CCME

2018 External Quality Review

UNITEDHEALTHCARE COMMUNITY PLAN MISSISSIPPI

Submitted: October 4, 2018

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies who contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This review determines the level of performance demonstrated by UnitedHealthcare Community Plan – Mississippi (UHC). This report contains a description of the process and results of the 2018 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The Goals of the review are to:

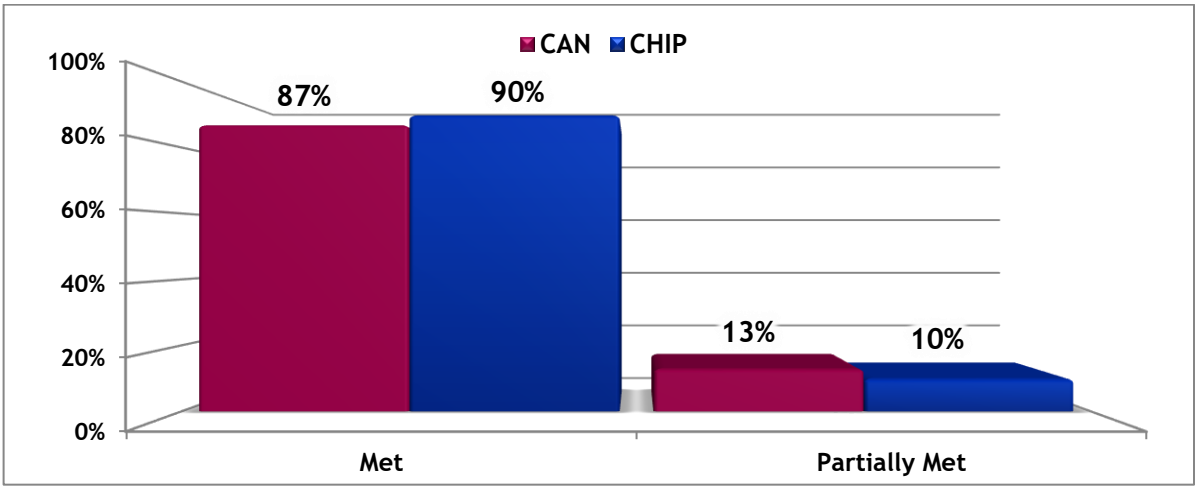
- Determine if UHC is in compliance with service delivery as mandated in the Coordinated Care Organization (CCO) contract with DOM.
- Provide feedback about potential areas of improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

The process used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO. The review includes a desk review of documents, results from a one-day onsite visit, a compliance review, validation of performance improvement projects and performance measures, member satisfaction survey and provider satisfaction survey validations, and an Information System Capabilities Assessment (ISCA) audit.

OVERVIEW

The 2018 EQR review of the CAN program reflects UHC achieved "Met" scores for 87% of the standards reviewed. As the following chart indicates, 13% of the standards were scored as "Partially Met". For the CHIP program, 90% of the standards received were scored as "Met" score and 10% of the standards were scored as "Partially Met."

Figure 1: 2018 Annual EQR Review Results for CAN & CHIP



Overall Findings

An overview of the findings for each section is included in this Executive Summary. Details of the review, as well as specific strengths, weaknesses, any applicable corrective action items and recommendations, are found in the respective sections and narrative of this report.

Management Information Systems

UHC has established adequate processes that uniquely identify enrollees, track member and encounter data across product lines, identify newborns, and correlate newborns with an existing Medicaid member. UHC reviews and monitors member and encounter demographics for accuracy regularly. In addition, UHC uses a National Committee for Quality Assurance (NCQA) accredited software for Healthcare Effectiveness Data and Information Set (HEDIS®) and state reporting. UHC has backup and disaster recovery plans in place and conducts regular recovery exercises to identify areas that might need remediation.

UHC's Information Systems Capabilities Assessment (ISCA) documentation indicates the organization is capable of meeting or exceeding the contractual requirements; however, UHC estimates that only 85-90% of claims are completed within the required timeframe.

Provider Services

The Provider Advisory Committee (PAC), chaired by Dr. Lionel Fraser, Chief Medical Officer, acts as the Health Plan's Credentialing Committee and meets quarterly to review recommendations made by the National Credentialing Committee (NCC). The PAC has the authority to approve, deny, or suspend the recommendations made by the NCC related to the Mississippi Medicaid network. The NCC reviews all credentialing/recredentialing

decisions and the local Health Plan is represented by a MS network provider with voting privileges on the NCC. CCME's onsite discussion confirmed the MS Chief Medical Officer attends NCC meetings frequently.

Credentialing plans for licensed independent practitioners and facilities address the procedures for credentialing/recredentialing providers into the network. CCME's review of CAN and CHIP files identified issues in the following areas: proof of queries such as the Social Security Death Master File (SSDMF), Office of Inspector General (OIG), System for Award Management (SAM), and/or National Plan and Provider Enumeration System (NPPES) not in the file; unexplained gap in work history not documented in the file; Clinical Laboratory Improvement Amendments (CLIA) not in the file when the application indicated laboratory services were performed; hospital plan not addressed for a psychiatrist; and ownership disclosure forms signed by a credentialing specialist when UHC's document states that provider entity signatures must be from an individual with the power to legally bind the entity.

The Provider Satisfaction Survey validation meets all requirements of the *CMS Survey Validation Protocol*. Recommendations to increase response rates and improve the generalizability of survey is recommended to the plan because the survey had a low response rate (4.7%).

Member Services

UHC has established policies that define requirements and processes for handling member grievances and complaints. Information about grievances is communicated to members and providers in the *CAN* and *CHIP Member Handbooks, Provider Manuals*, and on UHC's CAN and CHIP websites. CCME identified issues with grievance terminology, including outdated language and incomplete or missing definitions of grievance and complaint terminology in reviewed documents. Issues in documentation of grievance processes and requirements are also identified related to documentation of grievance filing timeframes, acknowledgement timeframes and processes, and grievance resolution and extension timeframes.

CCME's review of CAN and CHIP grievance files revealed only isolated issues. These issues were discussed with UHC staff and CCME provided suggestions to correct the issues. UHC uses grievance data quality improvement activities for both the CAN and CHIP products and membership.

CCME validated Member Satisfaction Surveys for both the CHIP and CAN populations. UHC used an NCQA-certified vendor to conduct both the CAN and CHIP Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. The surveys meet all requirements for validation; however, low response rates affect the generalizability of the surveys. CCME provided recommendations to increase future survey response rates.

UHC developed interventions for improvement based on survey results and includes the interventions in applicable work plans.

Quality Improvement

CCME's Quality Improvement review included a validation review of the HEDIS and non-HEDIS performance measures and validating the performance improvement projects for the CAN and CHIP programs. UHC is fully compliant and meets all the requirements for CAN and CHIP HEDIS measures. When comparing the MY 2015 CAN rates to the MY 2016 CAN rates, there were substantial improvement in rates for Body Mass Index (BMI) Percentile documentation for children/adolescents and Persistence of Beta-Blocker Treatment After a Heart Attack among others. CCME notes a decline in rates for Asthma Medication compliance and Antidepressant Medication Management. The comparison of the CHIP rates found several measures that had improvement of greater than 10%, including BMI Percentile documentation, lead screening, and Antidepressant Medication Management. Measures with a substantial decrease in rate include dental visits for 19-20-year olds and Initiation and Engagement of AOD Dependence Treatment (iet) for the 18+ age group.

CCME did not complete validation of the CAN non-HEDIS measures due to issues with DOM's reporting template. The Excel formulas in the reporting template are incorrect and do not provide the measure rates in accordance with the DOM specifications. The non-HEDIS performance measure for the CHIP program Developmental Screening in the First Three Years of Life is fully compliant.

UHC submitted four performance improvement projects for the CAN program and four projects for the CHIP program. All projects receive a score of "High Confidence in Reported Results." CCME provided recommendations to help improve some of the documentation in project documents.

Utilization Management

CCME's assessment of the Utilization Management (UM) section includes reviews of the program description, program evaluation, policies, committee minutes, *Provider Manual*, *Member Handbook,* and case management files. The *CAN* and *CHIP UM Program Descriptions* outline the purpose, goals, objectives, and staff roles. Policies define how case management services are operationalized to service members. CCME identified issues with appeals processes and provided recommendations to address them.

Table 1, Scoring Overview, provides an overview of the scores for each review section for the CAN and the CHIP programs.

Table 1: Scoring Overview

2018	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Management Information Systems						
CAN	3	1	0	0	0	4
CHIP	3	1	0	0	0	4
Provider Services						
CAN	46	6	0	0	0	52
CHIP	49	3	0	0	0	52
Member Services						
CAN	10	3	0	0	0	13
CHIP	10	3	0	0	0	13
Quality Improvement						
CAN	3	0	0	0	0	3
CHIP	3	0	0	0	0	3
Utilization Management						
CAN	25	3	0	0	0	28
CHIP	25	3	0	0	0	28

METHODOLOGY

On May 21, 2018, CCME sent notification to UHC that the annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials needed for the desk review and the EQR Review Standards for the CAN and CHIP programs.

Further, an invitation was extended to the health plan to participate in a pre-onsite conference call with CCME and DOM for purposes of offering UHC an opportunity to seek clarification on the review process and ask questions regarding any of the desk materials requested by CCME.

The review consisted of two segments. The first was a desk review of materials and documents received from UHC on June 20, 2018 for review at the CCME offices (see *Attachment 1*).

The second segment was a one-day, onsite review conducted August 22, 2018, at UHC's office in Ridgeland, Mississippi. CCME's onsite visit focused on areas not covered by the desk review and areas needing clarification (see *Attachment 2*). CCME's onsite activities included:

- Entrance and exit conferences (open to all interested parties)
- Interviews with UHC's administration and staff

The process used for the EQR is based on the CMS protocols for EQR of MCOs. This review focused on the three federally mandated EQR activities: compliance determination, validation of performance measures, and validation of performance improvement projects. In addition, the review included the optional activities of member and provider satisfaction survey validations.

FINDINGS

The findings of the EQR are summarized in the following pages of this report and are based on the regulations set forth in *42 CFR § 438.358* and the contract requirements between UHC and DOM. Strengths, weaknesses, any corrective actions needed, and recommendations are identified where applicable.

Areas of review are recorded in a tabular spreadsheet (*Attachment 4*) and identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated." Separate tabular spreadsheets for the respective "CAN" and the "CHIP" programs are included in *Attachment 4*.

I. Management Information Systems

With one exception, UHC's ISCA documentation indicates the organization is capable of meeting or exceeding the contractual requirements. The exception is related to the estimated paid clean claim rate. Ninety-nine percent (99%) of clean claim payments are required to be completed within 90 days, but UHC estimates 85-90% of its claims are complete within the noted timeframe.

UHC uses the state assigned Medicaid ID to uniquely identify enrollees and can track member and encounter data across product lines. Data within the state's 834 files is used to identify newborn enrollees and correlate newborns with an existing Medicaid member. UHC reviews and monitors member and encounter demographics for accuracy regularly.

UHC uses General Dynamics Information Technology's (GDIT) MedMeasures software, a National Committee for Quality Assurance (NCQA) accredited solution for analyzing and reporting performance and effectiveness data, for HEDIS and state reporting. Dedicated data warehouse reporting is validated against source data for accuracy.

ISCA documentation demonstrates UHC has a backup and disaster recovery plan in place. UHC performs regular table-top recovery exercises that track areas of success and any areas that need remediation.

As noted in *Figure 2, Management Information Systems Findings*, both the CAN and CHIP programs received "Met" scores for 75% of the standards in Management Information Systems.

Figure 2: Management Information Systems Findings

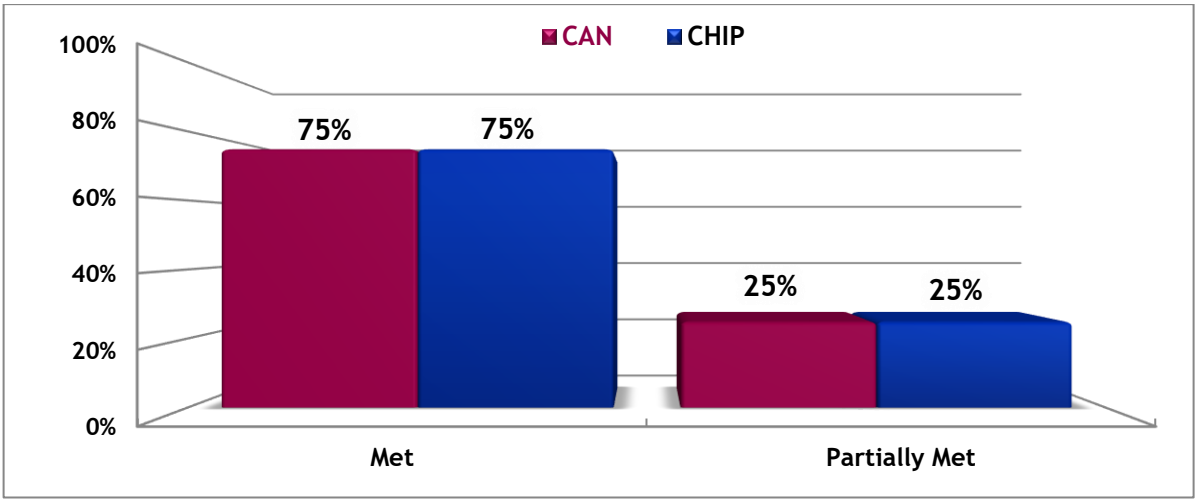


Table 2: CAN Management Information Systems

Section	Standard	CAN 2018 Review
Information Systems Capabilities Assessment (ISCA)	The CCO processes provider claims in an accurate and timely fashion	Partially Met

Table 3: CHIP Management Information Systems

Section	Standard	CHIP 2018 Review
Information Systems Capabilities Assessment (ISCA)	The CCO processes provider claims in an accurate and timely fashion	Partially Met

Strengths

- UHC has well-documented backup and disaster recovery plans, and testing is documented.
- UHC's data handling policy documentation is detailed and concise.

Weaknesses

- UHC's claims performance estimates do not meet contractual requirements to pay 99% of clean claims within 90 days.

Corrective Action

- Implement processes to ensure UHC meets the contractual requirements to pay 99% of clean claims within 90 days.

