2013

MATERIALS REQUESTED FOR ONSITE REVIEW

Items with an * should be provided as copies that can be retained by CCME. If possible, please provide these copies on a CD/flash drive.

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

2. Credentialing files (including signed Ownership Disclosure Forms) for:
    a. Ten PCP's; (include two NPs/PAs acting as PCP)
    b. Two OB/GYNs;
    c. Two specialists;
    d. Two network hospitals; and
    e. One file for each additional type of facility in the network.

3. Recredentialing files (including signed Ownership Disclosure Forms), if applicable for:
    a. Ten PCP's; (include two NPs/PAs acting as PCP)
    b. Two OB/GYNs;
    c. Two specialists;
    d. Two network hospitals; and
    e. One file for each additional type of facility in the network.

4. Grievance and Case Management files for enrollees on the attached list.

5. Documentation of any involuntary disenrollments for cause, including documentation of counseling provided and notices issued, if applicable.

6. Appeal files for enrollees on the attached list. Please include all information related to the initial denial.

7. All files for requests for State Fair Hearings.

8. Twenty medical necessity denial files made in the months of January 2013 through December 2013. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.

9. Twenty five utilization approval files (acute care and behavioral health) made in the months of January 2013 through December 2013, including any medical information and approval criteria used in the decision.

10. * Copies of the following policies:

- NM31-UHCSb (Title unknown)
- Any policy(ies) addressing inter-rater reliability testing and/or consistent application of review criteria

11. *Copy of the Notice of Extension letter for appeals.

12. *Copy of the 2013 Quality Improvement Program Evaluation.

13. *Copy of the 2014 Quality Improvement work plan.

14. *Copies of MSCAN grievance acknowledgement and grievance resolution letter templates.

15. *Copy of the most recent report: UnitedHealthcare Community Plan of Mississippi Primary Care Physician and Specialty Physician Availability Report and Analysis – MS CAN and CHIP

16. *Organizational charts for the credentialing center (indicating which employees work with MSCAN) and the Provider Services department.

The Carolinas Center *for* Medical Excellence

UnitedHealthcare Community Plan - Mississippi

2013 External Quality Review

Attachment 3

EQR Validation Worksheets

EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Name of PIP	**USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY			
STEP 1: Review the Selected Study Topic(s)			
	Component / Standard (Total Points)	**Score**	**Comments**
1.1	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Asthma was on the state approved topic list for PIPs.
1.2	Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3	Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS® measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used a HEDIS® measure for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.

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**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Collection was through HEDIS certified software.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in their documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Not able to judge. Too early in project cycle.

9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Not able to judge. Too early in project cycle.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Not able to judge. Too early in project cycle.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not able to judge. Too early in project cycle.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	0	NA
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	**99**
Project Possible Score	**99**
Validation Findings	**100%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Name of PIP	**ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Cardio vascular disease is the leading cause of death in Mississippi. Appropriate use of ACE/ARB Inhibitors should help reduce this threat.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS® measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used a HEDIS measure for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
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**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NA**	Collection was through HEDIS certified software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in their documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The project saw an improvement of over 3 percentage points from the previous measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	The reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Improvement noted from the previous measurement period was not statistically significant. ***RECOMMENDATION*** *Consider revising the interventions to help boost improvement rates.*

STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not able to judge. Too early in project cycle.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	0	NA
5.2	0	NA
5.3	0	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	0	NA
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	**105**
Project Possible Score	**106**
Validation Findings	**99%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Name of PIP	**COMPREHENSIVE DIABETES CARE**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi Medicaid population.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS® measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Line Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used HEDIS® measures for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid Methodology
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
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**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.

6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	The reported results for measure number six, re-measurement one is not correct. The reported numerator and denominator values do not match the reported rate. The reported rate or numerator / denominator need to be corrected. ***RECOMMENDATION*** *Revise the reported results for this measure to ensure they are correctly reported in the documentation.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NOT MET**	The Plan switched to the hybrid methodology. The major purpose of the hybrid methodology is to increase the accuracy of the reported rates; however, it is not valid to compare those rates with the rates received through the administrative method. ***RECOMMENDATION*** *Re-Measurement one should be established as the baseline so future measurements will be comparable.*
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to methodology change.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge due to methodology change.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to judge due to methodology change.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge due to methodology change.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

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

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	5
8.3	1	1
8.4	1	1
Step 9		
9.1	5	0
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	**114**
Project Possible Score	**124**
Validation Findings	**92%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Name of PIP	**ADULT, ADOLESCENT AND CHILDHOOD OBESITY**
Validation Period	2013
Review Performed	3/2014
SPECIAL NOTE	*Optional Activity 2 – Verify Study Findings was performed.*

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	**Score**	**Comments**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on the health needs of the Mississippi Medicaid population.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	The plan is using approved HEDIS® measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	**Score**	**Comments**
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	A clear study question is present in the documentation for the project.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	**Score**	**Comments**
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Study used HEDIS® measures for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	**Score**	**Comments**
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	**Score**	**Comments**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid Methodology.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	**Score**	**Comments**
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	A data source was clearly specified in the documentation.
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**	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis was specified in the documentation.

6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff was used by the plan for record abstraction piece of the hybrid method while the administrative part and ultimate calculation was handled by their certified software.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	**Score**	**Comments**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Reasonable interventions are described in the documentation.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	**Score**	**Comments**
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Project results were presented clearly and accurately in their documentation.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	The plan is using initial and repeat measurements over time. And the measures have a goal of 3% increase each year.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Documentation includes interpretation of their successes and the barriers that continue.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NOT MET**	The Plan switched to the hybrid methodology. The major purpose of the hybrid methodology is to increase the accuracy of the reported rates; however, it is not valid to compare those rates with the rates received through the administrative method. ***RECOMMENDATION*** *Re-Measurement one should be established as the baseline so future measurements will be comparable.*
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Unable to judge due to methodology change.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Unable to judge due to methodology change.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Unable to judge due to methodology change.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	**Score**	**Comments**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge due to methodology change.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement? **(20)**	**MET**	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

Summary of Aggregate Validation Findings and Summary

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

	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	0
9.2	0	NA
9.3	0	NA
9.4	0	NA
Step 10		
10.1	0	NA
Activity 2		
Verify Findings	20	20

Project Score	**119**
Project Possible Score	**124**
Validation Findings	**96%**

HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

EQR PM Validation Worksheets

CCME EQR PM VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Name of PM	**HEDIS MEASURES**
Reporting Year	2013
Review Performed	03/14

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2013

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**	Plan uses NCQA certified software MedMeasures™ from ViPS®. Review requirements for documentation have been 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**	Plan uses NCQA certified software MedMeasures™ from ViPS®. Review requirements for denominator have been 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**	Plan uses NCQA certified software MedMeasures™ from ViPS®. Review requirements for denominator have been 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**	Plan uses NCQA certified software MedMeasures™ from ViPS®. Review requirements for numerator have been 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**	Plan uses NCQA certified software MedMeasures™ from ViPS®. Review requirements for numerator have been met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**NA**	No abstractions were performed.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**NA**	No abstractions were performed.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**NA**	No abstractions were performed.
S2. Sampling	Sample treated all measures independently.	**NA**	No abstractions were performed.
S3. Sampling	Sample size and replacement methodologies met specifications.	**NA**	No abstractions were performed.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software MedMeasures™ from ViPS®. Review requirements for reporting have been met.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	State does not require any additional reporting requirements.

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	**0**	**NA**	**NA**
N4	**0**	**NA**	**NA**
N5	**0**	**NA**	**NA**
S1	**0**	**NA**	**NA**
S2	**0**	**NA**	**NA**
S3	**0**	**NA**	**NA**
R1	**10**	**MET**	**10**
R2	**0**	**NA**	**NA**

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	**50**
Measure Weight Score	**50**
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 Survey Validation Worksheets

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Survey Validated	**CONSUMER SATISFACTION**
Validation Period	2013
Review Performed	03/2014

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The purpose of this survey is to measure member satisfaction with UnitedHealthcare Community Plan of Mississippi (UnitedHealthcare), the network providers, and their overall healthcare experience.
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Sample members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. In addition, the survey is used to collect data on several measures from the Effectiveness of Care domain.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	The intended audience for findings of the member satisfaction survey is internal for various functional areas including: health plan, customer service, marketing, and member engagement. A high level summary of the results are also reported to network providers in the provider newsletter.

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Used an existing survey. The Center for the Study of Services administered the Adult Medicaid version of the 2013 HEDIS/CAHPS Health Plan Survey on behalf of UnitedHealthcare Community Plan.
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Used as existing survey. HEDIS/CAHPS 5.0H HEALTH PLAN SURVEY

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**	Adult - Eligible members were defined as plan members who were 18 years old or older as of December 31, 2012; were currently enrolled; had been continuously enrolled for 6 months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid. Children and Children with Chronic Conditions - Eligible members were defined as plan members who were 17 years old or younger as of December 31, 2012; were currently enrolled; had been continuously enrolled for 6 months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid.

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		Element Met / Not Met	Comments And Documentation
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Sampling frame: AdultSurvey Following the NCQA sampling protocol, the Center for the Study of Services selected a random sample from the complete list of eligible members provided by UnitedHealthcare Community Plan, MississippiCAN Program. Eligible members were defined as plan members who were 18 years old or older as of December 31, 2012; were currently enrolled; had been continuously enrolled for 6 months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid. Prior to sampling, the Center for the Study of Services carefully inspected the member file provided by the Plan and informed the Plan of any errors or irregularities found (such as missing address elements or subscriber numbers). Once the quality assurance process had been completed, the Center for the Study of Services processed member addresses through the USPS National Change of Address (NCOA) service to ensure that the mailing addresses were up-to-date. Random samples were generated as specified by NCQA, with no more than one member per household selected to receive the survey. The Center for the Study of Services assigned each sampled member a unique identification number, which was used to track the sample member's progress throughout the data collection period. Sampling frame: Child Survey Eligible members were defined as plan members who were 17 years old or younger as of December 31, 2012; were currently enrolled; had been continuously enrolled for 6 months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid. Sampling frame: Child Survey (Children with Chronic Conditions) The sample frame included a pre-screen status code to identify children that were likely to have a chronic condition based on claim and encounter records. Using this code, a second sample was drawn from the child Medicaid Children with Chronic Conditions population. Note: the analyses was based on a question on the questionnaire that asks the respondent to self-identify as a child with a chronic condition.