II. Provider Services

CCME conducted a review of UHC's Provider Services policies and procedures, credentialing and recredentialing processes and files, provider network information, and the Provider Satisfaction Survey.

The Provider Advisory Committee (PAC) is chaired by Dr. Lionel Fraser, Chief Medical Officer. Additional voting members of the committee include ten network providers with specialties in pediatrics, psychiatry, dentistry, OB/GYN, internal medicine, family medicine, and emergency medicine. The Committee Chair votes in case of a tie, and a quorum is met with 51% of voting members in attendance. The committee meets at least quarterly, and a report of providers credentialed by the National Credentialing Committee (NCC) is presented at each meeting. The *PAC Charter* states it is the local Credentialing Committee. The PAC acts as the health plan's Credentialing Committee, reviews the NCC recommendations, and has the authority to approve, deny, or suspend the recommendations made by NCC related to the Mississippi Medicaid network. The NCC reviews all credentialing/recredentialing decisions. During onsite discussions, CCME confirmed the MS Chief Medical Officer attends the meetings frequently. The NCC voting members include 16 network physicians from local plans, and Mississippi is represented by Dr. George Russell, Orthopedic Surgeon. A quorum is met with 51% of the voting members in attendance.

The *UnitedHealthcare Credentialing Plan 2017-2019* defines the procedures for credentialing and recredentialing licensed independent practitioners and facilities in to the network. Specific credentialing criteria for Mississippi are detailed in an addendum to the credentialing plan. Aperture conducts primary source verification.

The *United Behavioral Health Clinician and Facility Credentialing Plan 2017-2018* defines processes for behavioral health, and the *Optum Physical Health Credentialing Risk Management Plan 2018* defines processes for physical medicine providers, including chiropractic, physical therapy, occupational therapy, and speech therapy. During onsite discussions, CCME confirmed that UHC is integrating these credentialing programs into one credentialing process.

The credentialing and recredentialing file review showed the files were organized, but a few issues were identified in one or more files for CAN and CHIP regarding the following areas: proof of queries such as the SSDMF, OIG, SAM, and NPPES not in the file; unexplained gap in work history not documented in the file; CLIA not in the file when the application indicated laboratory services were performed; hospital admitting plan not addressed for a psychiatrist; and ownership disclosure forms signed by a credentialing specialist when UHC's document states provider entity signatures must be from an individual with the power to legally bind the entity.

Provider Satisfaction Survey Validation

As a part of this EQR, CCME validated the Provider Satisfaction Survey using the *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. Issues regarding the response rate was identified as an area needing improvements. *Table 4, Provider Satisfaction Survey Validation Results* reflects the section of the worksheet that needs improvement, the reason, and the recommendation. The complete worksheet is available as an attachment in this report.

Table 4: Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	The survey had a low response rate (4.7%). The low response rate may impact the generalizability of the survey.	Focus on strategies that would help increase response rates for this population. Solicit the help of the survey vendor.

As noted in *Figure 3, Provider Services Findings,* the CAN program received "Met" scores for 88% of the Provider Services standards. For the CHIP program, the percentage of "Met" scores in Provider Services was 94%.

Figure 3: Provider Services Findings

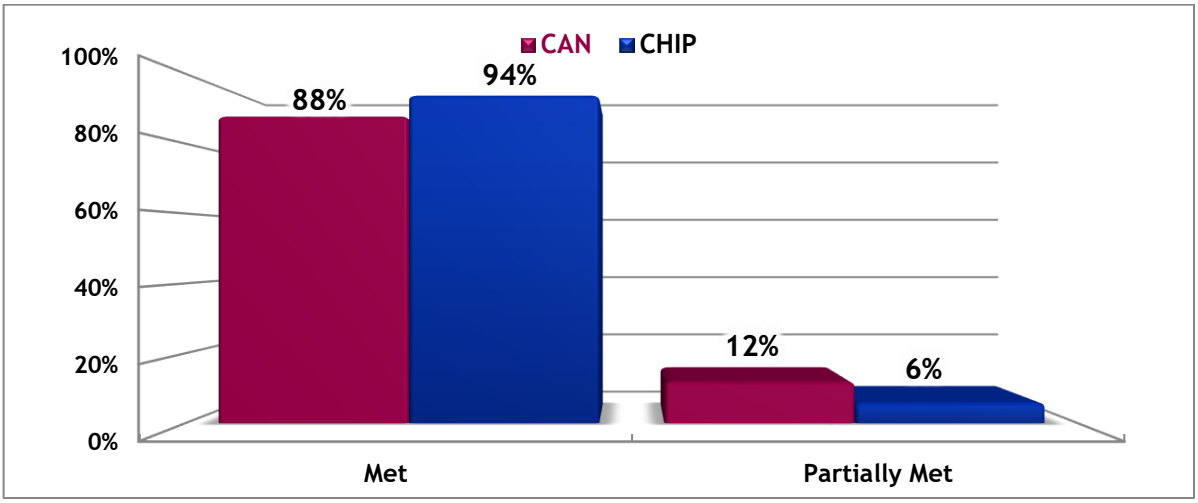


Table 5: CAN Provider Services

Section	Standard	CAN 2018 Review
Credentialing and Recredentialing	Credentialing: Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met
	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	Partially Met
	Ownership Disclosure Form	Partially Met
	Recredentialing: Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met
	Ownership Disclosure form	Partially Met
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met

Table 6: CHIP Provider Services

Section	Standard	CHIP 2018 Review
Credentialing and Recredentialing	Credentialing: Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Partially Met
	Recredentialing: Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met

Strengths

- A Mississippi network provider is a voting member of the National Credentialing Committee.

Weaknesses

- The following weaknesses relate to the CAN provider credentialing and recredentialing file review:
  - One credentialing file indicated on the Aperture checklist that no information was provided for an unexplained gap in the work history. There was no evidence in the file that the unexplained gap had been investigated.
  - Three credentialing files and three recredentialing files did not contain proof of querying the Social Security Death Master File (SSDMF). Per onsite discussion, effective 6/1/17, UHC implemented a national process to check the SSDMF and no longer uses Aperture to perform the checks. It does not appear that UHC has implemented a process to ensure the credentialing/recredentialing files reflect proof of querying the SSDMF.
  - One credentialing file for a psychiatrist reflected "yes" for the behavioral health center location providing laboratory services, but there was no CLIA in the file. During onsite discussion, UHC indicated it does not pursue CLIAs for behavioral health; however, if laboratory services are provided, the CLIA must be pursued and evidence should be in the credentialing file.
  - The *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* (Q10) defines parameters for who can legally provide the signature on the disclosure. It states that for Provider Entities, the signature must be from an individual with the power to legally bind the entity, such as an owner or officer. Office managers'/assistants' signatures are not acceptable. However, one

credentialing file and one recredentialing file reviewed for an entity reflected the form was signed by a credentialing specialist.

- One recredentialing file indicated on the Aperture checklist that the NPDB had been queried: however, proof of query was not in the file.
- One recredentialing file indicated on the Aperture checklist that the OIG had been queried: however, proof of query was not in the file.

- The following weaknesses relate to the CHIP provider credentialing and recredentialing file review:
  - One credentialing file and three recredentialing files did not show proof the Social Security Death Master File (SSDMF) was queried.
  - One credentialing file for a psychiatrist did not address the hospital plan on the application or the checklist.
- The review of organizational providers reflected the following issues for recredentialing files:
  - For CAN, two entity files did not contain proof of queries for SAM and NPPES.
  - For CAN, one entity file did not contain proof of CLIA. During the onsite visit, UHC provided a copy of an expired CLIA.
  - For CHIP, one entity file indicated Aperture verified the SAM electronically, but a copy of the query was not in the file.
- GEO Access reports for CAN and CHIP reflect the mileage standard for Emergency Care providers was assessed as "one within 60 miles" for Rural when the guideline is "one within 30 miles" for Rural.
- The Provider Satisfaction survey had a low response rate of 4.7%. The low response rate may impact the generalizability of the survey.

Corrective Action

- The following corrective actions apply to the CAN credentialing and recredentialing file review:
  - Ensure evidence of the SSDMF query is included in the credentialing and recredentialing files.
  - Ensure CLIAs are collected for any provider indicating laboratory services are provided.
  - Ensure ownership disclosure forms are signed by an appropriate individual with the power to legally bind the entity.

- For organizations, ensure credentialing/recredentialing files include proof of query for SAM and NPPES, and a current CLIA if providing laboratory services.

- The following corrective actions apply to the CHIP credentialing and recredentialing file review:
  - Ensure evidence of the SSDMF query is included in the credentialing and recredentialing files.
  - Ensure credentialing/recredentialing files address a hospital admitting plan for psychiatrists if they do not have hospital admitting privileges.

Recommendations

- The following recommendations apply to the CAN credentialing/recredentialing file review:
  - Ensure credentialing files reflect an explanation of any unexplained gaps in the work history.
  - Ensure credentialing/recredentialing files contain proof of query of the OIG.
  - Ensure credentialing/recredentialing files contain proof of query of the NPDB.
- The following recommendations apply to the CHIP credentialing/recredentialing file review:
  - Ensure copies of the queries for the SAM are placed in the organizational credentialing/recredentialing files.
- Ensure the quarterly GEO Access reports for CAN and CHIP reflect the correct mileage parameter for Rural Emergency Care providers.
- Regarding the Provider Satisfaction Survey (CAN and CHIP), focus on strategies that help increase response rates for this population. Solicit the help of the survey vendor.

III. Member Services

CCME's review of Member Services for UHC encompasses policies, requirements, internal processes for grievances, and grievance files for the CAN and CHIP lines of business.

Policies define requirements and processes for handling member grievances and complaints. In addition to the policies, information about grievances is found in the *CAN* and *CHIP Member Handbooks, Provider Manuals*, and on UHC's CAN and CHIP websites.

CCME identified several issues with grievance terminology, including:

- UHC CAN and CHIP website glossaries and the *CHIP Member Handbook* contain an incomplete definition of a grievance, and the *CHIP Provider Manual* does not define a grievance.

- The *CAN Member Handbook*, *CAN Provider Manual*, and CAN website glossary do not define a complaint.
- The *CAN Member Handbook* and *CAN Provider Manual* use the outdated term of "action" instead of "adverse benefit determination" when addressing grievances. This does not correspond with current contract and Federal Regulation terminology.

CCME also identified issues in documentation of grievance processes and requirements. Findings include:

- Lack of documentation that grievances may be filed at any time in the *CAN* and *CHIP Member Handbooks*, the *CHIP Provider Manual*, and in Optum's Mississippi CHIP Addendum to Enrollee Grievances
- Incorrect documentation that grievance filing is limited to within 30 days of the incident causing dissatisfaction in the *CAN Provider Manual*, Optum's Mississippi CAN Addendum to Enrollee Grievances, and CHIP Policy AG-03, Complaint and Grievance Policy and Procedures
- Errors in documentation of acknowledgement timeframes and processes in the Optum Mississippi CAN Addendum to Enrollee Grievances, the *CAN Provider Manual*, the *CAN Member Handbook*, and CHIP Policy AG-03
- Incorrect and missing information about grievance resolution timeframes and extensions of the timeframes in the Optum Mississippi CAN and CHIP Addenda to Enrollee Grievances, the *CHIP Member Handbook*, and *CHIP Provider Manual*

Review of CAN grievance files revealed only isolated issues, including a resolution letter that does not appear to correspond to the grievance, and a resolution letter that contained language the member might not understand. The CHIP grievance file review also revealed isolated issues, such as an acknowledgement letter sent after the required acknowledgement timeframe, a discrepancy in documentation of the receipt date, and insufficient documentation to determine if the resolution is appropriate.

Grievance data are reported to appropriate committees and used for quality improvement activities for both the CAN and CHIP products and membership.

Member Satisfaction Survey Validation

Member Satisfaction Surveys for both the CHIP and CAN populations underwent validation by CCME using *EQR Protocol 5, Validation and Implementation of Surveys (version 2.0, September 2012)*. DSS Research, an NCQA-certified vendor, conducted both the CAN and CHIP Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

The validations reveal sufficient sampling sizes; however, low response rates result in difficulty discerning the generalizability of the surveys:

- CAN Adult survey—response rate 22.87%
- CAN Child survey—response rates 20.79% (total) and 19.72% (general population)
- CHIP Child survey—response rates 28.49% (total) and 26.97% (general population)

CCME recommends that UHC focus on strategies that help increase response rates for the populations, such as setting an internal response rate goal (i.e., receiving a 2% increase over the previous year's response rate) as opposed to the target rate set by the Agency for Healthcare Research & Quality (AHRQ).

The survey results are presented and discussed in appropriate committee meetings, and interventions for improvement are included in applicable work plans.

The complete validation results are detailed in *Attachment 3, EQR Validation Worksheet*.

For CAN, 77% of the standards for Member Services are scored as "Met" and 23% of standards are scored as "Partially Met." For CHIP, the percentage of "Met" scores is 77% and "Partially Met" scores account for 23%. Standards scored as "Partially Met" are illustrated in Tables 7 and 8 below.

Figure 4: Member Services Findings

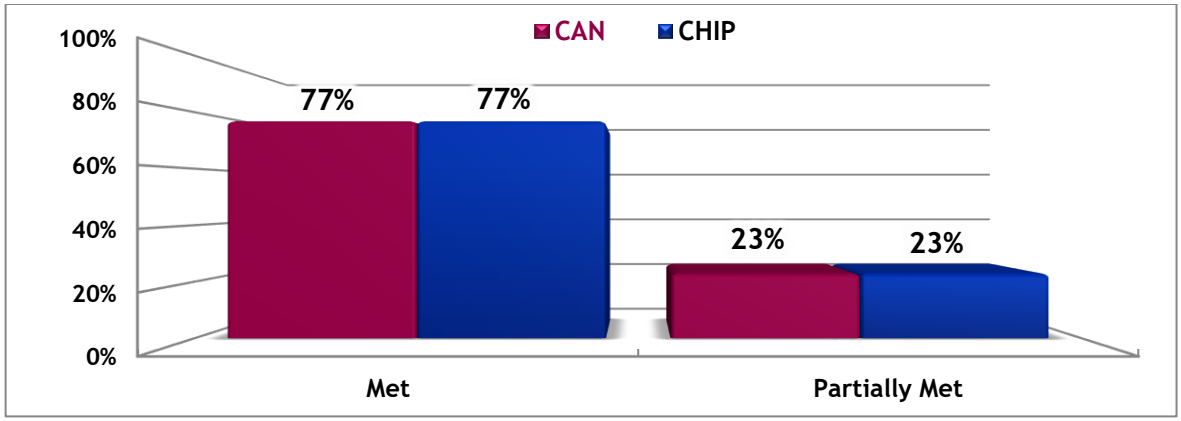


Table 7: CAN Member Services

Section	Standard	CAN 2018 Review
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to: definition of a complaint/grievance and who may file a complaint/grievance	Partially Met
	The procedure for filing and handling a complaint/grievance	Partially Met
	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Partially Met
	Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract	Partially Met

Table 8: CHIP Member Services

Section	Standard	CHIP 2018 Review
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to: definition of a complaint/grievance and who may file a complaint/grievance	Partially Met
	The procedure for filing and handling a complaint/grievance	Partially Met
	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Partially Met

Strengths

- Grievance files reflect staff consistently refers potential quality of care concerns for investigation.

Weaknesses

- The generalizability of the CAN and CHIP member satisfaction survey results is difficult to discern due to low response rates.

- Optum's Mississippi CAN Addendum to Enrollee Grievances was last revised in February 2017.
- Issues with the definition of a complaint include:
  - The *CAN Member Handbook* and UHC's CAN website glossary do not define the term "complaint."
  - The *CAN Provider Manual* alludes to the complaint process in the grievance section but does not define a complaint.
  - Page 31 of the *CAN Member Handbook* refers members to the "Complaints, Grievances, Appeals and State Fair Hearings" section of the handbook; however, the handbook does not have a section titled as such. The section on page 58 is titled "Grievances, Appeals and State Fair Hearings."
- The *CHIP Provider Manual* does not define the term "grievance."
- UHC's CAN and CHIP website glossaries and the *CHIP Member Handbook*, pages 49 and 50, contain incomplete definitions of grievances/complaints; they fail to include "about any matter other than an Adverse Benefit Determination." Refer to *42 CFR §438.400* and the *CAN Contract, Final Rule Amendment, Section 6 (K)* and *Exhibit D*.
- The following documents use the outdated term "action" rather than the correct terminology "adverse benefit determination" in the definition of a grievance:
  - *CAN Member Handbook*, page 58
  - *CAN Provider Manual*, pages 36 and 39
  - CHIP Policy AG-03
- The heading for the section on page 48 of the *CHIP Member Handbook* is "Appeals and Complaints." Throughout the section the terms "complaint" and "grievance" seem to be used interchangeably, which can be confusing for members since separate processes exist for complaints and grievances.
- The *CAN Member Handbook* does not define the timeframe to file a complaint.
- *42 CFR §438.402 (c) (2) (i)* allows grievances to be filed at any time. Issues with documentation of timeframes to file grievances include:
  - The *CAN Provider Manual*, page 39, and Optum's Mississippi CAN Addendum to Enrollee Grievances incorrectly state the timeframe to file a grievance is 30 days.
  - Page 4 of CHIP Policy AG-03, Complaint and Grievance Policy and Procedures, incorrectly defines the timeframe to file a grievance as 30 days.
  - The unlimited timeframe to file a grievance is not addressed in the *CHIP Member Handbook* and *CHIP Provider Manual*.

  - The Optum Mississippi CHIP Addendum to Enrollee Grievances does not address the unlimited timeframe to file a grievance; however, the timeframe is defined in the National Optum Enrollee Grievances: Medicaid policy.
- The *CHIP Member Handbook* contains very little information on grievances and the grievance filing process and does not indicate that UHC assists members in the grievance filing process, if needed.
- Onsite discussion confirmed UHC acknowledges receipt of written grievances within five calendar days of receipt. CCME noted the following issues in documentation:
  - Optum's Mississippi CAN and CHIP Addenda to Enrollee Grievances and CHIP Policy AG-03 incorrectly state grievances are acknowledged within five business days.
  - The *CAN Provider Manual*, page 37, states written grievances are acknowledged within 10 working days from receipt.
  - The *CAN Member Handbook*, page 58, states, "We will send you a letter telling you we received your grievance." There is no distinction between written and verbal grievances as noted in UHC's policy, and as written, sounds as if all grievances are acknowledged in writing.
- Optum's Mississippi CHIP Addendum to Enrollee Grievances and National Optum Enrollee Grievances: Medicaid policies do not address the resolution timeframe for complaints and expedited grievances.
- The *CHIP Member Handbook* does not include resolution timeframes for expedited grievances and does not include information on extensions of grievance resolution timeframes.
- The *CHIP Provider Manual* does not define the complaint and grievance resolution timeframes or provide information about extensions of grievance resolution timeframes.
- Optum's Mississippi CAN and CHIP Addenda to Enrollee Grievances do not address extensions of the grievance resolution timeframe. This information is found in the CAN and CHIP Optum National Enrollee Grievances: Medicaid policy.
- The retention timeframe for grievance documentation is not defined in Optum's Mississippi CAN Addendum to Enrollee Grievances or in Optum's National Enrollee Grievances: Medicaid policy.
- CCME's review of CAN grievance files reveals the following:
  - One resolution letter does not seem to match the stated grievance, and the file lacked notes of the investigation making it difficult to determine if the resolution is correct.

- One resolution letter used language the member might not understand (references to a GPS/tracking system called "Reveal") and contains incomplete sentences.

- CCME's review of CHIP grievance files reveals the following:
  - One acknowledgement letter was sent after the required timeframe for acknowledgement.
  - One file reflects discrepancies in documentation of the receipt date of the grievance.
  - One file has insufficient documentation regarding the services for which the member is billed, resulting in the inability to determine if the resolution is appropriate.

Corrective Actions

- Update the *CAN Member Handbook*, *CAN Provider Manual*, and website glossary to define the term "complaint."
- Update the *CHIP Provider Manual* to define the term "grievance."
- Revise the definition of a grievance/complaint in UHC's CAN and CHIP website glossaries and in the *CHIP Member Handbook*, pages 49 and 50, to include the full definition as defined in Federal Regulation and the CAN and CHIP Contracts.
- Revise the *CAN Member Handbook*, the *CHIP Member Handbook*, and the *CHIP Provider Manual* to state member grievances can be filed at any time.
- Update the *CAN Member Handbook* to define the timeframe to file a complaint.
- Correct the timeframe to file a grievance in the *CAN Provider Manual*, in Optum's Mississippi CAN and CHIP Addenda to Enrollee Grievances, and in CHIP Policy AG-03.
- Revise the *CHIP Member Handbook* to contain a complete overview of the grievance process and include information that states assistance with the grievance filing process is provided to members if needed.
- Correct the timeframe for grievance acknowledgement in the *CAN Provider Manual* and in Optum's Mississippi CAN Addendum to Enrollee Grievances.
- Clarify the *CAN Member Handbook*, page 58, to include the processes for acknowledging both written and verbal grievances.
- Update Optum's Mississippi CHIP Addendum to Enrollee Grievances to include resolution timeframes for complaints and expedited grievances.
- Revise the *CHIP Member Handbook* to include resolution timeframes for expedited grievances and information on extensions of grievance resolution timeframes.

- Revise the *CHIP Provider Manual* to include complaint and grievance resolution timeframes and information on extensions of grievance resolution timeframes.
- Revise the Optum Mississippi CAN Addendum to Enrollee Grievances to include the timeframe for grievance record retention.

Recommendations

- For the CAN and CHIP Member Satisfaction Surveys, focus on strategies that help increase response rates. Set internal response rate goals (such as receiving a 2% increase over the previous year's response).
- Review and revise the Optum Mississippi CAN Addendum to Enrollee Grievances annually.
- Update the heading on page 58 of the *CAN Member Handbook* to "Complaints, Grievances, Appeals and State Fair Hearings" as stated on page 31.
- Update the *CAN Member Handbook*, the *CAN Provider Manual*, and CHIP Policy AG-03 to use the current term of "adverse benefit determination" instead of "action." Refer to *42 CFR § 438.400 (b)*.
- Update the heading on page 48 of the *CHIP Member Handbook* to include grievances and revise this section of the *CHIP Member Handbook* to clearly define the differences between complaints and grievances and explain the processes for both.
- Update the Optum Mississippi CHIP Addendum to Enrollee Grievances to indicate grievances may be filed at any time.
- Revise Optum's Mississippi CAN and CHIP Addenda to Enrollee Grievances to include information about extensions of grievance resolution timeframes.
- Ensure grievance files contain:
  - sufficient documentation of investigation findings to verify resolution is correct
  - language members understand easily
  - evidence of timely acknowledgement
  - evidence that the date of receipt is consistently documented

IV. Quality Improvement

As part of the EQR for UHC, CCME conducted a validation review of the HEDIS and non-HEDIS performance measures and validated the performance improvement projects (PIPs) for the CAN and CHIP programs following CMS protocols. This section is an overview of that validation starting with the performance measure (PM) validation.

Performance Measure Validation

CCME reviewed and validated HEDIS measures in accordance with the HEDIS technical specifications. UHC is fully compliant and meets all the requirements for the reporting year MY 2016 (HEDIS 2017). All relevant HEDIS performance measures for UHC CAN are reported in *Table 9: HEDIS CAN Performance Measure Results* with a comparison to the MY 2015 (HEDIS 2016) rates. The change in rates is also presented. UHC reflects substantial improvement in rates for BMI Percentile documentation for children/adolescents, Persistence of Beta-Blocker Treatment After a Heart Attack, and others. A decline is noted in rates for Asthma Medication compliance and Antidepressant Medication Management.

Table 9: HEDIS CAN Performance Measure Results

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	73.22%	80.79%	7.57%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	34.06%	45.99%	11.93%
Counseling for Nutrition	39.90%	48.91%	9.01%
Counseling for Physical Activity	39.90%	40.63%	0.73%
Childhood Immunization Status (cis)			
DTaP	76.64%	77.86%	1.22%
IPV	90.51%	92.70%	2.19%
MMR	90.75%	90.75%	0.00%
HiB	87.83%	87.10%	-0.73%
Hepatitis B	90.27%	89.78%	-0.49%
VZV	91.00%	90.27%	-0.73%
Pneumococcal Conjugate	79.08%	77.13%	-1.95%
Hepatitis A	80.54%	76.89%	-3.65%
Rotavirus	65.21%	75.18%	9.97%
Influenza	20.92%	26.03%	5.11%
Combination #2	75.18%	73.48%	-1.70%
Combination #3	72.02%	69.83%	-2.19%
Combination #4	64.96%	59.61%	-5.35%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Combination #5	56.45%	61.31%	4.86%
Combination #6	17.76%	21.90%	4.14%
Combination #7	51.58%	52.31%	0.73%
Combination #8	16.79%	20.19%	3.40%
Combination #9	12.90%	19.71%	6.81%
Combination #10	12.41%	18.00%	5.59%
Immunizations for Adolescents (ima)			
Meningococcal	47.93%	51.58%	3.65%
Tdap	79.81%	79.81%	0.00%
HPV	11.53%	6.81%	-4.72%
Combination #1	47.20%	51.58%	4.38%
Combination #2	NR	6.08%	NA
Lead Screening in Children (lsc)	65.45%	66.52%	1.07%
Breast Cancer Screening (bcs)	47.78%	50.21%	2.43%
Cervical Cancer Screening (ccs)	60.00%	56.82%	-3.18%
Chlamydia Screening in Women (chl)			
16-20 Years	45.57%	48.43%	2.86%
21-24 Years	66.58%	62.73%	-3.85%
Total	58.71%	51.15%	-7.56%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	54.36%	62.76%	8.40%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.06%	29.49%	-0.57%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	35.34%	32.40%	-2.94%
Bronchodilator	63.15%	67.17%	4.02%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	64.32%	52.55%	-11.77%
5-11 Years: Medication Compliance 75%	35.24%	21.94%	-13.30%
12-18 Years: Medication Compliance 50%	58.06%	49.25%	-8.81%
12-18 Years: Medication Compliance 75%	31.34%	21.89%	-9.45%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
19-50 Years: Medication Compliance 50%	62.77%	50.97%	-11.80%
19-50 Years: Medication Compliance 75%	36.80%	23.30%	-13.50%
51-64 Years: Medication Compliance 50%	66.67%	57.45%	-9.22%
51-64 Years: Medication Compliance 75%	45.10%	40.43%	-4.67%
Total: Medication Compliance 50%	62.12%	51.38%	-10.74%
Total: Medication Compliance 75%	35.26%	23.69%	-11.57%
Asthma Medication Ratio (amr)			
5-11 Years	NR	82.52%	NA
12-18 Years	NR	67.70%	NA
19-50 Years	NR	47.69%	NA
51-64 Years	NR	46.67%	NA
Total	NR	62.44%	NA
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	43.07%	47.69%	4.62%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	53.85%	64.29%	10.44%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy: 21-75 Years (Male)	NR	69.29%	NA
Statin Adherence 80%: 21-75 Years (Male)	NR	37.25%	NA
Received Statin Therapy: 40-75 Years (Female)	NR	61.17%	NA
Statin Adherence 80%: 40-75 Years (Female)	NR	35.65%	NA
Received Statin Therapy: Total	NR	65.19%	NA
Statin Adherence 80%: Total	NR	36.49%	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	78.59%	87.10%	8.51%
HbA1c Poor Control (>9.0%)	67.64%	56.93%	-10.71%
HbA1c Control (<8.0%)	26.76%	35.04%	8.28%
HbA1c Control (<7.0%)	NR	NR	NA
Eye Exam (Retinal) Performed	71.05%	63.50%	-7.55%
Medical Attention for Nephropathy	93.19%	93.67%	0.48%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Blood Pressure Control (<140/90 mm Hg)	45.99%	49.39%	3.40%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	NR	NR	NA
Statin Adherence 80%	NR	NR	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	NR	NR	NA
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	56.19%	42.17%	-14.02%
Effective Continuation Phase Treatment	41.55%	24.65%	-16.90%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	49.19%	58.10%	8.91%
Continuation and Maintenance (C&M) Phase	67.65%	70.30%	2.65%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	60.83%	73.43%	12.60%
7-Day Follow-Up	38.96%	53.97%	15.01%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	NR	NR	NA
7-Day Follow-Up	NR	NR	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	NR	NR	NA
7-Day Follow-Up: 13-17 Years	NR	NR	NA
30-Day Follow-Up: 18+ Years	NR	NR	NA
7-Day Follow-Up: 18+ Years	NR	NR	NA
30-Day Follow-Up: Total	NR	NR	NA
7-Day Follow-Up: Total	NR	NR	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	NR	70.59%	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NR	67.25%	NA