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	Member Satisfaction Survey Answers.docx Random samples were generated as specified by NCQA, with no more than one member per household selected to receive the survey. Following the NCQA sampling protocol, the Center for the Study of Services selected a random sample from the complete list of eligible members provided by UnitedHealthcare Community Plan, MississippiCAN Program.
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**PARTIALLY MET**	Member Satisfaction Survey Answers.docx Sample Size: Adult Survey: 1890 Child Survey: 2310 ***RECOMMENDATION*** *Include in the documentation the acceptable margin of error and the level of certainty required.*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	The procedures used to select the sample were appropriate and protected against bias.

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	The Center for the Study of Services is a CAHPS certified vendor
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 34.15% for the adult survey and 22.03% for the child survey. This is lower than the CAHPS target response rate of 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample. ***RECOMMENDATION*** *Focus on strategies that promote high response rates. In the solicitation letter for the survey, include feedback to the consumer from previous surveys. Include plan's response to areas of dissatisfaction.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The Center for the Study of Services is a CAHPS certified vendor.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	The Center for the Study of Services is a CAHPS certified vendor.
5.3	Were confidentiality procedures followed?	**MET**	The Center for the Study of Services is a CAHPS certified vendor.

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	The data was analyzed.
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were used and applied correctly.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	All the survey conclusions were supported by the data and analysis.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.1	Identify the technical strengths of the survey and its documentation.	The use of an experienced vendor ensured that the collection and analysis of the survey data were consistent with the recommended CAHPS protocols for survey administration, analysis, and reporting. This is especially important if you want to compare results with those of other sponsors locally or through nationally merged data sets such as the National CAHPS Benchmarking Database (the CAHPS Database) or the National Committee for Quality Assurance's (NCQA) Quality Compass.
7.2	Identify the technical weaknesses of the survey and its documentation.	Documentation for the sample size does not include the acceptable margin of error nor the level of certainty required. ***RECOMMENDATION*** *Include in the documentation the acceptable margin of error and the level of certainty required.* The response rate was lower than CMS's recommendation of between 40% and 50%. ***RECOMMENDATION*** *Focus on strategies that promote high response rates*.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 34.15% for the adult survey and 22.03% for the children with chronic conditions survey. This is lower than the CAHPS target response rate of 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample. ***RECOMMENDATION*** *Focus on strategies that promote high response rates.*

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.4	What conclusions are drawn from the survey data?	Adult: -Of those consumers who returned the survey, most consumers were satisfied. The level of satisfaction improved from the 2012 survey or was statistically not different. Satisfaction was similar to regional and national benchmarks. The analyses of the survey data by The Center for the Study of Services revealed opportunities to improve rating of the health plan are: improve "getting care as soon as needed", improve "ease of getting needed care, tests, or treatment", improve "visits to doctor's office or clinic", and improve "Written materials or the Internet provided needed information". By improving these domains the rating of the health plan will increase. Child: - Of those consumers who returned the survey, most consumers were satisfied. The level of satisfaction improved or was the same when compared to the 2012 survey. Rating of health plan was lower than regional and national benchmarks. The analyses of the survey data by The Center for the Study of Services revealed opportunities to improve rating of the health plan are: improve "the percentage of children with a personal doctor", improve "ease of getting needed care, tests, or treatment", improve 'visits to doctor's office or clinic', improve" customer service providing needed information or help". By improving these domains the rating of the health plan will increase. For the Child survey, in regards to Children with Chronic conditions: Satisfaction with Access to Prescription Medicines was lower than the national benchmark, and satisfaction with getting needed information was lower than both regional and national benchmarks.
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	The survey report provided by Center for the Study of Services addressed the assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO.
7.6	Comparative information about all MCOs (as appropriate).	UnitedHealthcare's results were compared to relevant regional and national benchmarks. This comparison was the basis for the key driver analysis and the subsequent discussion of opportunities for improvement.

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	**UnitedHealthcare Community Plan MS**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2013
Review Performed	03/2014

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx To guide the improvement in the quality of services provided to healthcare providers under contract with UnitedHealthcare Community Plan in Mississippi (UnitedHealthcare).
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx 1. To gauge level of satisfaction among contracted providers with regard to their experience and interaction with UnitedHealthcare. 2. To increase understanding of the provider experience in doing business with UnitedHealthcare. 3. To identify opportunities to enhance provider service operations.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx The primary audience for survey findings is local health plan leadership. Results are analyzed and discussed at executive level, as well as in collaboration with provider relations, network management, and quality departments. Survey results are also shared and discussed with a participating physician focus group through the Physician Advisory Committee.

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**NOT MET**	UnitedHealthcare used a survey that they developed. There is no documentation on how the survey was developed or if input from industry experts and/or focus groups was received. Also, there is no documentation for face validity, content validity, construct validity, or predictive validity. ***RECOMMENDATION*** *Document the details of how the survey was developed and include the reliability of the survey instrument. Also, input from industry experts and/or focus groups should be considered.*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**PARTIALLY MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx Survey reliability is considered each year through review of previous year results and trends to ensure consistency in the measurement and how results are being used. There is no documentation of test/re-test reliability studies. ***RECOMMENDATION*** *Conduct and report test/re-test studies*

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**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx The survey population includes all contracted individual practitioners representing primary care providers and certain high-volume specialty types.
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx A duplicated sampling frame of 4,274 individual practitioners was developed. This list includes all contracted providers in Mississippi for the following specialty types: Family Practice, General Practice, Internal Medicine, OBGYN, Pediatrics, Adolescent Medicine, Allergy and Immunology, Cardiology, Endocrinology, Gastroenterology, Hematology, Infectious Disease, Maternal & Fetal Medicine, Neonatal/Perinatal Medicine, Nephrology, Neurology, Oncology, Ophthalmology, Otolaryngology, Pain Management, Podiatrist, Pulmonary Disease, Rheumatology, and Urology.
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx A randomized sample of 1200 individual Practitioners was drawn with sampling frame emphasis of 80% primary care physicians representation
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**Partially MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx A sample size of 1200 is standard approach for UnitedHealthcare provider survey processes. This sample size represents over 25% of targeted survey participants. The level of certainty and acceptable margin of error was not documented. ***RECOMMENDATION*** *Document the level of certainty and acceptable margin of error.*

ACTIVITY 3: REVIEW THE SAMPLING PLAN			
Survey Element		Element Met / Not Met	Comments And Documentation
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx Oversampling of PCPs is deliberately applied as a mechanism for promoting results that are representative of providers that regularly see UnitedHealthcare members. ***RECOMMENDATION*** *Include details on the strata and how the strata are analyzed.*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx Total Number of surveys fielded (1200) Number undeliverable (82) Number ineligible (34) = (1,084) Number of completed eligible returned surveys = 108 108/1,084 X 100 = 9.96 % Response rate.

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The annual Provider Satisfaction Survey (PSS) is conducted each fall by independent firms, Center for Study of Services and Market Strategies International (MSI). A Summer 2013 provider newsletter article was published to encourage participation. The survey was fielded via three-wave fax distribution from August 20th through October 4th. 1200 PCPs and high volume specialty types were included in the 2013 PSS sample. The 2013 response rates increased to 9.96% from 6.06% in 2012 survey. Survey communication is directed to physicians, but actual respondents include a variety of provider entity roles: physicians (61%), office/practice managers (23%), and other practice support staff (16%). A total of 108 completed surveys were returned. The response rate is low. The documentation does not address the impact of the low response rate and a variety of provider entity roles on generalizeability of the survey findings. Also, the documentation does not address the impact of oversampling of primary care physicians in the survey. ***RECOMMENDATION*** *Include in the documentation a detailed assessment of the response rate and bias, and implications of the response rate for the generalizability of the survey findings. Include a discussion of the representativeness of the sample.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	Validation of the 2013 UHC provider satisfaction survey - 05 15 2014.docx Yes. The Center for Study of Services, an independent research company, administers the survey on behalf of UnitedHealthcare. Quality control procedures are applied throughout all phases of survey administration. All records are assigned a unique ID to monitor the status of each sampled provider throughout fielding. During sampling, quality control measures included removing invalid records from the sample frames, checking for and correcting systemic errors in data files (e.g., first name and last name data provided in opposite fields). During fielding, test surveys are faxed to the Center for the Study of Services for review before the live fax blast is sent out to physicians including a review of all merged information. During data collection, survey responses are double key verified by different coders to ensure accuracy of the response data. Any discrepancies are flagged and verified by the second (more experienced) operator. During data cleaning, skip patterns are enforced in all response data to ensure only eligible responses to measures are included. Response data are reviewed at regular intervals to review for accuracy and identify any anomalies.
5.2	Did the implementation of the survey follow the planned approach?	**MET**	The vendor, the Center for the Study of Services, followed the planned approach.
5.3	Were confidentiality procedures followed?	**MET**	The confidentiality procedures were followed.

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		**Element Met / Not Met**	**Comments And Documentation**
6.1	Was the survey data analyzed?	**MET**	The survey data was analyzed.
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were used and applied correctly.
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	All survey conclusions were supported by the data and analyses.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.1	Identify the technical strengths of the survey and its documentation.	The use of an experienced vendor ensured that the collection and analysis of the survey data were consistent with a third party's protocols for survey administration, analysis, and reporting. The Centers for the Study of Services also provided benchmarks for comparison.
7.2	Identify the technical weaknesses of the survey and its documentation.	UnitedHealthcare created their own survey instrument. They bear the responsibility to demonstrate that the survey instrument is valid and reliable. The documentation lacks a demonstration of validity and reliability. The survey had a poor response rate. ***RECOMMENDATION*** *Document the validity and reliability of the survey instrument.* *Conduct tests to assess the validity and reliability of the survey instrument.* *Include input from survey experts and /or focus groups.* *Improve the response rate.* *In the survey solicitation consider providing feedback from previous surveys and how the plan addressed the concerns of providers. Use telephone follow-up of non-responders.*
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 9.96 %. This is lower than the CAHPS target response rate of 40 percent and 50 percent. A low response rate could potentially bias the sample and reduce the generalizability of the sample. ***RECOMMENDATION*** *Focus on strategies that promote high response rates.*
7.4	What conclusions are drawn from the survey data?	Provider satisfaction was noted as low. According to the document submitted by the health plan, 2013 proved to be a challenging year that included significant membership expansion in the MSCAN program, as well as benefit changes that featured the inclusion of behavioral health. In addition, the UnitedHealthcare MSCAN network expanded significantly in terms of both practitioner and hospital participation. With such significant program changes taking place it is not surprising to find that several measures of provider satisfaction have decreased when compared to 2012 scores.
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Among the providers surveyed there is low satisfaction with prior authorizations; availability of specialists; and the timeliness of exchange of information, communications, and reports.