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NR	NR	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	NR	56.87%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NR	35.42%	NA
6-11 Years	NR	23.23%	NA
12-17 Years	NR	21.21%	NA
Total	NR	22.39%	NA
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	87.07%	88.09%	1.02%
Diuretics	86.48%	87.08%	0.60%
Total	86.42%	87.33%	0.91%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	4.45%	2.88%	-1.57%
Appropriate Treatment for Children With URI (uri)	62.04%	60.15%	-1.89%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	34.75%	32.18%	-2.57%
Use of Imaging Studies for Low Back Pain (lbp)	71.82%	65.59%	-6.23%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NR	NA
6-11 Years	NR	NR	NA
12-17 Years	NR	NR	NA
Total	NR	NR	NA
Use of Opioids at High Dosage (uod)	NR	NR	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	NR	NR	NA
Multiple Pharmacies	NR	NR	NA
Multiple Prescribers and Multiple Pharmacies	NR	NR	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
20-44 Years	85.44%	86.31%	0.87%
45-64 Years	91.55%	91.83%	0.28%
65+ Years	87.18%	93.62%	6.44%
Total	87.49%	88.35%	0.86%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	96.37%	97.02%	0.65%
25 Months - 6 Years	92.06%	88.23%	-3.83%
7-11 Years	92.36%	92.46%	0.10%
12-19 Years	89.06%	89.78%	0.72%
Annual Dental Visit (adv)			
2-3 Years	35.13%	48.93%	13.80%
4-6 Years	64.27%	71.12%	6.85%
7-10 Years	70.28%	71.38%	1.10%
11-14 Years	63.86%	67.75%	3.89%
15-18 Years	54.92%	58.41%	3.49%
19-20 Years	37.37%	44.87%	7.50%
Total	59.61%	64.98%	5.37%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	NR	72.41%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	NR	8.74%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	NR	42.67%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	NR	6.57%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	NR	45.89%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	NR	6.80%	NA
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	69.85%	90.49%	20.64%
Postpartum Care	53.35%	62.93%	9.58%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NR	35.90%	NA

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
6-11 Years	NR	65.69%	NA
12-17 Years	NR	68.74%	NA
Total	NR	66.42%	NA
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	9.78%	4.15%	-5.63%
21-40 Percent	5.21%	1.95%	-3.26%
41-60 Percent	7.00%	3.41%	-3.59%
61-80 Percent	12.24%	8.29%	-3.95%
81+ Percent	65.76%	82.20%	16.44%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.92%	1.95%	-0.97%
1 Visit	2.43%	3.89%	1.46%
2 Visits	4.38%	6.08%	1.70%
3 Visits	7.54%	9.00%	1.46%
4 Visits	10.95%	10.46%	-0.49%
5 Visits	21.41%	17.03%	-4.38%
6+ Visits	50.36%	51.58%	1.22%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	56.51%	60.74%	4.23%
Adolescent Well-Care Visits (awc)	41.61%	45.01%	3.40%

NA: Indicates denominator was too small; NR: Not reported

CCME reviewed and validated the CHIP HEDIS measures in accordance with the HEDIS 2017 technical specifications for the reporting year 2016. All relevant HEDIS performance measures for UHC CHIP for the current review year (MY 2016) are reported in *Table 10: HEDIS CHIP Performance Measure Results* in addition to the MY 2015 rate and the change from 2015 to 2016. As shown, there are several measures that have improvement of greater than 10%, including BMI Percentile documentation, lead screening, and antidepressant medication management. Measures with a substantial decrease in rate include dental visits for 19-20-year olds and Initiation and Engagement of AOD Dependence Treatment (iet) for the 18+ age group.

Table 10: HEDIS CHIP Performance Measure Results

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	30.66%	46.23%	15.57%
Counseling for Nutrition	40.63%	46.72%	6.09%
Counseling for Physical Activity	36.74%	42.34%	5.60%
Childhood Immunization Status (cis)			
DTaP	79.72%	81.02%	1.30%
IPV	86.36%	89.78%	3.42%
MMR	91.61%	91.97%	0.36%
HiB	83.92%	87.59%	3.67%
Hepatitis B	86.36%	88.56%	2.20%
VZV	91.61%	90.27%	-1.34%
Pneumococcal Conjugate	80.42%	82.48%	2.06%
Hepatitis A	71.68%	79.56%	7.88%
Rotavirus	72.73%	78.10%	5.37%
Influenza	36.36%	31.63%	-4.73%
Combination #2	75.87%	76.89%	1.02%
Combination #3	74.13%	74.94%	0.81%
Combination #4	59.79%	64.48%	4.69%
Combination #5	64.69%	67.64%	2.95%
Combination #6	32.87%	27.98%	-4.89%
Combination #7	52.80%	57.91%	5.11%
Combination #8	28.32%	26.28%	-2.04%
Combination #9	30.42%	26.76%	-3.66%
Combination #10	26.22%	25.06%	-1.16%
Immunizations for Adolescents (ima)			
Meningococcal	47.93%	54.26%	6.33%
Tdap/Td	88.56%	85.40%	-3.16%
HPV	9.89%	13.63%	3.74%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Combination #1	47.93%	54.01%	6.08%
Combination #2	NR	12.65%	NA
Lead Screening in Children (lsc)	39.16%	63.50%	24.34%
Chlamydia Screening in Women (chl)			
16-20 Years	37.51%	37.56%	0.05%
*21-24 Years**	NA	NA	NA
Total	37.51%	37.56%	0.05%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	57.71%	66.05%	8.34%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	*66.81%*	*62.16%*	*-4.65%*
5-11 Years: Medication Compliance 75%	*32.75%*	*30.81%*	*-1.94%*
*12-18 Years: Medication Compliance 50%**	*53.17%*	*50.81%*	*-2.36%*
*12-18 Years: Medication Compliance 75%**	*29.27%*	*25.41%*	*-3.86%*
Total Medication Compliance 50%	60.55%	56.49%	-4.06%
Total Medication Compliance 75%	31.42%	28.11%	-3.31%
Asthma Medication Ratio (amr)			
5-11 Years	NR	86.39%	NA
12-18 Years	NR	77.11%	NA
Total	NR	81.63%	NA
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	NR	38.71%	NA
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	26.32%	47.62%	21.30%
Effective Continuation Phase Treatment	23.68%	33.33%	9.65%
Follow-up care for children prescribed ADHD Medication (add)			
Initiation Phase	49.62%	50.00%	0.38%
Continuation and Maintenance (C&M) Phase	65.38%	60.87%	-4.51%
Follow-Up After Hospitalization for Mental Illness (fuh)			

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
30-day follow-up	76.02%	76.97%	0.95%
7-day follow-up	54.59%	53.95%	-0.64%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	NR	50.00%	NA
6-11 Years	NR	28.33%	NA
12-17 Years	NR	28.46%	NA
Total	NR	28.65%	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.55%	1.78%	-0.77%
Appropriate Treatment or Children with URI (uri)	52.99%	54.17%	1.18%
Use of Imaging Studies for Low Back Pain (lbp)	NR	63.33%	NA
Access/Availability of Care			
Children and Adolescents'' Access to Primary Care Practitioners (cap)			
12-24 Months	98.96%	99.80%	0.84%
25 Months-6 Years	91.15%	91.38%	0.23%
7-11 Years	94.31%	94.24%	-0.07%
12- 19 Year	91.89%	92.72%	0.83%
Annual Dental Visit (adv)			
2-3 Years	53.45%	53.34%	-0.11%
4-6 Years	75.23%	75.82%	0.59%
7-10 Years	79.14%	80.69%	1.55%
11-14 Years	73.29%	75.35%	2.06%
15-18 Years	64.00%	67.14%	3.14%
19-20 Years	67.02%	51.69%	-15.33%
Total	71.62%	72.95%	1.33%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	53.13%	61.76%	8.63%
Engagement of AOD Treatment: 13-17 Years	3.13%	5.88%	2.75%
Initiation of AOD Treatment: 18+ Years	55.88%	43.75%	-12.13%
Engagement of AOD Treatment: 18+ Years	14.71%	3.13%	-11.58%

Measure/Data Element	MY 2015 Rates	MY 2016 Rates	Change
Initiation of AOD Treatment: Total	54.08%	53.03%	-1.05%
Engagement of AOD Treatment: Total	7.14%	4.55%	-2.59%
Prenatal and Postpartum Care (ppc)			
*Timeliness of Prenatal Care**	66.67%	50.00%	-16.67%
*Postpartum Care**	77.78%	16.67%	-61.11%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
*<21 Percent**	NR	0.00%	NA
*21-40 Percent**	NR	0.00%	NA
*41-60 Percent**	NR	33.33%	NA
*61-80 Percent**	NR	16.67%	NA
*81+ Percent**	NR	50.00%	NA
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	2.19%	1.59%	-0.60%
1 Visit	1.46%	2.87%	1.41%
2 Visits	1.46%	0.96%	-0.50%
3 Visits	6.57%	3.18%	-3.39%
4 Visits	5.11%	10.83%	5.72%
5 Visits	18.25%	15.29%	-2.96%
6+ Visits	64.96%	65.29%	0.33%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	58.29%	61.35%	3.06%
Adolescent Well-Care Visits (awc)	40.15%	47.45%	7.30%

**Small denominator for rate calculation; NR= Not Reported; NB= No Benefit; NA= not calculated*

Non-HEDIS Performance Measures

Non-HEDIS performance measures include Asthma Related ER visits, Asthma Related Readmissions, EPSDT Screening, CHF Readmissions, Pre/Post Natal Complications, and Pregnancy Outcome. Validation of the non-HEDIS measure required CCME to review the following for each measure:

- General documentation for the performance measure
- Denominator data quality
- Validity of denominator calculation
- Numerator data quality
- Validity of numerator calculation
- Data collection procedures (if applicable)
- Sampling methodology (if applicable)
- Measure reporting accuracy

This process assesses the production of these measures by UHC to verify that what is submitted to DOM complies with the measure specifications defined by DOM. Each CCO was provided a Microsoft® Excel (Excel) reporting template prepared by a DOM vendor for reporting their CAN non-HEDIS rates. During the onsite, CCME determined that the Excel formulas in the reporting template are incorrect and do not provide the measure rates in accordance with the DOM specifications. Based on this determination, CCME did not perform validation of the CAN non-HEDIS measures for the current review cycle.

The non-HEDIS performance measure, as per the CHIP contract, includes the measure: Developmental Screening in the First Three Years of Life. The MY 2016 rates for the Non-HEDIS CHIP measure are reported in *Table 11: CHIP Non-HEDIS Performance Measure Report Rates*.

Table 11. CHIP Non-HEDIS Performance Measure Reported Rates

Measure	Reported Rates for MY 2016
Developmental Screening in the First Three Years of Life (DEV-CH)	
Age 12 months	15.21%
Age 24 months	25.33%
Age 36 months	15.63%
Total	Not Reported

UHC CHIP is fully compliant and meets all the requirements for the non-HEDIS measures as per the report by Attest Health Care Advisors. *Table 12: CHIP Non-HEDIS Performance Measure Validation Results* provides an overview of the validation scores for the CHIP measures.

Table 12: CHIP Non-HEDIS Performance Measure Validation Results

Measure	Validation Scores
Developmental Screening in the First Three Years of Life (DEV-CH)	91% FULLY COMPLIANT

The complete validation results are found in *Attachment 3, EQR Validation Worksheet*.

Performance Improvement Project (PIP) Validation

CCME conducted validation of PIPs in accordance with CMS protocol, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are:

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

UHC submitted four PIPs for the CAN program. The topics included Adult, Adolescent and Childhood Obesity, Comprehensive Diabetes Care, Annual Monitoring for Patients on ACE/ARB Inhibitors, and Adult Member Satisfaction. The previous review noted concerns with data analysis plans and presentation of results. For the current review, prior issues were corrected. All four projects received validation scores within the "High Confidence" range as noted in *Table 13: CAN Performance Improvement Project Validation Scores*.

Table 13: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Adult, Adolescent and Childhood Obesity	103/116=89% Confidence in Reported Results	116/116=100% High Confidence in Reported Results
Comprehensive Diabetes Care	106/116=91% High Confidence in Reported Results	116/116=100% High Confidence in Reported Results
CHF- Annual Monitoring for Patients on Ace/ARB Inhibitors	86/96=90% High Confidence in Reported Results	96/96=100% High Confidence in Reported Results
Adult Member Satisfaction	Not Previously Validated	92/98=94% High Confidence in Reported Results

The tables that follow list the specific errors by project and include recommendations to correct the errors.

Table 14: Adult Member Satisfaction

Section	Reasoning	Recommendation
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	A barriers/causal analysis was conducted, although interventions to address the member and provider barriers were not documented.	Initiate interventions to address member and provider barriers and document the interventions and start data in Section IV of the report.
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?	Baseline data did have interpretation in the Rationale section. However, the results narrative should be in Section III.	Adjust report so that analysis of baseline and remeasurement results are in Section III. Include follow-up activities based on the results in the interpretation.

For CHIP, UHC submitted four projects for desk review. As per the contract, a PIP regarding obesity should be selected annually for continuous evaluation. The topics are Adolescent Well Child Visits, Follow Up after Hospitalization for Mental Illness, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, and Getting the Care Needed CAHPS, which is still awaiting state approval to replace the ASM PIP. In the previous EQR, issues for the PIPs involved clarification of the research question, data analysis plan, actual analysis, and improvement in rates for the follow-up after hospitalization PIP. For the current review, those issues are corrected. The results of the validation for the CHIP program PIPs follows.

Table 15: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Adolescent Well Child Visits	109/109=100% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- formerly called Reducing Adolescent and Childhood Obesity	109/109= 100% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Getting Needed Care CAHPS	Not Previously Validated	92/98=94% High Confidence in Reported Results
Follow Up After Hospitalization for Mental Illness	90/96=94% High Confidence in Reported Results	95/95=100% High Confidence in Reported Results

As shown, all projects received a score of "High Confidence in Reported Results." The tables that follow list the specific errors by project and include recommendations to correct the errors.

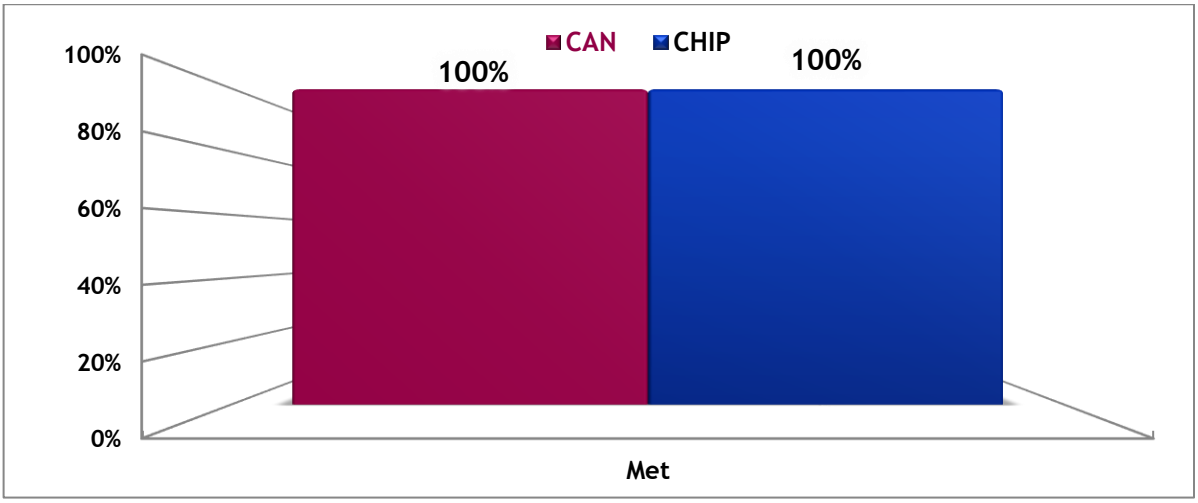
Table 16: Getting Needed Care CAHPS

Section	Reasoning	Recommendation
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Barriers are documented. Interventions to address the provider and member barriers are not documented.	Include interventions that address the barriers noted in the fishbone analysis.
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?	Conclusions were offered, and follow-up plans were documented, but they were not included in the appropriate section of the report (Section III.B).	Revise report so that interpretation of results is documented in Section III.B. of the report.

Details of the validation activities for the performance measures and PIPs, and specific outcomes related to each activity may be found in *Attachment 4, CCME EQR Validation Worksheets*.

Figure 5, Quality Improvement Findings indicates that for the CAN and CHIP programs, 100% of the standards received a "Met" score.

Figure 5: Quality Improvement Findings



Strengths

- PIPs are based on analysis of comprehensive aspects of enrollee needs and services and rationale for each topic is documented.
- HEDIS performance measures are fully compliant.
- All PIPs received validation scores in the high confidence range.

V. Utilization Management

CCME conducted a review of Utilization Management (UM), including appeals, care management, and transitional care management. The review encompasses policies, program descriptions, program evaluations, committee minutes, and appeal and care management files.

UHC has established policies detailing appeal requirements and processes for the CAN and CHIP programs. Appeals requirements and processes are also found in *Member Handbooks* and *Provider Manuals*. Review of all information provided reveals numerous instances of outdated language that defines appeals terminology in CAN and CHIP materials. Incorrect or missing information about timeframes for appeal acknowledgement are noted in CHIP materials, including Policy AG-04, the *CHIP Member Handbook*, the *CHIP Provider Manual*, and Optum Behavioral Health appeals policies. CCME also notes incorrect documentation of the timeframe to request a State Fair Hearing in a CAN letter template, a CAN policy, and the *CAN Member Handbook*.

Despite these documentation issues, CCME's review of CAN and CHIP appeal files finds that appropriate processes are followed by UHC staff when receiving, reviewing, and resolving member appeals.

The CAN and CHIP Case Management (CM) policies and procedures, as well as the program descriptions, provide guidance to staff performing CM activities. The different levels of risk stratification are primarily determined by the score generated from the Health Risk Assessment (HRA). CCME has provided several recommendations to improve documentation in various Care Management documents for both the CAN and CHIP Care Management Programs. The review of CAN and CHIP Care Management files reflect UHC staff conduct appropriate CM activities for members' conditions and assigned risk levels. The review of CAN and CHIP Transitional Care Management programs and documentation reflect appropriate collaboration of the interdisciplinary care team in managing member needs.

As noted in *Figure 6, Utilization Management Findings*, UHC received "Met" scores for 89% of the standards in the UM section of the review for CAN and 89% of the standards in the UM section of the review for CHIP.

Figure 6: Utilization Management Findings

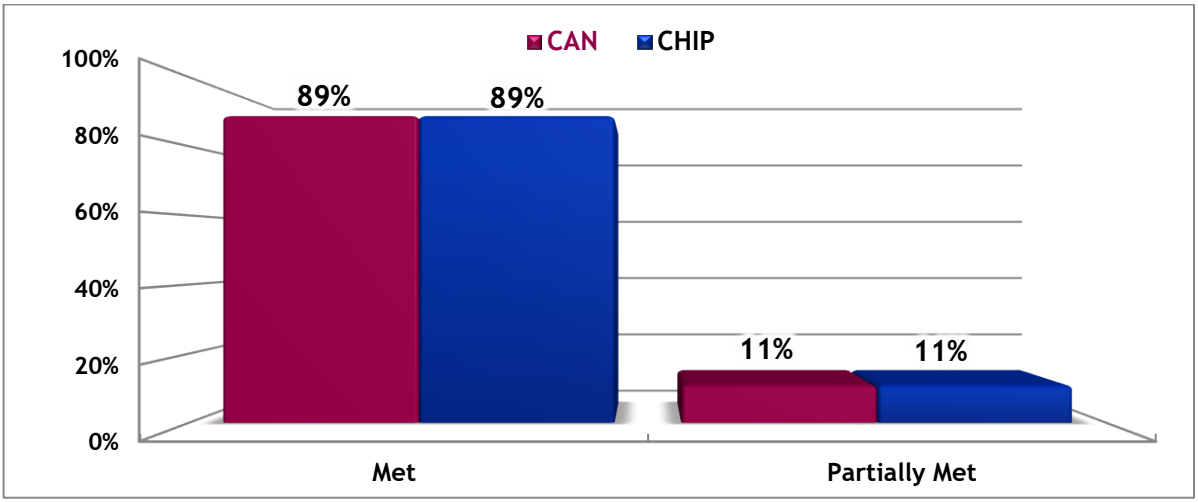


Table 17: CAN Utilization Management

Section	Standard	CAN 2018 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met
	Written notice of the appeal resolution as required by the contract	Partially Met
	Other requirements as specified in the contract	Partially Met

Table 18: CHIP Utilization Management

Section	Standard	CHIP 2018 Review
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met
	The procedure for filing an appeal	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met

Strengths

- Case Management files reflect UHC uses available resources to provide quality services to members.

- Overall, the format and reading level of the letter templates are easy to understand.

Weaknesses

- The term "adverse benefit determination" is defined in Policy AG-02, Standard and Expedited Appeal and State Hearing Policy and Procedures (Draft 2018). However, on pages 6, 7, 9, 10, and 16 the term "action" is used instead of adverse benefit determination. Refer to *42 CFR §438.400 (b)*. The following documents also use the term "action" instead of "adverse benefit determination":
  - Policy MSCANSFH-02, Handling of Administrative and Fair Hearing Request
  - Policy AG-04, Standard and Expedited Appeal Process and Procedures
  - *CAN Member Handbook* (pages 59, 60, and 62)
  - *CAN Provider Manual* (pages 34, 35, and 40)
  - *CHIP Member Handbook*
  - *CHIP Provider Manual* (pages 29 through 31) uses both "action" and "adverse action"
- The *CAN Provider Manual*, page 34, does not indicate that written consent from the member is required when the provider files an appeal on the member's behalf.
- According to the *CAN Contract, Section K*, the timeframe for filing a State Fair Hearing is 120 calendar days from the date of the appeal resolution notice. The following documents incorrectly define the timeframe for requesting a State Fair Hearing:
  - The *CAN BH Appeal Uphold* notice indicates a State Fair Hearing must be filed within 30 days.
  - The *CAN Member Handbook*, page 31, indicates a State Fair Hearing should be filed within 60 calendar days of UHC's final decision.
  - Policy MSCANSFH-02, Handling of Administrative and Fair Hearing Requests, indicates a State Fair Hearing must be filed within 30 days.
- *42 CFR §438.406 (b) (1)* requires acknowledgement of each appeal, and UHC staff indicated during onsite discussion that appeal acknowledgment letters are sent to CHIP members within 10 days of receiving the appeal request. The following issues are identified:
  - Policy AG-04 does not include processes or timeframes for acknowledging appeals.
  - The *CHIP Member Handbook* does not inform members that appeals will be acknowledged.
  - Page 30 of the *CHIP Provider Manual* indicates appeals will be acknowledged in one working day for expedited appeals and within five working days for standard

appeals. However, as noted above, UHC staff indicated acknowledgement is provided within 10 days of receipt of an appeal.

- The instructions for filing an appeal in the *CHIP Provider Manual* interchangeably use the terms "appeal" and "grievance." This is could be confusing for readers.
- A *Grievance and Appeal Form* is located on page 53 of the *CHIP Member Handbook*; however, there is no reference to this form or instructions for the use of the form elsewhere in the *CHIP Member Handbook*.
- Optum's Enrollee Appeals of Adverse Benefits Determinations: Medicaid policy and the Optum Mississippi CHIP Addendum to Enrollee Appeals of Adverse Benefit Determinations, Provider Appeals and Independent External Process addendum define resolution timeframes for CHIP appeals as 30 calendar days for standard appeals and 72 hours for expedited appeals.
- Page 14 of the *CAN and CHIP Member Handbooks* state, "If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program." This may limit members' understanding of the scope of conditions for which Care Management may be appropriate.
- Per UHC staff, risk levels are assigned to members based on scores generated from the completion of the HRA or the care manager's clinical judgment, as needed. A score greater than 140 is considered high risk level. A description of risk scores with corresponding risk levels was not identified in any of the CAN and CHIP Care Management documents.
- Page 9 of the *CAN Care Management Program Description and Addendum* lists conditions included in the core disease management programs available to members, but the list does not include hypertension, obesity, and organ transplants.
- Page 9 of the *CHIP Care Management Program Description and Addendum* lists conditions included in the core disease management programs available to members, but the list does not include obesity, attention deficit hyperactivity disorder, and organ transplants.
- CCME is unable to determine the care management services provided to CHIP members in the high-risk level from CHIP Care Management policies and other documents.

Corrective Actions

- Update the following to use the term "adverse benefit determination" instead of "action" and "adverse action:
  - Policy AG-02, Standard and Expedited Appeal and State Hearing (Draft 2018)
  - Policy MSCANSFH-02, Handling of Administrative and Fair Hearing Request
  - Policy AG-04, Standard and Expedited Appeal Process and Procedures

- *CAN Provider Manual*
- *CHIP Provider Manual*
- *CAN Member Handbook*
- *CHIP Member Handbook*

- Update the *CAN Provider Manual* to include a statement that written consent from the member is required when the provider files an appeal on the member's behalf.
- Correct the timeframe for filing a State Fair Hearing in the CAN BH Appeal Uphold notice, the *CAN Member Handbook* (page 31), and in Policy MSCANSFH-02, Handling of Administrative and Fair Hearing Requests, to reflect State Fair Hearing requests must be filed within 120 calendar days from the date of the appeal resolution notice.
- Revise Policy AG-04 to include processes and timeframes for acknowledging appeals.
- Update the *CHIP Member Handbook* to inform members that appeals are acknowledged and include the timeframe for acknowledgement.
- Update the *CHIP Provider Manual* to include the correct timeframe for appeal acknowledgement.
- Ensure timeframes for resolution of behavioral health appeals are documented in Optum's Mississippi CHIP Addendum to Enrollee Appeals of Adverse Benefit Determinations, Provider Appeals and Independent External Process according to guidelines in the *CHIP Contract, Exhibit E*.

Recommendations

- Revise the *CHIP Provider Manual* to remove the interchangeable use of the words "appeal" and "grievance" in the appeals section to reduce confusion for the reader.
- Communicate in the appeals section of the *CHIP Member Handbook* that a *Grievance and Appeals Form* is available on page 53 and provide instructions for its use to file an appeal.
- Include examples of health conditions other than diabetes and asthma when listing diseases that may qualify for Care Management on page 14 of both the *CAN and CHIP Member Handbooks*.
- Include a description of the risk-score with its corresponding risk-levels in Care Management documents, such as Policy MS 002 Rider 2, Case Management Process, Policy NCM 002 Rider 1, Case Management Process, and the *CAN and CHIP Care Management Program Descriptions*.
- Update the list of conditions included in the disease management program on page 9 of the *CAN Care Management Program Description and Addendum* to include hypertension, obesity, and organ transplants.

- Update the list of conditions included in the disease management program on page 9 of the *CHIP Care Management Program Description and Addendum* to include obesity, attention deficit hyperactivity disorder, and organ transplants.
- Update Policy NCM 002 Rider 1, Case Management Process, to clearly identify the services provided to members assigned to the high-risk level.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

I. Attachment 1: Initial Notice, Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
12040 Regency Parkway, Suite 100, Cary, NC 27518-8597 • 919.461.5500 • 800.682.2650 • www.thecarolinascenter.org

May 21, 2018

Mr. Jeff Wedin
Chief Executive Officer
UnitedHealthcare Community Plan - Mississippi
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

Dear Mr. Wedin:

At the request of the Mississippi Division of Medicaid (DOM), this letter serves as notification that the 2018 External Quality Review (EQR) of UnitedHealthcare Community Plan – Mississippi is being initiated. The review will include the MississippiCAN and Mississippi Children's Health Insurance Program (CHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review.

The onsite visit will be conducted at UnitedHealthcare Community Plan - Mississippi's office on **August 22, 2018** for the MississippiCAN Program and the Mississippi CHIP Program.

In preparation for the desk review, the items on the enclosed **MississippiCAN Materials Requested for Desk Review** and **Mississippi CHIP Materials Requested for Desk Review** lists should be provided to CCME no later than **June 20, 2018**.

Please upload all the desk materials electronically to CCME through our secure file transfer website. The file transfer site can be found at: https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will simultaneously be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance.