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY		
Results Elements		**Validation Comments And Conclusions**
7.6	Comparative information about all MCOs (as appropriate).	Results were compared with the 2012 and 2011 results as well as UHC's 2013 national results. In general UnitedHealthcare remained consistent compared to 2012 and 2011. UnitedHealthcare was significantly lower in satisfaction than the national UnitedHealthcare provider satisfaction survey. According to the document provided, overall measures of provider satisfaction decreased from 66% in 2012 to 52% in 2013. However, the likelihood of renewing the UHC-MSCAN contract remained steady among participating providers at 80%. Also, although UHC processes 99% of all claims within 6 days, provider satisfaction with timeliness of claims processing dropped from 67% to 62%. One area of focused improvement during 2013 was the provider administrative manual, and efforts to communicate more effectively through that document resulted in an increase from only 47% satisfaction in 2012 to 52% in 2013. Complete scorecard results are provided as an attachment.

UnitedHealthcare Community Plan - Mississippi

2013 External Quality Review

Attachment 4
Tabular Spreadsheet

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to enrollees, both directly and indirectly.	X					The majority of the policies utilized by UHC Community Plan - Mississippi are national policies that have been adopted by the plan. Many of the national policies discuss processes in general terms with little information specific to the MS plan. Onsite discussion confirmed that UHC MS is in the process of reviewing all the policies and implementing local policies when the national ones do not address local guidelines. The plan uses standard operating procedures to define many of their processes and CCME suggested that the policies should reference the applicable standard operating procedure. *Recommendation: When standard operating procedures define a process, they should be referenced in the applicable policy.*
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 enrollees. At a minimum, this includes designated staff performing in the following roles:						
1.1 Full time Chief Executive Officer, and/or Chief Operations Officer located in Mississippi;	X					Jocelyn Chisholm Carter serves as chief executive officer and president for the Mississippi plan. Richard Flores is the Chief Operating Officer.
1.2 Chief Financial Officer;	X					
1.3 Chief Information Officer;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Information Systems personnel;	X					The plan receives IT support from UnitedHealth Group IT in Minnesota.
1.5 Claims Administrator;	X					
1.6 Provider Services Manager;	X					
1.7 Enrollee Services Manager;	X					The organizational chart received in the desk materials showed the Member Services Manager position as vacant. Onsite discussion confirmed the position was filled as of May 19th, 2014.
1.8 Intake, investigation, resolution, and reporting of enrollee and provider complaints and grievances;	X					
1.9 Utilization management functions;	X					
1.10 A designated health care practitioner, qualified by training and experience, to serve as Quality Management Director;	X					The Quality Management Director is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service complaints and evaluation of quality improvement initiatives involving member and provider outreach. The Quality Management Director works with the Compliance Officer to assure compliance with regulatory and accreditation standards.
1.11 Provider credentialing and education;	X					The Provider Relations staff is responsible for provider education and the National Credentialing Center is responsible for conducting provider credentialing.
1.12 Enrollee service and education;	X					Enrollee services and education are conducted through the Member Services and Community Outreach departments.
1.13 Marketing and/or Public Relations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Deirdre Phillips, a physician licensed in MS, serves as the Medical Director. She provides clinical oversight for health plan staff and chairs the Physician Advisory Committee (PAC) and Healthcare Quality & Utilization Management (HQUM) committee.
1.15 A designated compliance officer and a compliance committee that are accountable to senior management and that have effective lines of communication with all the CCO's employees.	X					Terence Christopher is the Compliance Officer responsible for the strategy, implementation, and oversight of the Compliance Program for MS. He chairs the UnitedHealthcare Community Plan – Mississippi Compliance Committee which reports on plan-specific compliance program activities to plan leadership, UHC Government Programs Corporate Responsibility and Compliance and UHC Government Programs Leadership. The committee meets on a monthly basis.
1.16 Medical records system supervisor/director	X					
2. Operational relationships of CCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions.	X					
4. A professionally staffed all service/HelpLine/Nurse Line which operates 24 hours per day, 7 days per week.	X					The NurseLine operates 24 hours per day, 7 days per week to serve members and provides clinical information and resources.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					UHC has detailed processes, policies, and procedures in place to ensure that claims are handled in a timely and accurate manner. Reviewing their completeness and accuracy data showed that they have set very stringent guidelines for claims handling performance, and reviewing the data shows that they consistently perform above the targeted levels.