We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site. We will also send written desk instructions on how to use the file transfer site as well. Ensuring successful upload of desk materials is our priority and we value the opportunity

to provide support. Of course, additional information and technical assistance will be provided as needed.

An opportunity for a pre-onsite conference call with your management staff, in conjunction with the DOM, to describe the review process and answer any questions prior to the onsite visit, is being offered as well.

Please contact me directly at 919-461-5588 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Karen Smith
Project Manager

Enclosure(s)
cc: DOM

UnitedHealthcare Community Plan - MS

External Quality Review 2018 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MSCAN program, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence for the MSCAN program.

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base for the MSCAN program. Include copies of the most recent Network Geographic Access (GeoAccess) reports (complete reports), provider network assessment, enrollee demographic studies, and population needs assessments. Please include any provider identified limitations on panel size considered in the network assessment.

5. Reports of any assessments made of provider compliance with the appointment and after-hours standards for the MSCAN Program.

6. The total number of unique specialty providers for MSCAN as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

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

8. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy programs for MSCAN.

9. The Quality Improvement work plans for MSCAN for 2017 and 2018.

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

11. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:

- full documentation of the abstraction process and tool used during abstraction, and
- 15 sample records from those abstracted charts.

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

12. Minutes of all committee meetings in the past year (May 2017 through April 2018) for all committees reviewing or taking action on MSCAN related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

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

14. A complete list of all members for MSCAN enrolled in the Care Management program from May 2017 through April 2018. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

17. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of May 2017 through April 2018.

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

19. A list of physicians for the MSCAN and CHIP programs currently available for utilization consultation/review and their specialty.

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

21. All performance measures calculated and required to be reported to the state for the MSCAN program. 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., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/10 and/or CPT-4 codes, member months/years calculation, other specified parameters);
d. if non HEDIS, 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.

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

23. Provide electronic copies of the following files for the MSCAN program:
    a. Credentialing files (including signed Ownership Disclosure Forms and provider office site visits as appropriate) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers

v. Two network hospitals; and
vi. One file for each additional type of facility in the network.

Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

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

UnitedHealthcare Community Plan - MS

External Quality Review 2018 for Mississippi CHIP

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the CHIP program, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position and any current vacancies. Identify staff members who are assigned to MSCAN and which staff members are assigned to CHIP.

3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence for the CHIP program.

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base for the CHIP program. Include copies of the most recent Network Geographic Access (GeoAccess) reports (complete reports), provider network assessment, enrollee demographic studies, and population needs assessments. Please include any provider identified limitations on panel size considered in the network assessment.

5. Reports of any assessments made of provider compliance with the appointment and after-hours standards for the CHIP Program.

6. The total number of unique specialty providers for CHIP as well as the total number of unique primary care providers, broken down by specialty, currently in the network.

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

8. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy programs for CHIP.

9. The Quality Improvement work plans for CHIP for 2017 and 2018.

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

11. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
    a. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    b. For projects with measures derived from medical record abstraction:

- full documentation of the abstraction process and tool used during abstraction, and
- 15 sample records from those abstracted charts.

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

12. Minutes of all committee meetings in the past year (May 2017 through April 2018) for all committees reviewing or taking action on Mississippi CHIP related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.

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

14. A complete list of all members for CHIP enrolled in the Care Management program from May 2017 through April 2018. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

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

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

17. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of May 2017 through April 2018.

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

19. A list of physicians for the MSCAN and CHIP programs currently available for utilization consultation/review and their specialty.

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

21. All performance measures calculated and required to be reported to the state for the CHIP program. 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., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/10 and/or CPT-4 codes, member months/years calculation, other specified parameters);
d. if non HEDIS, 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.

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

23. Provide electronic copies of the following files for the CHIP program:
    a. Credentialing files (including signed Ownership Disclosure Forms and provider office site visits as appropriate) for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers, if applicable
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;

iii. Two specialists;
iv. Two behavioral health providers, if applicable
v. Two network hospitals; and
vi. One file for each additional type of facility in the network.

Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

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

II. Attachment 2: Materials Requested for Onsite Review

UnitedHealthcare Community Plan – MississippiCAN

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Non-HEDIS Performance Measure 2017 Annual Rates.
3. Programming logic and State specifications for Pregnancy Outcome measure.
4. Copy of the 2017 Annual QI Program Evaluation.
5. Copy of the Annual Evaluation of Accessibility of Services report completed in 2017.
6. Copy of the Annual Evaluation of Network Adequacy completed in 2017.

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

UnitedHealthcare Community Plan – Mississippi CHIP

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. DEV-CH non-HEDIS Annual Rates for 2017 (if available); if not, 2016 Annual Rates.

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

III. Attachment 3: EQR Validation Worksheets

- Provider Satisfaction Survey Validation CAN and CHIP
- Member Satisfaction Survey Validation CAN (Adult and Child)
- Member Satisfaction Survey Validation CHIP (Child)
- HEDIS PM Validation CAN
- HEDIS PM Validation CHIP
- NON-HEDIS PM Validation CHIP
- PIP Validation CAN
  - REDUCING ADULT, ADOLESCENT AND CHILDHOOD OBESITY
  - ADULT MEMBER SATISFACTION, GETTING CARE QUICKLY
  - COMPREHENSIVE DIABETES CARE
  - ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS
- PIP Validation CHIP
  - ADOLESCENT WELL CARE
  - FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS
  - CHILD MEMBER SATISFACTION, GETTING NEEDED CARE
  - WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY/REDUCING ADOLESCENT AND CHILDHOOD OBESITY

CCME EQR Survey Validation Worksheet

Plan Name	**UHC CHIP/CAN**
Survey Validated	**PROVIDER SATISFACTION SURVEY**
Validation Period	2017
Review Performed	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(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**	-Used Provider Satisfaction Survey developed by vendor and plan *Documentation:* *-2017 Market Strategies Physician Scorecard*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	- Used Provider Satisfaction Survey developed by vendor and plan *Documentation:* *-2017 Market Strategies Physician Scorecard*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Used Provider Satisfaction Survey developed by vendor and plan *Documentation:* *-2017 Market Strategies Physician Scorecard*

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**	-Survey is based on NCQA standards criteria. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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**	--Survey is based on NCQA standards criteria. *Documentation:* *-2017 Market Strategies Physician Scorecard*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	-Study population was clearly identified. *Documentation:* *-2017 Market Strategies Physician Scorecard*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined and appropriate. *Documentation:* *-2017 Market Strategies Physician Scorecard*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	-Sampling strategy was noted. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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	**MET**	-Sample size is sufficient. *Documentation:* *-2017 Market Strategies Physician Scorecard*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	-Procedures to select the sample were appropriate. *Documentation:* *-2017 Market Strategies Physician Scorecard*

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**	- Response rate calculation was provided in the documentation and was appropriate. *Documentation:* *-2017 Market Strategies Physician Scorecard*
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.	**MET**	Response rates were calculated appropriately. *Documentation:* *-2017 Provider Satisfaction Survey Results*

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**	- Survey instrument was administered by Market Strategies, an experienced survey organization. Its standard procedures were used for this survey. *Documentation:* *-2017 Statement of Work*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-2017 Provider Satisfaction Survey Results*
5.3	Were confidentiality procedures followed?	**MET**	- Confidentiality procedures were appropriate. *Documentation:* *-2017 Provider Satisfaction Survey Results*

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**	- Data were analyzed. *Documentation:* *-2017 Provider Satisfaction Survey Results*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	- Appropriate statistical tests used and applied correctly. *Documentation:* *-2017 Market Strategies Physician Scorecard*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions supported by the data and analysis. *Documentation:* *-2017 Provider Satisfaction Survey Results*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of Market Strategies allows for a standardized and audited approach to the implementation and analysis of the surveys. - Market Strategies, as a vendor, provides a full report of process and results that meets the necessary requirements and expectations of a survey report. Documentation: *-2017 Market Strategies Physician Scorecard*
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were identified.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	Response rate of the 2017 survey was approximately 4.7% (*n*=117) which is decreased from prior year (6.6%, *n*=130) and slightly below the historical national response range of 5.0%-11.4% (2017 National range was not available at the time of completing this report). ***Recommendation:*** *Focus on strategies that help increase response rates for this population. Solicit the help of the survey vendor and set an internal goal for response rate increase from the previous year.* *Documentation:* *-2017 Provider Satisfaction Survey Results*
7.4	What conclusions are drawn from the survey data?	The 2017 results yielded significant overall improvements in NPS drivers (*overall*) and all ten domains. These improvements were favorable to last year and the prior four years' results. Of the 41 items, only two saw declines from prior year (exchanging information with behavioral health providers (-4) and availability of disease management programs (-3)). Both domains over these items saw improvements. The most significant improvements were noted in the domains of Customer Service (+15), Claims Processing (+14), and Overall Image (+17). *Documentation:* *-2017 Provider Satisfaction Survey Results*
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).	Not applicable.
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**UHC CAN**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID ADULT)**
Validation Period	2017
Review Performed	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(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**	-Uses CAHPS and its standardized purpose *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: DSS Research
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**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: DSS Research

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	- Study population was clearly defined. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* -DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017
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	**MET**	- Sample size was sufficient for intended use of the survey. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	- Procedures to select the sample were appropriate. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
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.	**MET**	- Response rate was calculated appropriately according to completed questionnaire criteria. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS 5.0H guidelines and HEDIS Volume Three Technical Update Specifications. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. -DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate (22.87%). ***Recommendation:*** *Focus on strategies that help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
7.4	What conclusions are drawn from the survey data?	Overall, Mississippi CAN meets the goal in six (6) out of seven (7) categories for the Adult CAHPS survey. *Documentation:* -Member Experience 3.1.18
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).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in the report. *Documentation:* *-DSS Research 2017 CAHPS Adult Medicaid Survey Summary Report: June 2017*
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**UHC CAN**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD AND CHILD WITH CCC)**
Validation Period	2017
Review Performed	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(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**	-Uses CAHPS and its standardized purpose *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: DSS Research
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**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: DSS Research

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	- Study population was clearly defined. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
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	**MET**	- Sample size was sufficient for intended use of the survey. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	- Procedures to select the sample were appropriate. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
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.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS 5.0H guidelines and HEDIS Volume Three Technical Update Specifications. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. -DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate (20.79% total; 19.72% for the general population). ***Recommendation:*** *Focus on strategies that help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
7.4	What conclusions are drawn from the survey data?	Member satisfaction with customer service did not meet the NCQA 50th percentile (88.05) goal for the Child CAHPS (88.02) by 0.03 percentage points. Getting the information or help from your health plan you needed scored 81.82, indicating getting information or help from the health plan may negatively impacted member experience with customer service. UHC met the goal in two (2) out of six (6) categories (1 was scored "NA" due to the denominator being below 30). *Documentation:* -Member Experience 3.1.18
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).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in the report. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR Survey Validation Worksheet

Plan Name	**UHC CHIP**
Survey Validated	**CONSUMER SATISFACTION (MEDICAID CHILD AND CHILD WITH CCC)**
Validation Period	2017
Review Performed	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(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**	-Uses CAHPS and its standardized purpose *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	-Uses CAHPS and its standardized objectives. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	-Uses standard CAHPS for measurement and use *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: DSS Research
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**	-Uses standard CAHPS for measurement via a certified vendor *Documented:* -Survey version 5.0H administrated -Vendor: DSS Research

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	- Study population was clearly defined. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	-Specifications for sample frame were clearly defined. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	**MET**	- Sampling strategy was appropriate. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
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	**MET**	- Sample size was sufficient for intended use of the survey. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	- Procedures to select the sample were appropriate. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	- Specifications for calculating raw and adjusted response rates are documented. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
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.	**MET**	- Response rate was calculated appropriately, according to completed questionnaire criteria. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their CAHPS 5.0H guidelines and HEDIS Volume Three Technical Update Specifications. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	-Based on the timelines provided, the survey followed the planned approach. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
5.3	Were confidentiality procedures followed?	**MET**	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

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**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	-Uses standard CAHPS for measurement via a certified Vendor *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	- Conclusions were supported by data analysis of responses *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. -DSS Research as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	- No noted weaknesses.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate (28.49% total; 26.97% for the general population). ***Recommendation:*** *Focus on strategies that help increase response rates for this population. Set an internal response rate goal as opposed to the target rate set by AHRQ (e.g., receiving a 2% increase over the previous year's response rate).* *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
7.4	What conclusions are drawn from the survey data?	Member satisfaction with customer service did not meet the NCQA 50th percentile (88.05) goal for the Child CAHPS (88.02) by 0.03 percentage points. Getting the information or help from your health plan you needed scored 81.82 indicating getting information or help from the health plan may negatively affect member experience with customer service *Documentation:* -Member Experience 3.1.18
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).	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO is provided in the report. *Documentation:* *-DSS Research 2017 CAHPS Child Medicaid and Child with CCC Survey Summary Report: June 2017*
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR PM Validation Worksheet

Plan Name:	**UHC CAN**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2016**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2017

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, Inovalon. Review requirements for documentation are 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, Inovalon. Review requirements for denominator data sources are 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, Inovalon. Review requirements for denominator calculation are 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) were complete and accurate.	MET	Plan uses NCQA certified software, Inovalon. Review requirements for numerator data sources are met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software, Inovalon. Review requirements for numerator calculation are met.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	MET	Plan uses Altegra for medical record abstraction.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	MET	Plan uses Altegra for medical record abstraction.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	MET	Plan uses Altegra for medical record abstraction.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	MET	Sampling methods passed audit.
S2. Sampling	Sample treated all measures independently.	MET	Sampling methods passed audit.
S3. Sampling	Sample size and replacement methodologies met specifications.	MET	Sampling methods passed audit.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	MET	Measures were reported accurately.
R2. Reporting	Was the measure reported according to technical specifications?	MET	Plan uses NCQA certified software, Inovalon. Review requirements for reporting are met.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

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	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**UHC CHIP**
Name of PM:	**HEDIS MEASURES**
Reporting Year:	**Measurement Year 2016**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2017

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, Inovalon. Review requirements for documentation 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, Inovalon. Review requirements for denominator data sources 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, Inovalon. Review requirements for denominator calculation 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) were complete and accurate.	MET	Plan uses NCQA certified software, Inovalon. Review requirements for numerator data sources met.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software, Inovalon. Review requirements for numerator calculation met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	MET	Plan uses Altegra for medical record abstraction.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	MET	Plan uses Altegra for medical record abstraction.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	MET	Plan uses Altegra for medical record abstraction.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	MET	Sampling methods passed audit.
S2. Sampling	Sample treated all measures independently.	MET	Sampling methods passed audit.
S3. Sampling	Sample size and replacement methodologies met specifications.	MET	Sampling methods passed audit.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	MET	Measures are reported accurately.
R2. Reporting	Was the measure reported according to technical specifications?	MET	Plan uses NCQA certified software, Inovalon. Review requirements for reporting met.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

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	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM Validation Worksheet

Plan Name:	**UHC CHIP**
Name of PM:	**NON HEDIS MEASURE: DEV-CH**
Reporting Year:	**Measurement Year 2017**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
OHSU- CHIPRA

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	Programming specifications were submitted.