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					UHC does an extensive analysis of the demographics and enrollment of their members. They track a large number of parameters regarding the percentages of behaviors (e.g., smoking cessation) and procedures (e.g., well child screenings) and have taken steps to use this demographic data to enhance participation/compliance.
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					CCME's review found UHC's information systems capabilities to fully meet the ISCA specifications.
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					UHC has the systems, plans, and processes in place to ensure that virtually any disaster scenario would be a fully recoverable event. They have well-defined scenario exercises that they use for testing, and perhaps most importantly, they have a mechanism for incorporating the findings from disaster recovery testing into the formal plan going forward.
I D. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Confidentiality is addressed as a part of the United Compliance curriculum which includes required trainings for all UnitedHealthcare staff. The Privacy Policy Manual addresses the HIPAA Privacy Rule.
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.			X			UnitedHealthcare utilizes the national 2013-2014 Credentialing Plan to define the credentialing and recredentialing process and guidelines for licensed independent practitioners and facilities. A state specific rider is supposed to address requirements for MS and has never been updated. In the previous EQR, recommendations were made for UHC to address and implement MS specific guidelines and, to date many of the recommendations have not been added. The following information should be included in the credentialing/recredentialing process and addressed in the MS rider: • Collect a copy of the malpractice insurance coverage face sheet. •Collect a copy of the CLIA Certificates or Certificates of Waiver for practitioners that indicate they bill laboratory services on the application. (A printed copy of a CLIA website search is acceptable.) •Conduct office site visits for initial credentialing and include evidence of the site review in the file. •Conduct a follow-up site review for member complaints within 45 calendar days. Include evidence of the follow-up visit in the credentialing file. •For Nurse Practitioners that are acting as PCPs, confirm the plan for admitting patients. Also, under the new contract that will be implemented in 2014, the plan must verify that NPs acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. •Address Disclosure of Ownership forms in the credentialing/recredentialing process. •A copy of the signed attestation should be in the file. If using CAQH, a copy of the electronic re-attestation page is acceptable if a copy of the original signed attestation is included in the file.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Proof of primary/secondary source verifications (i.e. license, DEA/CDS, board certification, if applicable) and proof of queries (NPDB, SAM, OIG, State Sanctions) must be in the file. A printed copy of website searches is acceptable. *Corrective Action: Include the MS credentialing/ recredentialing requirements in the UnitedHealthcare Credentialing plan and any applicable policies.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					Dr. Deirdre Phillips, medical director, locally reviews all applications for credentialing and recredentialing. If the files are clean, they are approved and later presented to the local Provider Advisory Committee (PAC). If there are issues, Dr. Phillips renders a recommendation and the files are referred to the National Credentialing Committee (NCC) for review and discussion. The results are then presented to the local Provider Advisory Committee (PAC) which is chaired by Dr. Phillips. The NCC meets at least monthly and the PAC meets on a quarterly basis. A quorum is met for both committees with a minimum of 51 percent of voting members in attendance. *Recommendation: CCME recommends that UHC include any provider credentialing/recredentialing discussions in the PAC meeting minutes.*
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.			X			Credentialing files reviewed onsite contained many of the issues that had been identified in the previous EQR. Disclosure of ownership forms were not found in the credentialing files. Only one credentialing file for a federally qualified health clinic had an ownership disclosure form. *Corrective Action: Disclosure of ownership forms should*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						be collected at credentialing.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat enrollees;			X			Credentialing files reviewed onsite indicated electronic verification of the license but proof of the license verification was not in the files. *Corrective Action: A copy of the license or proof of the license verification should be in each credentialing file.*
3.1.2 Valid DEA certificate and/or CDS Certificate;			X			Credentialing files reviewed onsite indicated electronic verification of the DEA but proof of the DEA verification was not in the majority of the files. Only one file (NP) reviewed had proof of the DEA search in the file. *Corrective Action: A copy of the DEA/CDS certificate or proof of the DEA/CDS verification should be in each credentialing file.*
3.1.3 Professional education and training, or board certification if claimed by the applicant;			X			For the credentialing files reviewed onsite, electronic searches were performed if the provider indicated board certification or if the application section was not completed, but proof of the search was not in the files for the providers that were board certified. *Corrective Action: If board certification is indicated by the provider, proof of the board certification verification should be in each credentialing file.*
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;			X			Proof of the malpractice insurance was inconsistent. Several of the files reviewed had copies of the malpractice insurance in the file, but at least two files reviewed used the attestation to meet the verification and proof of the insurance was not in the files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Proof of malpractice insurance should be in each credentialing file.
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;			X			Credentialing files reviewed onsite reflected copies of the CAQH electronic last attestation page, but none of the files contained a copy of the signature page showing what the provider originally attested to. For CAQH files, the credentialing files should contain a copy of the original attestation statement signed by the provider. The electronic re-attestation page is acceptable as long as a copy of the original signature page is in the file. At the onsite, UHC provided copies of the Information Release/Acknowledgements pages for the files that show the provider's signature. However this section only shows the provider is giving consent to the disclosure, inspection and copying of information/documents related to credentials, qualification and performance, among other things, and was not the required attestation page. *Corrective Action: Credentialing files should contain a copy of the original signed attestation. Electronic re-attestments are acceptable as long as a copy of the original signed attestation is in the file.*
3.1.7 Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM);	X					Credentialing files reviewed onsite contained proof of the NPDB searches. The checklist in the files showed that a query was made for the System for Award Management. *Recommendation: Ensure that proof of the SAM queries is placed in the credentialing files when the new contract begins in 2014.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.8 Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)			X			Credentialing files reviewed onsite indicated electronic verification via checklist of the Mississippi State Board of the specific discipline, but proof of verification was not in the files. *Corrective Action: Proof of query of the Mississippi State Board for the specific discipline should be in the files.*
3.1.9 Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE);			X			Credentialing files reviewed onsite indicated electronic verification via checklist was made for the OIG but proof of verification was only found in one file. *Corrective Action: Proof of the OIG search should be present in the credentialing files.*
3.1.10 In good standing at the hospital designated by the provider as the primary admitting facility.		X				Hospital privileges were appropriately verified in all credentialing files except for one nurse practitioner (NP) file. The NP application was incomplete for the hospital privileges section and the checklist indicated no information provided. The NP file should have contained at least the arrangements for admitting patients. *Corrective Action: Hospital privileges should be addressed for nurse practitioners acting as PCPs. Also, under the new contract that will be implemented in 2014, the plan must verify that NPs acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.*
3.1.11 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.			X			Proof of CLIA certificates/waivers was not in the credentialing files for the providers that indicated on the application they perform laboratory services. In fact, this information was not even recorded as an item on the credentialing checklist. Several of the applications were showing incomplete for the Laboratory Services section.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Proof of verification of CLIA certificates/waivers should be in the files for all providers that indicate they perform laboratory services. If the Laboratory Services section of the application is blank, the plan should verify if the provider performs laboratory services.
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			Site assessments were not performed during the credentialing process for MS practitioners. This was an issue in the previous EQR. *Corrective Action: Site assessments should be performed for initial credentialing of MS practitioners.*
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.			X			Recredentialing files reviewed onsite contained many of the issues that had been identified in the previous EQR. Disclosure of ownership forms were not found in any of the recredentialing files reviewed onsite. This was an issue in the previous EQR. In addition, for hospital privileges, one file indicated attestation verified when primary or secondary source verification should have been conducted. *Corrective Action: Disclosure of ownership forms should be collected at recredentialing and hospital privileges should be verified.*
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat enrollees;			X			The majority of the recredentialing files reviewed onsite did not have proof of the license verification in the files. Two files reviewed had a copy of the license and/or verification. All the other files indicated electronic verification on the checklist. *Corrective Action: A copy of the license or proof of the license verification should be in each recredentialing file.*
4.2.2 Valid DEA certificate and/or CDS Certificate;			X			Recredentialing files reviewed onsite indicated electronic verification of the DEA but proof of the DEA verification was not in the files reviewed onsite. *Corrective Action: A copy of the DEA/CDS certificate or proof of the DEA/CDS verification should be in each recredentialing file.*
4.2.3 Board certification if claimed by the applicant;			X			For the recredentialing files reviewed onsite, electronic searches were performed if the provider indicated board certification or if the application section was not completed, but proof of the search was not in the files for the providers that were board certified. *Corrective Action: If board certification is indicated by the provider, proof of the board certification verification should be in each recredentialing file.*
4.2.4 Malpractice claims since the previous credentialing event;			X			Proof of the malpractice insurance was present in two of the recredentialing files reviewed. The other files were checklist verified and proof of the malpractice insurance was not in the file. One file only showed $500,00/$500,00 limits with no explanation. *Corrective Action: Proof of malpractice insurance should be in each recredentialing file.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.5 Practitioner attestation statement;			X			Recredentialing files reviewed onsite reflected copies of the CAQH electronic last attestation page, but only one file reviewed contained a copy of the original signed attestation page. For CAQH files, the electronic re-attestation page is acceptable as long as a copy of the original signature page is in the file. At the onsite, UHC provided copies of the Information Release/Acknowledgements pages for the files that show the provider's signature. However, this section of the application only shows the provider is giving consent to the disclosure, inspection and copying of information/documents related to credentials, qualification and performance, among other things, and not the required attestation page. *Corrective Action: Recredentialing files should contain a copy of the original attestation with signature. Electronic re-attestments from CAQH are acceptable as long as a copy of the original signature is in the file.*
4.2.6 Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM);	X					Recredentialing files reviewed onsite contained proof of the NPDB searches. The checklist in the files showed that a query was made for the System for Award Management. *Recommendation: UHC will need to ensure that proof of the SAM queries are placed in the recredentialing files when the new contract begins in 2014.*
4.2.7 Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)			X			Recredentialing files reviewed onsite indicated electronic verification via checklist of the Mississippi State Board of the specific discipline, but proof of verification was not in the files. *Corrective Action: Proof of query of the Mississippi State Board for the specific discipline should be in the files.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE);			X			Recredentialing files reviewed onsite indicated electronic verification via checklist was made for the OIG in all files reviewed but one. However, proof of verification was not in files. The one aforementioned file did not even list the OIG electronic verification on the checklist. *Corrective Action: Proof of the OIG search should be present in the credentialing files.*
4.2.9 Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.			X			Proof of CLIA certificates/waivers was not in the recredentialing files for the providers that indicated on the application they perform laboratory services. Also, this information was not included as an item on the recredentialing checklist. *Corrective Action: Proof of verification of CLIA certificates/waivers should be in the files for any provider that indicates they perform laboratory services.*
4.3 Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space if the health plan established complaint/grievance threshold has been met.	X					Policy NQM-056, Ongoing Monitoring of Office Site Quality, defines the process used by UHC to manage, track and resolve potential Quality of Service (QOS) issues related to the physical accessibility, physical appearance and/or adequacy of the waiting and exam room space. The policy defines site visit thresholds and states that the site visit vendor performs the Site Visit Review within 45 calendar days of the receipt of the complaint on page three, but a 60 day timeframe is listed on page five. Information received in the desk materials stated that during the look back period of January 1-December 31, 2013, there were no providers who met the threshold requiring an onsite visit.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Correct page five of policy NQM-056, Ongoing Monitoring of Office Site Quality, to reflect 45 days. It is correctly listed on page three.
4.4 Review of practitioner profiling activities.	X					
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues.	X					
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of enrollees and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the enrollees assigned.	X					Policy PS10, PCP Panel Notification, states that it is the policy of UHC to notify PCPs of the enrollees assigned to them, including notification of panel changes, within five business days of the date on which the CCO receives the enrollment report from DOM. UHC generates weekly emails to provider group contacts in order to inform them of the changes to patient panels. Providers are given information regarding their online portal access.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Out-Of-Network Provider-Member Enrollment Verification, states it is the policy of UHC that out-of-network providers are able to verify the enrollment of an enrollee. The telephone number is listed on member cards for all providers to verify enrollment of an enrollee.
1.3 The PCP to enrollee ratio does not exceed one (FTE) PCP per every 2500 enrollees.	X					
1.4 Enrollees have a PCP located within a 30-mile radius or travel no more than 30-minutes of their residence. For rural regions, Enrollees have a PCP located within a 60-mile radius or travel no more than 60-minutes of their residence .		X				Policy PS3, Access Standards – Primary Care Services, states members enrolled in the MississippiCAN program will not need to travel more than 60 minutes/miles for rural areas or 30 minutes/miles for urban/suburban areas. Policy UHC.QMP.001, Availability of Practitioners and Providers is the corporate policy. GEO Access reports received in the desk materials reflected the standard of one provider within 30 miles for urban and one within 60 miles for rural. This was utilized for PCP providers and specialists when the contract specifies a standard of two PCPs for evaluating the network. Per onsite discussion and written response, UHC utilizes the two PCP guideline and this was a typographical error on the report document. A correction will be applied to all future GEO Access Report documents. *Corrective Action: Ensure the GEO Access reports reflect the 2 PCP criteria for measuring the network.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty.	X					
1.6 The sufficiency of the provider network in meeting enrolleeship demand is formally assessed at least biennially.	X					GEO Access reports are run on a quarterly basis.
1.7 Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy UHC.QMP.001, Availability of Practitioner and Providers, states that an assessment of the cultural/ linguistic makeup of the health plans is conducted at the time of the geographic and numeric availability assessment to enable services to be provided in a culturally competent manner and accessible to all members. Evidence of the annual needs analysis is addressed in the 2013 Quality Improvement Evaluation.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting enrolleeship demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures 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-Availability Requirements for Emergency Medical and Primary Care Physician Services, states the urgent, routine, and well-care requirements that comply with contract guidelines. However, the access standards for Behavioral Health are not addressed in this policy and not mentioned in the Provider Manual. An annual assessment was conducted in July 2013 with outbound calls placed to PCPs, OBGYNs and five high volume medical specialists: cardiology, general surgery, ophthalmology, orthopedic surgery and otolaryngology. The results showed low numbers for after hours,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						emergent and urgent visits. This was addressed in the 2013 QI Program Evaluation and interventions were mentioned to address the issues. Onsite discussion revealed that UHC is considering moving the access and availability evaluation function from the provider services area to the quality area. *Corrective Action: Address Behavioral Health standards that comply with contract guidelines in a policy and include the guidelines in the Provider Manual.*
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy PS11, Provider Orientation Plan, states that it is the policy of UHC to conduct timely outreach to all newly contracted providers in order to provide orientation into Community Plan networks. A Provider Advocate places a welcome call to each new provider within the first 30 days of a new contract effective date. An onsite orientation meeting is scheduled at the provider's earliest convenience. Orientation activity is recorded in the online Advocate Resource Tool.
2. Initial provider education includes:						
2.1 CCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Enrollee benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and enrollee grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of an enrollee to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures.	X					Ongoing education is provided through onsite visits, bulletins, provider newsletters, webinars and the website.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its enrollees that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					UHC adopts preventive health guidelines that are reviewed by the Medical Technology Assessment Committee (MTAC) and approved by the National Medical Care Management Committee (NMCMC). The MTAC evaluates guidelines from the most current and reasonable medical evidence available, including, but not limited to, the U.S. Preventive Services Task Force, the Centers for Disease Control and specialty organizations. Maintenance of guidelines is completed by the Medical Policy Development Team. The guidelines are approved locally by the Provider Advisory Committee (PAC).
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO enrollees to providers.	X					Policy NQM-029, Clinical Practice Guidelines, states that links to the guidelines are provided on UHC's website. Providers are notified of the existence of the guidelines and where to retrieve them via the provider newsletter and annual postcard. It is also mentioned in the Provider Manual. A review of the website showed all the practice guidelines; however, a few of the links for the guidelines