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	Data sources were submitted for denominator.
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	Specifications for calculation of denominator were 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) were complete and accurate.	MET	Data sources were submitted for numerator.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Specifications for calculation of numerator were met.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	NA	
S2. Sampling	Sample treated all measures independently.	NA	
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	PARTIALLY MET	Measures were reported accurately for the 12-month, 24-month, and 36-month ages, but the combined rate was not submitted. ***Recommendation**: Include all four rates, as per the specifications.*
R2. Reporting	Was the measure reported according to technical specifications?	MET	Rates were reported according to specifications.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	NA	NA
N4	5	NA	NA
N5	5	NA	NA
S1	5	NA	NA
S2	5	NA	NA
S3	5	NA	NA
R1	10	PARTIALLY MET	5
R2	5	MET	5

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	**55**
Validation Findings	**91%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CAN**
Name of PIP:	**REDUCING ADULT, ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	MS is the most obese state in the country.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data were analyzed yearly and quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results for annual rates and quarterly rates are presented clearly.
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**	Repeat measurements are recorded.
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**	Conclusions were offered, and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent across measurement periods.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement occurred for all four measures.

Component / Standard (Total Points)	Score	Comments
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**	Improvement appears to be results of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Improvement from year-to-year is statistically significant for a majority of the re-measurements.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement occurred for repeated measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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

Steps	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	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	5
Verify	**NA**	**NA**

Project Score	**116**
Project Possible Score	**116**
Validation Findings	**100%**

HIGH CONFIDENCE IN REPORTED RESULTS

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 CAN**
Name of PIP:	**ADULT MEMBER SATISFACTION, GETTING CARE QUICKLY**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	UHC does not meet the 50th percentile benchmark for Getting Care Quickly.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated in the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in Section B
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**	Measures are related to enrollee satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Partially Met**	A barriers/causal analysis was conducted, although interventions to address the member and provider barriers were not documented. ***Recommendation:*** *Initiate interventions to address member and provider barriers and document the interventions and start data in Section IV of the report.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data were analyzed according to data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Rate at baseline is presented.
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)**	**NA**	Baseline data only.
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)**	**Not Met**	Baseline data has interpretation in the Rationale section; however, the results narrative should be in Section III. ***Recommendation****: Adjust report so that analysis of baseline and re-measurement results are in Section III. Include follow-up activities based on the results and include in the interpretation.*

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
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**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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

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

Project Score	92
Project Possible Score	98
Validation Findings	94%

HIGH CONFIDENCE IN REPORTED RESULTS

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 CAN**
Name of PIP:	**COMPREHENSIVE DIABETES CARE**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	MS ranks second highest in the United States for overall prevalence of obesity.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B. Measures #5 and #6 have been retired.
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.
STEP 5: Review Sampling Methods		
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**	CDC HEDIS specifications for determining sample size were used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	CDC HEDIS specifications for determining sample size were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	CDC HEDIS specifications for determining sample size were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and computed as a percentage using HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted quarterly and yearly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly in Table format with baseline and all re-measurement rates for annual comparison.
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**	Repeat measurements were presented.
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**	Conclusions were offered and revisions were made to increase success.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Measure 1, 3, 7 are above DOM goal; Measures 2 and 4 are below DOM goal.

Component / Standard (Total Points)	Score	Comments
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**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical tests were conducted and show that some improvements were statistically supported while others are not.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement was demonstrated through repeated measurements over annual time periods.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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

Steps	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	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	5
Verify	**NA**	**NA**

Project Score	**116**
Project Possible Score	**116**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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 CAN**
Name of PIP:	**ANNUAL MONITORING FOR PATIENTS ON ACE/ARB INHIBITORS**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	CVD is a leading cause of death in MS and accounts for 41% of the deaths in MS.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is clearly defined.
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**	Measure is related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
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**	Sampling is not used for this PIP.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling is not used for this PIP.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling is not used for this PIP.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will to collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses were conducted yearly, and quarterly.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Rates for all measures were presented in a Table.
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**	Repeat measurements were presented.
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**	Conclusions were offered and revisions made to increase success.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodologies were used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement was documented for measure.
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**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistical tests were conducted and results were not statistically significant. However, rates are increasing, and statistical testing is not required when sampling is not utilized to show true improvement.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Improvement was demonstrated through repeated measurements.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	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	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	5	5
Verify	NA	NA

Project Score	96
Project Possible Score	96
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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 CHIP**
Name of PIP:	**ADOLESCENT WELL CARE**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	HEDIS rate for AWC is below the NCQA benchmark.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in Section B.
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**	Measure is related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well-documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Data analyses were presented quarterly and annually.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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**	Baseline data and one remeasurement period are presented.
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**	Conclusions were offered and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement in rate is occurring.

Component / Standard (Total Points)	Score	Comments
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**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	There is statistical evidence that the improvement is significant.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Only one repeat measurement; too early to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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

Steps	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	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	**111**
Project Possible Score	**111**
Validation Findings	**100%**

HIGH CONFIDENCE IN REPORTED RESULTS

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:	**UHC CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	There is lack of performance improvement for Medicaid plans in mental health aftercare.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.
STEP 5: Review Sampling Methods		
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**	Sampling was not utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well-documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are conducted according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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**	Initial and repeat measurements are documented; statistical analysis was conducted.
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**	Conclusions were offered and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Rates increased for Measure 1 but not for Measure 2. The rate for measure 2 is above the DOM goal and NCQA rate.
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**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing is not required because sampling was not utilized.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**Met**	Rates are overall increasing over time, although the second measurement decreased slightly in the latest annual rate.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	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	5
9.2	1	1
9.3	5	5
9.4	NA	NA
Step 10		
10.1	5	5
Verify	NA	NA

Project Score	95
Project Possible Score	95
Validation Findings	100%

HIGH CONFIDENCE IN REPORTED RESULTS

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:	**UHC CHIP**
Name of PIP:	**CHILD MEMBER SATISFACTION, GETTING NEEDED CARE**
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	UHC shows a downward trend for the question that related to getting needed care.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measure is defined in Section B.
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**	Measure is related to enrollee satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Partially Met**	Barriers are documented. Interventions to address the provider and member barriers are not documented. ***Recommendation:*** *Include interventions that address the barriers noted in the fishbone analysis.*
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Baseline data are presented.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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)**	**NA**	Baseline data only.
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)**	**Not Met**	Conclusions were offered and follow-up plans were documented, but they were not included in the appropriate section of the report (Section III.B). ***Recommendation****: Revise report so that interpretation of results is documented in Section III.B. of the report.*

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline measure only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline measure only.
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**	Baseline measure only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline measure only.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline measure only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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

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

Project Score	92
Project Possible Score	98
Validation Findings	94%

HIGH CONFIDENCE IN REPORTED RESULTS

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:	UHC CHIP
Name of PIP:	WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY/REDUCING ADOLESCENT AND CHILDHOOD OBESITY
Reporting Year:	2016
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	MS is the most obese state in the country.
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**	The plan addresses a key aspect of enrollee care and services.
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**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Research question is clearly stated on page 1.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Measures are defined in Section B.
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**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
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**	Population studied was intended population.
STEP 5: Review Sampling Methods		
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**	HEDIS specifications were used.
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 specifications were used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	HEDIS specifications were used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	Sources of data were clearly specified in Data Collection section.
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**	Method of collecting data is reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Data Sources were documented
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis was indicated as quarterly and yearly.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Personnel who will collect the data are listed in the report and are qualified.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Met**	Barriers and interventions were well-documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Baseline data and re-measurement 1 are presented in results.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
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**	Initial and repeat measurements are presented.
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**	Conclusions were offered and follow-up plans were documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	Methodology is consistent.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Met**	Improvement in rates is occurring.
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**	Improvement appears to be result of interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**Met**	Statistically significant increase found for measure 1; increases for measures 2 and 3 were not statistically significant.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline and one re-measurement are presented; too early to judge

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	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

Steps	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	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	111
Project Possible Score	111
Validation Findings	100%

HIGH CONFIDENCE IN REPORTED RESULTS

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.*

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CAN**
Review Performed:	2018