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						were not active. *Recommendation: Review the web links for the practice guidelines to ensure they are actively working.*
3. The preventive health guidelines include, at a minimum, the following if relevant to enrollee demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	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 enrollee high-risk groups.	X					
4. The CCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					UHC measures population-based performance against selected clinical guidelines annually. The Provider Manual states that when a provider demonstrates a pattern of noncompliance with clinical practice guidelines, the medical director may contact the provider by phone or in person to review the guideline and identify any barriers that can be resolved.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its enrollees 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 Clinical Practice Guidelines were approved by the Medical Technology Assessment Committee in September 2013. The National Medical Care Management committee approved the guidelines in October 2013 and the Provider Advisory Committee approved the guidelines in December, 2013.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO enrollees to providers.	X					Policy NQM-029, Clinical Practice Guidelines, states that links to the guidelines are provided on the UHC website. Providers are notified of the existence of the guidelines and where to retrieve them via the provider newsletter and annual postcard. It is also mentioned in the Provider Manual.
3. The CCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					On an annual basis, UnitedHealthcare monitors performance against at least two important aspects of two clinical guidelines for acute or chronic medical conditions and at least two important aspects of two behavioral conditions. For 2013 the quality department selected diabetes and asthma as the two chronic medical conditions and depression and ADHD medication for the behavioral health conditions to monitor provider adherence with the clinical practice guidelines. Interventions geared toward increasing provider awareness and compliance were implemented as a result of the analysis.
II F. Continuity of Care						
1. The CCO monitors continuity and coordination of care between the PCPs and other providers.	X					The procedures for addressing network gaps, transition of care and continuity of care is addressed in policy UCSMM.06.21, Out-of-Network Requests and Continuing Care. The 2013 QI Program Description states that an annual analysis is conducted to review the continuity and coordination of medical care provided to UHC members across settings and / or during transitions of care. The scope of activities includes transitions in care including changes in management of care among

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						practitioners, changes in settings including inpatient and ambulatory location or other changes in which practitioner's partner to provide ongoing care for a member.
II G. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the enrollee medical records maintained by primary care physicians.	X					Policy NQM-025, Ambulatory Medical Record Review Process, defines the process of monitoring provider medical record documentation to facilitate patient confidentiality, communication, coordination, and continuity of care. Defined medical record charting standards and a copy of the standards audit tool are also listed in the Provider Manual.
2. Medical Record Audit						
2.1 The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					UnitedHealthcare Community Plan completed a Medical Record Audit in December 2013. A few areas of noncompliance were identified and corrective action was implemented for provider education. Actions will be tracked by the Clinical Practice Consultant team. Information in the June 28, 2013 QMC meeting stated that for Mississippi, a total of 28 sites were visited for the record review. Compliance was assessed on a total of 20 UHC providers. Total compliance was 96.8 percent. Five areas were identified for ongoing improvement: advanced directive information provided for adults 18 & older and emancipated minors, identification of primary language and cultural/religious preferences in the medical record, pages fastened, evidence of a depression screening, and evidence of coordination of care with behavioral health. The clinical consultant team will provide education to providers as well as perform interim medical record reviews.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO ensures that the enrollees' medical records or copies thereof are available within 14 business days from receipt of a request to change providers.	X					
III. ENROLLEE SERVICES						
III A. Enrollee Rights and Responsibilities						
1. The CCO formulates and implements policies outlining enrollee rights and responsibilities and procedures for informing enrollees of these rights and responsibilities.	X					Members are provided a copy of their rights and responsibilities at enrollment, annually, and upon request. They are also accessible on the Plan's website.
2. Enrollee 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 Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;						
2.4 To participate in decision-making regarding their health care without prohibitions or restrictions on the clinical dialogue between patient and provider;						
2.5 To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;						
2.6 To voice grievances about the CCO or about the medical care and/or services they receive;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 To appeal decisions adversely affecting coverage, benefits, services, or their relationship with the CCO;						
2.8 To formulate advance directives;						
2.9 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.10 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;						
2.11 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;						
2.12 To have free exercise of rights and the exercise of those rights do not adversely affect the way the CCO and its providers treat the enrollee.						
2.13 To be furnished with health care services in accordance with 42 CFR § 438.206 – 438.210.						
3. Enrollee Responsibilities include, the responsibility;		X				Member responsibilities are detailed in Attachment A of policy NQM-051, Members Rights and Responsibilities, and in its associated rider, NQM-051 Rider-MS 1. The policy does not include all the member responsibilities required by the *DOM Contract, Section 4.10* and addressed in the standards below. *Corrective Action: Update materials to ensure information regarding member responsibilities is complete and consistent in all documents.*

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;						Not found in policy NQM-051, Members Rights and Responsibilities, Attachment A – NQM-051, or the policy's rider NQM-051 Rider-MS1.
3.2 To corporate 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 Enrollee has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff.						Not found in policy NQM-051, Members Rights and Responsibilities, Attachment A – NQM-051, or the policy's rider NQM-051 Rider-MS1.
III B. Enrollee CCO Program Education						
1. Enrollees are informed in writing within 14 days from CCO's receipt of enrollment data from the Division of all benefits to which they are entitled, including:			X			Policy MBR2a, Information Packets to Enrollees, indicates that an information packet will be sent to members no later than 14 days after UHC receives notice of the beneficiary's enrollment. The packet will contain at a minimum an introductory letter, ID card, Provider Directory, and Enrollee Handbook. Members can contact the Member Services department Monday – Friday from 8:00 a.m. – 6:00 p.m., and the NurseLine is available 24 hours per day. This standard received a Not Met score because a deficiency identified during the previous EQR has not been corrected prior to this review. This issue and new issues identified with the requirements for enrollee education are detailed in the standards below.
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 direct access for female enrollees 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, maximum allowable benefits and claim submission procedures; includes that no cost is passed on to the enrollee for OON services;						The Enrollee Handbook indicates there is no limit on the number of ER visits, yet the MS CAN Resource Guide, page 20, documents a limit of 6 visits per calendar year for physician services for ER visits. Onsite discussion confirmed that the MS CAN Resource Guide is incorrect and there is no limit on physician services for ER visits. *Corrective Action: Correct the MS Can Resource Guide to remove the limit on physician services for ER visits.*
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;						Onsite discussion confirmed that the MS CAN Resource Guide is used for internal training and as a reference for UHC staff members. The MS CAN Resource Guide, page 23, states, "If you cannot find an 11 Mississippian provider that meets your needs, call Member Services at 1.877.743.8731." Onsite discussion confirmed that this is a typographical error. *Recommendation: Correct the typographical error in the statement above in the MS CAN Resource Guide.*
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The MS CAN Resource Guide, page 16, indicated that appointments for urgent (but not emergent) care are required within 48 hours. The *DOM Contract, Section 5.3*, requires appointments for urgent care within one day. Incorrect timeframes for access to care were noted in the MS CAN Resource Guide during the 2012 EQR

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and the document continues to contain incorrect timeframes for access to care standards. *Corrective Action: Update the MS CAN Resource Guide to reflect accurate information regarding appointment access standards.*
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The Enrollee Handbook provides detailed information on prescription medications and medical equipment, including limits and restrictions.
1.8 Policies and procedures for notifying enrollees affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The *DOM Contract, Section 4.3,* specifies that at the time an enrollee is first enrolled into the plan, the enrollee must be notified that they will be given written notice within 15 days of notice of or issuance of a provider termination. There is no mention in the Enrollee Handbook that members will be notified of provider termination from the network or the timeframe and method of notification. *Corrective Action: Add information to the Enrollee Handbook regarding the process for notifying enrollees of provider terminations.*
1.9 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.10 Procedures for disenrolling from the CCO;						
1.11 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The Enrollee Handbook, page six, and the MS CAN Resource Guide, page 15, indicate that alternate languages spoken by network providers will be listed in the Provider Directory. The review of the printed Provider Directory indicates that it does not include alternate languages spoken by providers. This was identified as an issue during the last EQR and has not been corrected. *Corrective Action: Update the printed Provider Directory to contain alternate languages spoken by providers.*
1.13 Additional information as required by the contract and by federal regulation.						There is no mention in the Enrollee Handbook of members' right to obtain family planning services from any approved Medicaid provider, even if they are not in the UHC network, as required by the *DOM Contract, Section 4.6, (f) (i).* *Corrective Action: Add information to the Enrollee Handbook that enrollees may obtain family planning services from any approved Medicaid provider, even if that provider is not part of the UHC network.*
2. Enrollees are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.		X				During onsite discussion, staff stated that when there are significant changes to benefits, services, and/or the provider network, members are notified via updated member portal, community outreach, call center staff, and changes are made in the Enrollee Handbook. Staff confirmed that notifications are also mailed to members. A copy of this notification letter was requested during the onsite visit, but was not provided. *Federal Regulation §438.10 (f) (4)* and the *DOM Contract, Section 4.3*, require written notice of significant changes to be given to enrollees at least 30 days before the intended effective date of the change.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MBR 8a, Proper Notice to Enrollees on Written Notices, page one, correctly indicates that UHC will give enrollees 30 days written notice of any significant change in the information specified in the contract before its effective date. Page two of the same policy contains a contradiction and indicates that enrollees will be notified at least 14 days before implementation of changes to covered services, benefits or processes used to access benefits. There is no specification on page two of the policy that the notification will be in writing. •Page 2 of policy MBR 17, Enrollee Handbook Requirements, also states that enrollees will be notified at least 14 days before implementation of changes to covered services, benefits or processes used to access benefits. *Corrective Action: Correct the timeframe for notifying enrollees of changes in benefits, services, or processes used to access benefits in policies MBR 8a, page two, and MBR 17, page two.*
3. Enrollee 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					
4. The CCO maintains and informs enrollees of how to access a toll-free vehicle for 24-hour enrollee access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Detailed information on the NurseLine, including the phone number and TDD number, is provided to enrollees in the Enrollee Handbook. Interpreter services are available free of charge and member materials are available in alternate languages and formats.
5. Enrollee grievances, denials, and appeals are reviewed to identify potential enrollee misunderstanding of the CCO program, with reeducation occurring as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Materials used in marketing to potential enrollees are consistent with the state and federal requirements applicable to enrollees and enrollees.	X					
III C. Enrollee Disenrollment						
1. Enrollee disenrollment is conducted in a manner consistent with contract requirements.		X				Enrollee disenrollment is addressed in the Enrollee Handbook, including discussion of processes for both mandatory and voluntary member disenrollment. Policy MBR 9, Open Enrollment Period, contains no distinction between mandatory and voluntary enrollees' ability to disenroll from a CCO. The policy states only that "Members will have an open enrollment period during the ninety (90) days following their initial enrollment in UnitedHealthcare during which they can enroll in a different Care Coordination Organization without cause or disenroll from the program without cause." The policy doesn't document that the mandatory member population will be able to change plans one time only within 90 days, and after that 90-day period is over, they are locked in to the Plan. They are not able to disenroll from the program. *Corrective Action: Update policy MBR 9 to contain complete language regarding disenrollment for both mandatory and voluntary enrollees. This language can be found in the DOM Contract, Section 4.1 (a) and (b).*
III D. Preventive Health and Chronic Disease Management Education						
1. The CCO enables each enrollee to choose a PCP upon enrollment and provides assistance as needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO informs enrollees about the preventive health and chronic disease management services that are available to them and encourages enrollees to utilize these benefits.	X					The Enrollee Handbook provides charts of recommended preventive services for men, women, and children. Additionally, members are notified of, and encouraged to participate in, recommended preventive health services via mailings, postcards, newsletters, member outreach, etc.
3. The CCO identifies pregnant enrollees; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant enrollees in their recommended care, including participation in the WIC program.	X					Pregnant enrollees are identified through various means, including the initial health risk assessment (HRA); claims and encounter data; hospital admission and discharge data; pharmacy and lab data; data obtained through the UM process, internal, provider, or member referrals; and NurseLine referrals. The Enrollee Handbook indicates that members who participate in the Healthy First Steps program receive education and support during the pregnancy, as well as assistance with finding community services such as WIC, behavioral health care and social services.
4. The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages enrollees to utilize these benefits.	X					Claim and encounter data are monitored to identify enrollees in need of EPSDT exams and related services. Outreach calls are placed to encourage participation in recommended EPSDT services, and members are sent age-based cards, brochures, etc. reminding of and encouraging participation in recommended screenings, testing, and/or immunizations.
5. The CCO provides educational opportunities to enrollees regarding health risk factors and wellness promotion.	X					Many methods are used for enrollee education and wellness promotion, including age-appropriate mailers and cards; brochures and other materials provided to practitioner offices; and outreach calls. Members in case/disease management programs receive verbal and written education from their case/disease managers.
III E. Enrollee Satisfaction Survey						

CCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO conducts a formal annual assessment of enrollee satisfaction with CCO benefits and services. Such assessment includes, but is not limited to:	X					
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total enrolleeship;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from CCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Adverse decisions regarding CCO claim decisions.	X					
2. The CCO analyzes data obtained from the enrollee satisfaction survey to identify quality problems.	X					
3. The CCO implements significant measures to address quality problems identified through the enrollee satisfaction survey.	X					
4. The CCO reports the results of the enrollee satisfaction survey to providers.	X					
5. The CCO reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
III F. Grievances						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO formulates reasonable policies and procedures for registering and responding to enrollee grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MBR5a, Member Complaint, Grievance and Appeal Procedures, details UHC's processes for handling grievances. Additional policies detailing grievance processes include policy MBR 13, Plan Enrollees are Informed about Complaint and Grievance Procedure, and MBR 13a, Plan Enrollees are Informed about Complaint and Grievance Procedure.
1.1 Definition of a grievance and who may file a grievance;		X				Policy MBR5a, Member Complaint, Grievance and Appeal Procedures, and policy MBR 13a, Plan Enrollees are Informed about Complaint and Grievance Procedure, both contain an appropriate definition of a grievance. Policy MBR13, Plan Enrollees are Informed about Complaint and Grievance Procedure, contains a list of other definitions but contains no definition of a grievance. *Corrective Action: Ensure that the definition of a grievance is included in policy MBR 13.*
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				Policy MBR5a, Member Complaint, Grievance, and Appeal Procedures, correctly states that grievance resolution will occur within 30 calendar days of receipt, including notification. The timeframe may be extended by 14 calendar days if the member requests an extension or if there is a need for additional information and the extension is in the member's interest. For an extension not requested by the member, notice will be given to the member within 2 working days of the decision to use the extension. The grievance resolution timeframe documented in policy MBR13, Plan Enrollees are Informed about

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Complaint and Grievance Procedure, is incorrect. Page 4, item 7, indicates that the timeframe for resolution and notification of a grievance is 90 calendar days from the date of receipt, and page 4, item 8, lists a timeframe of 45 calendar days, but doesn't specify what this timeframe is for. Policies MBR13 and MBR13a both incorrectly state that members will be notified within 5 business days of the extension of the timeframe for a grievance resolution which was not requested by the enrollee. The *DOM Contract, Section 7.2*, requires enrollee notification of the reason for an extension within 2 working days when the extension was not requested by the enrollee. *Corrective Action: Correct the timeframe for resolution and notification of a grievance in policy MBR 13. Correct the timeframe for notification of an extension for a grievance when the extension is not requested by the enrollee in policies MBR 13 and MBR 13a.*
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 Notification to the enrollee of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated;		X				The *DOM Contract, Section 7.5*, indicates that enrollees may request a State Fair Hearing within 30 days of receiving notice of the action or within 30 days of the final decision by the Plan. The Enrollee Handbook instructs members correctly that they must file for a State Fair Hearing within 30 days from the date of receipt of a Notice of Action from UnitedHealthcare. Policy MBR13, Plan Enrollees are Informed about Complaint and Grievance Procedure, incorrectly states that enrollees must request a Medicaid Fair Hearing within 90 calendar days of receipt of UHC's notice of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resolution or within 90 calendar days of receipt of the UHC's notice of Action. *Corrective Action: Correct the timeframe for requesting a State Fair Hearing in policy MBR 13, in the UHC appeal uphold letter and the UBH appeal uphold letter.*
1.6 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					Grievance logs submitted for desk review on 03/26/14 contained very little information, and indicated that there were a total of 83 grievances for the entire year of 2013. This number is inconsistent with data reported in the 2013 QI Program Evaluation document, which states that there were a total of 128 grievances for 2013. Onsite discussion indicated that there was a change in staffing in the appeals and grievances department in May 2013, which could account for the discrepancy. *Recommendation: Ensure that grievances are accurately recorded on grievance logs.*
2. The CCO applies the grievance policy and procedure as formulated.	X					
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Onsite discussion with staff confirmed that grievances are tallied and categorized based upon data entered into the documentation system. This system allows reports to be generated with grievances tallied, categorized, and trended. This data is then reported to the various committees for review and identification of potential quality improvement opportunities. All QMC meeting minutes contained documentation that this was discussed.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III G. Practitioner Changes						
1. The CCO investigates all enrollee 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 grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees.	X					The quality improvement program for UnitedHealthcare is outlined in three key documents. The Quality Improvement Program Description, the work plan, and the annual evaluation. The 2013 Quality Improvement Program Description outlines the program's structure and standards for evaluating, monitoring and enhancing the quality of care and quality outcomes.
2. The scope of the QI program includes monitoring of provider compliance with CCO wellness care and disease management guidelines.	X					The 2013 work plan included activities for measuring the effectiveness of the approved guidelines. Two indicators from each guideline are included in this monitoring.
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					UnitedHealthcare provided their 2013 QM and UM work plan. The work plan identifies planned activities related to program priorities that address the quality and safety of clinical care and services. The work plan lists the tasks or topics, objectives, measures, actions, target

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						completion, and date of committee review. The responsible owner(s) of the tasks or topics was not included on the work plan. This was discussed during the onsite and a copy of the 2014 work plan was provided which included the responsible party for each activity.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Management Committee is the decision-making body this is ultimately responsible for the implementation, coordination, and integration of all quality improvement activities for the health plan. These responsibilities have been delegated to this committee by the Board of Directors/Executive Committee.
2. The composition of the QI Committee reflects the enrolleeship required by the contract.	X					Membership for the Quality Management Committee includes senior level staff members and representatives from program service areas. All members have voting privileges except the quality specialists and the clinical practice consultants. The committee's charter is clearly documented in the QI Program Description and included with the minutes.
3. The QI Committee meets at regular quarterly intervals.	X					The Quality Management Committee meets quarterly. UnitedHealthcare has defined the quorum for this committee as a minimum of 51 percent of committee membership. All of the minutes reviewed met the quorum except for the June 2013 meeting. For June's meeting the quorum was only 44 percent. The minutes were re-reviewed by the quality staff and it was found that one voting member attended via phone and a designee was not recorded as attending the meeting. The minutes were corrected and submitted for review.
4. Minutes are maintained that document proceedings of the QI Committee.	X					The minutes for the Quality Management Committee are well documented. The committee attendance,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussions, recommendations and any needed follow-up are included in the minutes. The minutes document any guests that attend each meeting. Several of the guests listed as attending the meetings were included as non-voting members on the 2013 Mississippi Committee Matrix for the Quality Management Committee. UnitedHealthcare's QI staff revised the format of the meeting minutes during the onsite and is now listing the non-voting members of the committee as non-voting participants. *Recommendation: Non-voting members for any of the committee minutes should not be listed as guests attending the meeting.*
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					CCME conducted a validation review of the performance measures following the protocols developed by CMS. UHC uses MedMeasures™ by ViPS®, an NCQA certified HEDIS® software vendor, for their performance measures. The plan was found to be fully compliant and met all the CMS validation requirements for the performance measures. Details of the validation results may be found in the *CCME EQR Validation Worksheets*, Attachment 3.
IV D. Quality Improvement Projects/Focused Studies						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the enrollee population or as directed by DOM.	X					The quality improvement projects included topics for Reducing Adult, Adolescent and Childhood Obesity, Use of Appropriate Medications for People with Asthma, Annual Monitoring for Patients on ACE/ARB Inhibitors, and Comprehensive Diabetes Care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol.	X					All of the projects scored within the *High Confidence* range and met the CMS validation protocol. Details of the validation results may be found in the *CCME EQR Validation Worksheets*, Attachment 3.
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					UnitedHealthcare has a plan for providing their network physicians with feedback regarding their performance with the HEDIS and utilization measures. Physician Performance Profiles are supplied to practitioners so that they can review their quality performance and utilization data as compared to their peers within the state.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Annually UnitedHealthcare evaluates the effectiveness of their quality improvement program. The health plan uses the results of this evaluation to develop and prioritize activities that will be included in the next year's work plan.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors and DOM.	X					The 2013 Quality Improvement Program Evaluation was reviewed during the onsite visit. This program evaluation provided a summary of the results of all QI activities. UnitedHealthcare recognized that their results of the Healthcare Effectiveness Data and Information Set (HEDIS®) were not meeting some of the goals set by the health plan and the Division of Medicaid. Clinical Practice Consultants were hired to develop educational tools and complete provider visits to educate the physicians on the HEDIS measures and rates. This evaluation is presented to the Quality Management

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee for review and approval before submitting to the health plan Board of Directors.
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:			X			The UnitedHealthcare 2013 Utilization Management (UM) Program Description is a national document that provides a general overview of UM objectives, scope, services, roles and responsibilities, service initiatives, and accountability. The UM Program Description contains no description of mechanisms used to detect and document overutilization or underutilization of medical services. This was addressed as a corrective action plan item on the previous EQR but has not been corrected. Other issues identified are discussed in the standards below. *Corrective Action: Include a description of the mechanisms used to detect and document over- and underutilization in the UM 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			Guidelines and standards used in making UM decisions are discussed in the UM Program Description. The process for making utilization criteria available to providers is not included in the Program Description. This was addressed as a corrective action plan item on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the previous EQR but has not been corrected. *Corrective Action: Update the UM Program Description to include the process for making utilization review criteria available to providers.*
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;			X			Timeliness of UM determinations and notifications is not included in the UM Program Description. This was addressed as a corrective action plan item on the previous EQR but has not been corrected. *Corrective Action: Update the UM Program Description to include timeliness requirements for UM determinations and notifications.*
1.5 consideration of new technology;	X					
1.6 the appeal process, including a mechanism for expedited appeal;			X			The UM Program Description gives brief information on which departments handle appeals and grievances for the different lines of business, but doesn't contain a description of the appeals process for Mississippi enrollees and providers. This was addressed as an issue on the previous EQR and has not been corrected. *Corrective Action: Include a description of the processes used for both enrollee and provider appeals in the UM Program Description.*
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 the absence of quotas establishing a number or percentage of claims to be denied.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Deirdre Phillips provides oversight of all Utilization Management processes.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy UCSMM.06.10, Clinical Review Criteria, outlines the evidenced-based clinical review criteria used by UHC. Criteria is evaluated annually and approved by the Medical Director.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy UCSMM.06.10, Clinical Review Criteria, states the clinical review criteria are evidenced-based, applied consistently, and that individual patient circumstances are considered making clinical decisions.
4. Utilization management standards/criteria are consistently applied to all enrollees across all reviewers.	X					Policy UCSMM.06.10, Clinical Review Criteria, indicates that annual inter-rater reliability (IRR) testing is performed to ensure the same utilization review standards are maintained by each individual reviewer, promoting consistency surrounding the decision-making process. No documentation of the IRR process was found in the materials presented for desk review. The UCS Annual Milliman Care Guidelines Interrater Reliability document was received at the onsite review and details the process and benchmark requirements for IRR testing.
5. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					The Preferred Drug List (PDL) is updated routinely and the P&T committee oversees the development of pharmacy policies and procedures.
5.2 If the CCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Per the Pharmacy Overview, UHC makes coverage determinations for exception requests based on medical necessity and how prescribing practitioners must provide information in support of exception requests.
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					UHC uses the prudent layperson definition of an emergency and requires no authorization in or out of network for emergency care. Policies COV 2a, Emergency Services – Coverage and Notification Standards, and COV 3a, Coverage for Post-Stabilization Care, were presented during the onsite visit with a narrative note that they were reviewed and approved in the June 2013 Health Quality and Utilization Committee meeting. However, the policies presented during the onsite visit indicate a last review date of 3/15/12. The Healthcare Quality and Utilization Management Committee (HQUM) minutes from June 2013 confirm that the policies were reviewed and approved, but the review date was not updated on these policies. *Recommendation: Update the review date on the policies referenced above.*
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
9. Initial utilization decisions are made promptly after all necessary information is received.			X			In policy UCSMM.06.19, Information Based Clinical Review, page two, item D (iii), states that if information has been requested but is not forthcoming within the timeframe allotted, one of the following will be initiated…the case will be suspended. Onsite discussion confirmed that this is an error in the policy. In the same policy, page 2, item D (3) (ii), states that if the request is for a standard pre- or post-service review, the consumer or consumer's representative is notified of the specific information required and is given 45 days to provide the information. <u>This was addressed as a corrective action plan item on the previous EQR but has not been corrected.</u> *Federal Regulation §438.210 (d) (1)* and the *MS DOM Contract, Section 5.7*, require that for standard authorization decisions, notice must be provided within 14 calendar days following the receipt of the request for services with a possible extension for up to 14 days. *Corrective Action: The following corrections are required in policy UCSMM.06.19:* *•Correct the error regarding suspending cases when requested information is not received.* *•Correct the timeframe given for requested information to be provided on page 2, item D (3) (ii).* *•Correct the reference to requesting information from the consumer or the consumer's representative. Clinical information should be requested from providers and not from enrollees.*
10. Denials						
10.1 A reasonable effort that is not burdensome on the enrollee or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
10.3 Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denial of service and the procedure for appeal.		X				Page one of the initial notice of action letters submitted for desk review states that enrollees have 30 days after receiving the letter to file an appeal; however, the attached document titled "Your Appeal Rights" indicates that appeals may be requested within 30 days from the date of the letter or action to file an appeal. The *DOM Contract, Section 7.3 (C),* allows appeals to be requested within 30 calendar days of receiving the notice of action. *Corrective Action: Correct the timeframe for requesting appeals in the document titled "Your Appeal Rights".*
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					Policy MBR5a, Member Complaint, Grievance, and Appeals Procedures, addresses UHC's processes for handling and responding to appeals. Issues identified are addressed in the standards below.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				The website glossary defines an appeal as a request for UHC to review a decision or action, yet there is no definition of an action in the website glossary. The following documents do not include information that the definition of an action includes the denial for a resident of a rural area with only one CCO to obtain services outside the network: •Policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures •Policy MBR 13a, Plan Enrollees Are Informed About Complaint and Grievance Procedure

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Policy MBR 14, Expedited Review Process •Enrollee Handbook, page 26 •MS CAN Resource Guide, page 21. *Corrective Action: Include the full definition of an action in policy MBR 5a, policy MBR 13a, policy MBR14, the Enrollee Handbook, and the MS CAN Resource Guide. Add the definition of an action to the website glossary. Please refer to the DOM Contract, Section 7.3.*
1.2 The procedure for filing an appeal;	X					
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 enrollee would be jeopardized by delay;		X				The *DOM Contract, Section 7.4 (G) (2),* requires plans to make reasonable efforts to give the Enrollee prompt oral notice of the denial of an expedited appeal request and to follow up with a written notice within two (2) calendar days. However, Policy MBR 14, page 6, says that this written notice must be provided within 3 calendar days. Discrepancies were noted in policies MBR 14, Expedited Review Process, and MBR 5a, Member Complaint, Grievance, and Appeal Procedures. •Policy MBR 5a, page 13, says that if UHC denies a request for an expedited appeal, it must transfer the appeal to the 45-day resolution timeframe. •Policy MBR 14, Expedited Review Process, says on page 6 that they will be transferred to a 30-day timeframe for resolution. *Corrective Action: Correct the timeframe for notification of a denial of an expedited appeal request in policy MBR*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						14. Correct the discrepancies in the timeframes for resolution of an appeal when an expedited appeal request is transferred to the standard appeal process in policies MBR 14 and MBR 5a.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;			X			1. The Provider Manual and policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures, document standard appeal resolution timeframes as 30 days (pre-service) and 45 days (post-service). However, some documents don't include the pre-service resolution timeframe. <u>This was addressed as a corrective action plan item on the previous EQR but has not been corrected in all documents.</u> •The MS CAN Resource Guide, page 22, lists only a 45 day timeframe for appeals. •The United Behavioral Health policy titled "Member Appeals and Grievances of Non-Coverage Determinations" lists only a 45 calendar day resolution requirement for appeals. UBH/Optum should operate under the same timeframes as UHC for appeals. •The initial denial letter attachment titled "Your Appeal Rights" states that the resolution will be sent within 45 days. There is no distinction that there are different timeframes for pre-service vs standard appeals. 2. Discrepancies and other issues were identified with timeliness of standard appeal resolutions in other documents, and include: •The Enrollee Handbook, page 27, contains one paragraph that documents one resolution timeframe for appeals—45 days. The next paragraph on page 27 documents different timeframes for pre-service appeals (30 days) and standard appeals (45 days). This could lead to confusion for enrollees. The incorrect paragraph should be removed. •Policy RX-22, Pharmacy Grievances and Appeals, page 1, states that pharmacy appeals should follow the UHC

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policies and procedures; however, a reference chart on page 5 of the policy indicates that standard appeals response time is 15 calendar days and expedited appeals response time is 72 hours. 3. Although some documents correctly list the expedited appeal resolution timeframe as 3 business days, incorrect information was noted in other documents, including: •Policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures (page 13), does not state the timeframe for notifying enrollees of the extension when the extension is not requested by the enrollee. •The Provider Manual, page 32, states UHC will make reasonable efforts to give the enrollee prompt verbal notice of an expedited appeal not wholly resolved in their favor and will follow-up with a written notice of action within two calendar days. •Policy RX-022, Pharmacy Grievances and Appeals, contains a table on page 5 that specifies turnaround times for expedited pharmacy appeals as 72 hours. Policy MBR 5a indicates the timeframe as 3 business days for expedited appeals. 4. Regarding extensions of appeal resolution timeframes, the following issues were identified: •The MS CAN Resource Guide contains no information regarding extension of appeal resolution timeframes. •Policy MBR 5a, Member Complaint, Grievance, and Appeal Procedures, does not state the timeframe requirement for notifying enrollees of a plan-requested extension for an expedited appeal. The policy states that written notification is required, but does not document the timeframe (page 13). •Policy MBR 13a, Plan Enrollees Are Informed about Complaint and Grievance Procedure, states on page 5 that enrollees will be notified of a plan-requested appeal extension within 5 business days. The *DOM Contract,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Section 7.2, requires this notification within 2 business days. *Corrective Action:* *•Include both the pre-service and post-service appeal resolution timeframes in all documents, including the MS CAN Resource Guide, the United Behavioral Health policy titled "Member Appeals and Grievances of Non-Coverage Determinations", and the initial denial letter attachment titled "Your Appeal Rights".* *•Correct the discrepancies and other errors identified above in the Enrollee Handbook timeframe for resolution of appeals on page 27.* *•Choose the timeframe that will be used for pharmacy appeals, and ensure that the chosen timeframe is documented accurately throughout policy RX-22.* *•Correct the errors in the expedited appeal resolution timeframe in policies MBR 5a and RX-022 as well as the Provider Manual.* *•Add information regarding the extension of appeal resolution timeframes to the MS CAN Resource Guide.* *•Add the timeframe for notifying enrollees of an extension of an expedited appeal to policy MBR 5a.* *•Correct the timeframe for notifying enrollees of plan-requested appeal extensions in policy MBR 13a.*
1.6 Written notice of the appeal resolution as required by the contract;		X				The *DOM Contract, Section 7.5*, allows enrollees to request a State Fair Hearing up to 30 days from the date of receipt of a notice of the Action or within 30 days of the final decision by the Contractor. The United Behavioral Health appeal uphold letter states that enrollees unhappy with the decision to uphold the original denial determination may request a State Fair Hearing "within 30 days from the original notice of denial from UBH".

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Correct the timeframe for requesting a State Fair Hearing in the UBH appeal uphold letter.
1.7 Other requirements as specified in the contract.		X				Requirements for continuation of benefits pending the outcome of an appeal can be found in *Federal Regulation §438.420* and in the *DOM Contract, Section 7.3 (L)*. Errors and discrepancies were noted in multiple documents regarding the timeframe to request continuation of benefits: •The Enrollee Handbook, page 28, says that benefits must be requested within 10 days of the date on the Notice of Action. •Policy MBR 13a, page 6, states that benefit continuation must be requested within 10 business days after the notice of action is mailed. •United Behavioral Healthcare policy, "Member Appeals and Grievances of Non-coverage Determinations" states on page 9 that continuation of benefits must be requested within 30 days from the date on the Notice of Action. •The initial denial letter, the reduction in service letter, and the United Behavioral Health medical necessity denial letter state in their attachment titled "Your Appeal Rights" that continuation of benefits must be requested within 10 days of the date on the letter. •The UnitedHealthcare and United Behavioral Health Appeal Uphold Letters state benefits must be requested within 10 days from the date the enrollees receives the decision. The *DOM Contract, Section 7*, requires that enrollees have the right to file a request for a State Fair Hearing with the Division of Medicaid upon notification of a contractor action, or concurrent with, subsequent to, or in lieu of an appeal of the contractor action. The following issues related to requests for State Fair Hearings were noted in the United Behavioral Health (UBH) policies:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The UBH policy titled "Member Appeals and Grievances of Non-Coverage Determinations indicates that expedited appeals may be requested for services not yet rendered at the same time as an urgent appeal to the MS DOM. The policy contains no documentation that all appeals to MS DOM (standard and expedited) may be requested, before, at the same time as, or after a plan level appeal. •The same policy states on page 6 that if UBH fails to make a determination and issue a notice within the timeframe requirements, an enrollee may be permitted to bypass the UBH internal appeal process and have the case reviewed by MS DOM. •The UBH policy titled "Management of Behavioral Health Benefits" states on page 13 that notices of action for non-coverage determinations will include information about the enrollee's right to request a State Fair Hearing through the MS DOM when the internal appeal review process has been completed. *Corrective Action:* *Correct the timeframe to request continuation of benefits in the Enrollee Handbook, policy MBR 13a, the UBH policy titled "Member Appeals and Grievances of Non-coverage Determinations, the initial denial letter, the reduction in service letter, the document titled "Your Appeal Rights" that is attached to the UBH medical necessity denial letter, the UHC appeal upheld letter, and the UBH appeal uphold letter.* *The following documents should be corrected to indicate that all appeals can be requested before, at the same time as, or after a plan level appeal as required in the DOM Contract, Section 7:* *•The UBH policy titled "Member Appeals and Grievances of Non-Coverage Determinations, and* *•The UBH policy titled "Management of Behavioral*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Health Benefits"
2. The CCO applies the appeal policies and procedures as formulated.	X					
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					
V. D Case Management/Disease Management						
1. The CCO utilizes case management techniques to insure comprehensive, coordinated care for all enrollees through the following minimum functions:	X					UHC has implemented the use of a Readmission Risk Assessment (RRA) along with transition case management (TCM). The RRA evaluates which enrollees are high risk for hospital readmissions, and attempts to engage them in TCM. The goal is to provide information on disease management, meet immediate needs, such as for DME, medication instruction, track and encourage follow-up appointments and the use of a patient-centered record/personal health record, to ensure continuity across providers and settings. Statistically, the enrollees in TCM for 60 or more days had fewer hospital readmissions.
1.1 Enrollee choice of primary care health professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the Enrollee requests otherwise;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Appropriate referral and scheduling assistance for Enrollees needing specialty health care services, including those identified through EPSDT;						
1.3 Documentation of referral services and medically indicated follow-up care in each Enrollee's medical record;						
1.4 Monitoring and treatment of Enrollees with ongoing medical conditions according to appropriate standards of medical practice;						
1.5 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
1.6 Coordination of hospital discharge planning;						
1.7 Determination of the need for non-covered services and referral of Enrollees to the appropriate service setting, utilizing assistance as needed from the Division.						
1.8 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), Part B and Part C; the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program;						
1.9 Ensuring that Enrollees are entitled to the full range of their health care providers' opinions and counsel about the availability of medically necessary services under the provisions of this Contract. Any contractual provisions, including gag clauses or rules, that restrict a health care provider's ability to advise patients about medically necessary treatment options violate federal law and regulations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Ensuring that Medicaid providers are not limited in the scope of practice, as defined by federal and state law, in providing services to Plan Enrollees;						
1.11 Ensuring that when a provider is no longer available through the Plan, the Contractor allows Enrollees who are undergoing an active course of treatment to have continued access to that provider for a limited period of time;						
1.12 The Contractor shall provide for a second opinion from a qualified health care professional within the network, or arrange for the Enrollee to obtain one outside the network, at no cost to the Enrollee;						
1.13 If the Network is unable to provide necessary medical services covered under the contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						
1.14 The Contractor must produce a treatment plan for Enrollees determined to need a course of treatment or regular care monitoring. The treatment must be developed by the Enrollee's primary care provider with Enrollee participation, and in consultation with any specialists caring for the Enrollee.						
2. The CCO has disease state management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					
V E. Evaluation of Over/ Underutilization						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization addresses UnitedHealthcare's process for monitoring PCP over and under-utilization and provider profiling.
2. The CCO monitors and analyzes utilization data for under and over utilization.	X					Over and Under Utilization trends are monitored on a quarterly basis. Some of the data provided in the desk materials included the following topics in regards to utilization: outpatient visits per 1000, ER visits per 1000, prior authorizations, and average inpatient length of stay.
V I. DELEGATION						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					UnitedHealthcare has delegated contracts with the following entities: Vision Service Plan, United Dental, Optum, United C&S Prior Authorization, United Clinical Services, MHG & Physicians Corporation, Hattiesburg Clinic, Mississippi Health Partners, River Region, HubHealth, and University Physicians. The vendor list received in the desk materials also listed Appeals & Grievances and Pharmacy as delegated. A sample agreement was received in the desk materials.
2. The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions.		X				Evidence of annual oversight was presented in the desk materials. A review of the oversight tools showed the following issues: •The review of the annual delegation oversight tool used for oversight of appeals and grievances revealed that details of the standards and requirements which were evaluated were not included. The tool includes only general statements such as "decision time standard" and "written time standard", but does not define what those standards are. •No oversight tool was received for behavioral health. The Optumhealth Credentialing Program for 2013 received in the desk materials did not reflect any specific

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						credentialing requirements for MS. In fact, Attachment B (State Specific Requirements) did not include MS. •Evidence of annual monitoring for credentialing/ recredentialing delegation was received but a review of the tools only showed NCQA requirements and no information specific to MS requirements. The tool should include requirements for the following: proof of primary/secondary source verifications (i.e. license, DEA/CDS, board certification, if applicable, etc.) and proof of queries (NPDB, SAM, OIG, State Sanctions) must be in the file; site reviews for initial credentialing; site reviews for member complaints within 45 days instead of the 60 days listed in the tool; proof of malpractice insurance; signed attestation and current re-attestment if using CAQH; copy of CLIA certificate/waiver; hospital privileges should be addressed for nurse practitioners acting as PCPs; and delegates should be collecting ownership disclosure forms for credentialing and recredentialing. •Many of the tools used for credentialing/recredentialing oversight did not list Medicaid in the Audit Findings tab, section "Product(s) supported by delegate". *Corrective Action: Update the delegation oversight tools to ensure they reflect the actual standards being evaluated and that those standards are the same requirements that UHC is being held to as an organization.*
V I I. STATE-MANDATED SERVICES						
A. The CCO tracks provider compliance with:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. administering required immunizations;	X					The 2013 Quality Improvement Program Description indicates that annual PCP utilization and quality profiles summarize utilization history for specific utilization and quality indicators, including encounters, ER and hospital visits, visits by age range for children, immunizations by age range, etc. This monitoring generates statistically significant profiles. Individual provider scores are compared to network peer scores. Providers in the lowest quartile are targeted for quality improvement initiatives. Policy COV 5c, Early and Periodic Screening, documents the processes and measures used to identify and encourage immunization of all enrollees under one year old whose medical records indicate that immunizations are not up to date. Policy COV 5d, Early and Periodic Screening, documents the plans processes for outreach and follow-up of all children and adolescents regarding recommended preventive and screening services. To their credit, UHC has hired an EPSDT coordinator to oversee the program, monitor compliance of members and providers, provide education and report as required by the CCO Contract.
2. performing EPSDTs/Well Care.	x					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
B. Core benefits provided by the CCO include all those specified by the contract.	X					
C. The CCO addresses deficiencies identified in previous independent external quality reviews.			X			The following items were identified as deficiencies on the 2012 EQR review and have not been corrected: •The printed Provider Directory does not include alternate languages spoken by providers. •The UM Program Description contains no description of mechanisms used to detect and document overutilization or underutilization of medical services. •The UM Program Description does not document the process for how utilization review criteria are made available to providers. •Timeliness requirements for UM determinations and notifications are not included in the UM Program Description. •The appeal process for enrollees and providers is not included in the Program Description. •The timeframe for submission of additional information needed to review a request for medical necessity has not been corrected in policy UCSMM.06.19. •The 2012 Corrective Action Plan included a requirement that all documents be updated to include the process for using a different timeframe for pre-service and post-service appeals. There are still documents that do not reflect the different timeframes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The following issues were identified in the credentialing/recredentialing processes, policies, and files. These issues were listed as deficiencies during the 2012 EQR and have not been corrected or implemented: •Collect a copy of the malpractice insurance coverage face sheet. •Collect a copy of the CLIA Certificates or Certificates of Waiver for practitioners that indicate they bill laboratory services on the application. •Conduct office site visits for initial credentialing. •Follow-up site visits should be conducted of offices which received member complaints within 45 calendar days. Include evidence of the follow-up visit in the credentialing file. •For Nurse Practitioners that are acting as PCPs, confirm the plan for admitting patients. •Address Disclosure of Ownership in the credentialing/recredentialing process. *Corrective Action: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.*