I. Management Information Systems

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. Information Systems Capabilities Assessment (ISCA)						
1. The CCO processes provider claims in an accurate and timely fashion.		X				UHC did not provide actual monthly clean claim payment statistics and internal per-month goals/benchmarks for review. UHC notes, "Completeness is estimated using claims completion models that account for trend, seasonality, unit cost changes, special adjustments and claims payment speed. Claim completeness varies by month and by category. In general, claims are 85% to 90% complete after 3 months." These claim completion estimates fall below the requirement for 99% of clean claim payments completed within 90 days. Refer to the *CAN Contract, Section 17 (A).* *Corrective Action: Implement processes to ensure UHC meets contractual requirements to pay 99% of clean claims within 90 days.*
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					UHC uses the state assigned Medicaid ID to uniquely identify enrollees. Additionally, UHC's systems can track member and encounter data across product lines. To identify newborn enrollees, UHC relies on the newborn data included within the state's 834 files to correlate newborns with an existing Medicaid member. Finally, member and encounter demographics are monitored and regularly reviewed for accuracy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					UHC uses General Dynamics Information Technology's (GDIT's) MedMeasures software for HEDIS and state reporting. MedMeasures is a National Committee for Quality Assurance (NCQA) accredited solution for analyzing and reporting performance and effectiveness data. Dedicated data warehouse reporting is validated against the source data for accuracy.
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					ISCA documentation demonstrates UHC has clearly communicated backup and disaster recovery plans in place. To test these plans, UHC performs regular table-top recovery exercises that track the areas of success and any areas that need remediation.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Credentialing and Recredentialing						
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					The *UnitedHealthcare Credentialing Plan 2017-2019* defines the procedures for credentialing and recredentialing licensed independent practitioners and facilities into the network. Specific credentialing criteria for Mississippi are detailed in an addendum to the credentialing plan. Primary source verification is conducted by Aperture. The *United Behavioral Health Clinician and Facility Credentialing Plan 2017-2018* defines processes for behavioral health, and the *Optum Physical Health Credentialing Risk Management Plan 2018* defines processes for physical medicine providers, including chiropractic, physical therapy, occupational therapy and speech therapy. Onsite discussion confirmed that UHC is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						integrating these credentialing programs into one credentialing process.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					The Provider Advisory Committee (PAC) is chaired by Dr. Lionel Fraser, Chief Medical Officer. Additional voting members of the committee include ten network providers with specialties of pediatrics, psychiatry, dentistry, OB/GYN, internal medicine, family medicine, and emergency medicine. The Committee Chair votes in case of a tie, and a quorum is met with 51% of voting members in attendance. The committee meets at least quarterly and a report of providers credentialed by the National Credentialing Committee (NCC) is presented at each meeting. The *PAC Charter* states it is the local Credentialing Committee. The PAC acts as the health plan's Credentialing Committee, reviews the NCC recommendations, and has the authority to approve, deny, or suspend the recommendations made by NCC related to the Mississippi Medicaid network. The NCC reviews all credentialing/recredentialing decisions. Onsite discussion confirmed the MS Chief Medical Officer attends the meetings frequently. The NCC voting members include 16 network physicians from local plans, and Mississippi is represented by Dr. George Russell, Orthopedic Surgeon. A quorum is met with 51% of the voting members in attendance.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					One credentialing file indicated on the Aperture checklist that no information was provided for an unexplained gap in the work history, and there was no evidence in the file the unexplained gap was investigated. *Recommendation: Ensure credentialing files reflect an explanation for any unexplained gaps in the work history.*
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF)		X				Three credentialing files did not show proof the Social Security Death Master File (SSDMF) was queried. Per onsite discussion, effective 6/1/17, UHC implemented a national process to check the SSDMF and no longer uses Aperture to perform the checks. UHC Policy Social Security Death Master File Database Cleanse defines the protocol for identifying and taking action with provider data when the provider information appears on the Social Security Administration Death Master (SSDMF) file. Providers within the UHC National Database (NDB) are compared to the SSDMF weekly. If the provider information is found on the Death Master File, the provider is removed from UHC directories, outbound verification may occur to confirm the provider is deceased, and UHC databases are updated accordingly. Ongoing weekly validation of UHC NDB provider records against the SSDMF, will identify any provider in the enrollment and re-enrollment process as deceased. However, it does not appear UHC has implemented a process to ensure the credentialing files reflect proof of query of the SSDMF. *Corrective Action Plan: Ensure evidence of the SSDMF query is included in the credentialing files.*
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 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				One credentialing file for a psychiatrist reflected "yes" for the behavioral health center location providing laboratory services, but there was no CLIA in the file. During onsite discussion, UHC indicated it does not pursue CLIAs for behavioral health; however, if laboratory services are provided, the CLIA must be pursued and evidence should be in the credentialing file. *Corrective Action: Ensure CLIAs are collected for any provider indicating laboratory services are provided.*
3.1.15 Ownership Disclosure Form.		X				Policy Provider Disclosures/National Disclosure Program establishes the requirements for collecting disclosure of ownership, controlling interest, and management information from providers who are credentialed for Medicaid and/or CHIP. The *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* (Q10) defines parameters for who can legally provide the signature on the disclosure. It states that for Provider Entities, the signature must be from an individual with the power to legally bind the entity, such as an owner or officer. Office managers'/assistants' signatures are not acceptable. However, one credentialing file reviewed for an entity reflected the form was signed by a credentialing specialist. *Corrective Action Plan: Ensure ownership disclosure forms are signed by the appropriate individual with the power to legally bind the entity.*
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,	X					The credentialing plan document, "Additional State and Federal Credentialing Requirements" for MS defines that an initial site visit is to be conducted during credentialing on PCPs & OB/GYNs. Evidence of site visits was in the credentialing files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
record keeping methods, and confidentiality measures.						
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 were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					One recredentialing file indicated on the Aperture checklist that the NPDB had been queried: however, proof of query was not in the file. *Recommendation: Ensure recredentialing files contain proof of query of the NPDB.*
4.2.7 Requery the System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					One recredentialing file indicated on the Aperture checklist that the OIG had been queried: however, proof of query was not in the file. *Recommendation: Ensure recredentialing files contain proof of query of the OIG.*
4.2.10 Query of the Social Security Administration's Death Master File (SSDMF);		X				Three recredentialing files did not show proof the SSDMF was queried. Per onsite discussion, effective 6/1/17, UHC implemented a national process to check the SSDMF and no longer uses Aperture to perform the checks. UHC Policy Social Security Death Master File Database Cleanse, defines the protocol for identifying and taking action with provider data when the provider information appears on the Social Security Administration Death Master (SSDMF) file. Providers within the UHC National Database (NDB) are compared to the SSDMF weekly. If the provider information is found in the Death Master File, the provider is removed from UHC directories, outbound verification may occur to confirm the provider is deceased, and UHC databases are updated accordingly. Ongoing weekly validation of UHC NDB provider records against the SSDMF will identify any provider in the enrollment and re-enrollment process as deceased. However, it does not appear that UHC has implemented a process to ensure the recredentialing files reflect proof of query of the SSDMF. *Corrective Action Plan: Ensure evidence of the SSDMF query is included in the recredentialing files.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Query of the National Plan and Provider Enumeration (NPPES);	X					
4.2.12 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					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure form.		X				Policy Provider Disclosures/National Disclosure Program establishes the requirements for collecting disclosure of ownership, controlling interest, and management information from providers that are credentialed for Medicaid and/or CHIP. The *Provider Disclosure of Ownership and Control Interest Statement Frequently Asked Questions* (Q10) defines parameters for who can legally provide the signature on the disclosure. It states for Provider Entities, the signature must be that of an individual with the power to legally bind the entity, such as an owner or officer. Office managers'/assistants' signatures are not acceptable. However, one recredentialing file reviewed for an entity reflected the form was signed by a credentialing specialist. *Corrective Action Plan: Ensure ownership disclosure forms are signed by the appropriate individual with the power to legally bind the entity.*
4.3 Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room	X					UnitedHealthcare Services Policy, Ongoing Monitoring of Office Site Quality, defines the process Clinical Services follows to manage, track, and resolve potential Quality of Care (QOC) issues related to the physical accessibility, physical appearance, cleanliness, and adequacy of the waiting and exam room space. Complaints about a physician's office site and facilities are recorded,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
space, if the health plan established complaint/grievance threshold has been met.						investigated, and appropriate follow-up conducted to assure members receive care in a clean, accessible, and appropriate environment. UHC conducts an additional provider office site visit within 45 calendar days when a complaint, grievance, or appeal threshold is met concerning a participating physician's office sites and facilities as defined in Policy QM-02, Timeframes for Ongoing Monitoring of Office Site Visit Quality.
4.4 Review of practitioner profiling activities.	X					The *UnitedHealthcare Credentialing Plan 2017-2019* states during recredentialing, an applicant is subject to review of malpractice history and quality of care/quality of service concerns within the recredentialing cycle. If histories of malpractice claims exceed established thresholds and/or substantiated quality of care concerns are found, the Credentialing Committee conducts a thorough review of these findings and the applicant may be subject to a denial of recredentialing. UHC has systems and processes in place to monitor member utilization and the information is communicated using profiles for primary care physicians as defined in Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization. At a minimum, the profiles are generated annually and distributed to appropriate identified network physicians and health plan staff.
5. The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO.	X					UnitedHealthcare Services Policy, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy & Procedure, defines the process for investigating and evaluating quality of care concerns which includes Medical Director review and peer committee review as appropriate. If adverse disciplinary action such as suspension or termination is taken against a physician or health care professional as a result of a QOC investigation, a notice is provided for the opportunity for a fair hearing.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				The *UnitedHealthcare Credentialing Plan 2017-2019* defines the procedures for credentialing and recredentialing facilities in to the network. Specific credentialing criteria for Mississippi are detailed in an addendum to the credentialing plan. Primary source verification is conducted by Aperture. The file review reflected the following issues for recredentialing files: •Two entity files did not contain proof of queries for SAM and NPPES. •One entity file did not contain proof of CLIA. UHC provided a copy of an expired CLIA. *Corrective Action Plan: Ensure credentialing/ recredentialing files for organizations include proof query for SAM and NPPES, and a current CLIA if providing laboratory services.*
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 members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy PS10a, PCP Panel Notification, states it is the policy of UHC to notify PCPs about the enrollees assigned to them, including notification of panel changes, within five business days of the date on which UHC receives the Member Listing Report from DOM. The policy details the process, which includes making information available to all participating PCPs via the secure provider portal. Changes in member panels are communicated via post card notification. The Provider Services call center is available for questions.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment, states it is the policy of UHC that out-of-network providers can verify the enrollment of an enrollee. All providers, including out-of-network providers, can call the telephone number on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the back of the member ID card to verify member enrollment.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Policy PS10a, PCP Panel Notification, states during initial credentialing and contracting setup, PCPs may communicate desired restrictions regarding member panel composition to UHC. For closed panels, no members are assigned to the provider. If no restrictions are requested, it is understood that the PCP agrees to accept all members as assigned. PCPs can request changes to their panel profile information at any time, and this information is updated in the provider data and applied to member assignment processes. UHC makes member panel details available to all participating PCPs via the secure provider portal to notify providers of panel composition and keep them informed of any changes to their member panels. The online *Provider Directory* specifies whether the provider is accepting new patients.
1.4 Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties.	X					The geographic access standards for primary care providers for the CAN and CHIP programs are defined in Policy PS3, Geographic Access Standards. The standards for urban and rural measurement comply with contract guidelines. GEO access reports show the standards are measured appropriately. The *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report reflected PCPs for CAN and CHIP (Family/General Practice, Internal Medicine, and Pediatrics) met the goal of 90% compliance to the defined standards. In fact, all categories were 100% compliant to the urban and rural standards.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not	X					Policy PS3, Geographic Access Standards, defines the geographic standards for evaluating specialists and the information complies with contract guidelines. UHC provided GEO Access reports for review and the following was noted:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
available, the member may utilize an out-of-network specialist with no benefit penalty.						•Emergency Care providers were run as "one within 60 miles" for Rural when the guideline is "one within 30 miles" for Rural. The *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report reflected measurement of high volume/high impact specialties such as Cardiology, Oncology, Allergy & Immunology, OB/GYN, ENT Otolaryngology, and Orthopedics. All specialties met the goal of 90% compliance for CAN and CHIP. *Recommendation: Ensure the quarterly GEO Access reports reflect the correct mileage parameter for Rural Emergency Care providers.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Geographic access reports are produced quarterly to assess network compliance as defined in Policy PS3, Geographic Access Standards. The reports are delivered each quarter to DOM, as well as the *Service Quality Improvement Subcommittee* for reporting, tracking, and trend analysis.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report reflected UHC's assessment of cultural, ethnic, racial and linguistic availability. The data related to the UHC practitioner network, including member complaint and survey data, indicated there were no gaps related to language and cultural/ethnicity.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to	X					Appointment availability standards are defined in Policy PS2, Access Standard – Appointment Availability Requirements. The standards comply with contract requirements and are listed in the *Provider Manual* and reinforced through provider education. Quarterly

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
practitioners and that are consistent with contract requirements.						assessments are performed to gauge the level of compliance among PCPs, OBGYNs, and Behavioral Health providers. Quarterly and annual assessments are performed to gauge level of compliance among high-volume specialty providers. These results are submitted to DOM and the UHC Service Quality Improvement Subcommittee for monitoring, tracking, trending, and to support identification of improvement opportunities and development of corrective action initiatives. CCME reviewed the *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report and determined it is a comprehensive report that reflects UHC's efforts to ensure member access to their providers. UHC utilizes Dial America to make calls to PCP offices to assess appointment availability (urgent, routine, well care visits) and after-hours access. Results for CHIP and CAN for 2017 showed the goal of 80% was met for all three categories: urgent care (82.84%); routine care (85.99%); and after-hours care (95.23%).
II C. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.	X					CCME performed Provider Satisfaction Survey validation using a validation worksheet based on the *CMS Survey Validation Protocol*. The survey had a low response rate of 4.7%. The low response rate may impact the generalizability of the survey. The complete worksheet is available as an attachment in this report. *Recommendation: Focus on strategies that help increase response rates for this population. Solicit the help of the survey vendor.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The survey was analyzed by the plan.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QMC committee in March 2018.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The generalizability of the survey results is difficult to discern due to low response rates. The response rates are: •Adult survey—22.87% •Child/children with chronic conditions—20.79% (total) and 19.72% (general population) *Recommendation: Focus on strategies that help increase response rates. Set internal response rate goals (such as receiving a 2% increase over the previous year's response rate) as opposed to the target rate set by AHRQ.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					
3. The CCO reports the results of the member satisfaction survey to providers.	X					Member satisfaction results are reported to providers in a provider newsletter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QMC in March 2016 and action plans are documented.
III B. Complaints/Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy AG-01, Complaint and Grievance Policy and Procedures, defines UHC's processes for receiving and responding to member grievances. UHC submitted a draft version of Policy AG-01 which has been updated to comply with new contract language/requirements and is pending approval by DOM. An addendum to Policy AG-01, titled, *Mississippi CAN Addendum to Enrollee Grievances*, defines Optum's processes for receiving and responding to member grievances related to behavioral health. The policy was last revised in February 2017. *Recommendation: Review and revise Optum's Mississippi CAN Addendum to Enrollee Grievances annually.*
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;		X				The term "compliant" is appropriately defined in Policy AG-01, Complaint and Grievance Policy and Procedures, the draft version of Policy AG-01, and in Optum's Mississippi CAN Addendum to Enrollee Grievances. Issues with the definition of a complaint include: •The *CAN Member Handbook* and UHC's CAN website glossary do not define the term "compliant." •The *CAN Provider Manual* alludes to the complaint process in the grievance section but does not define a complaint. •Page 31 of the *CAN Member Handbook* refers members to the "Complaints, Grievances, Appeals and State Fair Hearings" section of the handbook. No section titled as such exists in the handbook. The section on page 58 is titled "Grievances, Appeals and State Fair Hearings."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						UHC's website glossary defines a grievance as a "statement of dissatisfaction with any part of your care," but does not include "about any matter other than an Adverse Benefit Determination." Refer to *42 CFR §438.400* and the *CAN Contract, Final Rule Amendment, Section 6 (K)* and *Exhibit D.* The following documents use the outdated term "action" rather than the correct term "adverse benefit determination" in the definition of a grievance: •*CAN Member Handbook*, page 58 •*CAN Provider Manual*, pages 36 and 39 *Corrective Action: Update the CAN Member Handbook, CAN Provider Manual and website glossary to define the term "complaint." Revise the definition of a grievance on UHC's website to include the full definition.* *Recommendation: Update the heading on page 58 of the CAN Member Handbook to "Complaints, Grievances, Appeals and State Fair Hearings" as stated on page 31. Update the CAN Member Handbook, page 58, and the CAN Provider Manual, pages 36 and 39, to use the current term of "adverse benefit determination" instead of "action."*
1.2 The procedure for filing and handling a complaint/grievance;		X				Issues with documentation of timeframes to file grievances and complaints include: •The *CAN Member Handbook* does not define the timeframe to file a complaint. •The *CAN Provider Manual* incorrectly states on page 39 that the timeframe to file a grievance is 30 days. •Optum's Mississippi CAN Addendum to Enrollee Grievances incorrectly states the timeframe to file a grievance is 30 days from the date of the event that causes dissatisfaction. Onsite discussion confirmed UHC acknowledges receipt of written grievances in writing within five calendar days of receipt. The following issues are noted in documentation:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Optum's Mississippi CAN Addendum to Enrollee Grievances incorrectly states grievances are acknowledged in five business days. •The *CAN Member Handbook*, page 58, states, "We will send you a letter telling you we received your grievance." There is no distinction between written and verbal grievances as noted in the policy, and as written, sounds as if all grievances are acknowledged in writing. •The *CAN Provider Manual*, page 37, states written grievances are acknowledged within ten working days from receipt. *Corrective Action: Update the CAN Member Handbook to define the timeframe to file a complaint. Correct the timeframe to file a grievance in the CAN Provider Manual and in Optum's Mississippi CAN Addendum to Enrollee Grievances. Correct the timeframe for grievance acknowledgement in the CAN Provider Manual and in Optum's Mississippi CAN Addendum to Enrollee Grievances document. Clarify the CAN Member Handbook, page 58, to include the processes for acknowledging both written and verbal grievances.*
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;	X					Information on grievance resolution timeframes and extensions is appropriately documented in the draft version of Policy AG-01, Complaint and Grievance Policy and Procedures, the *CAN Member Handbook*, and the *CAN Provider Manual*. Optum's Mississippi CAN Addendum to Enrollee Grievances appropriately defines the grievance resolution timeframe but does not address extensions of the grievance resolution timeframe. This information is found in Optum's National Enrollee Grievances: Medicaid policy. *Recommendation: Revise Optum's Mississippi CAN Addendum to Enrollee Grievances document to include information regarding extensions of grievance resolution timeframes.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract.		X				The draft version of Policy AG-01, Complaint and Grievance Policy and Procedures, states records are retained for the entire term of the contract and ten years thereafter unless an audit, litigation, or other legal action is in progress. Optum's Mississippi CAN Addendum to Enrollee Grievances addresses maintaining a log for grievance data but does not address the retention timeframe. This is also not addressed in Optum's National Enrollee Grievances: Medicaid policy. Onsite discussion confirmed Optum maintains the behavioral health grievance records. *Corrective Action: Revise the Optum Mississippi CAN Addendum to Enrollee Grievances document to include the timeframe for grievance record retention.*
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					CCME's review of CAN grievance files revealed the following: •One resolution letter does not match the stated grievance, and the file does not contain notes of the investigation, making it difficult to determine if the resolution is correct. •One resolution letter uses language the member might not understand (references to a GPS/tracking system called "Reveal") and contains incomplete sentences. Service Quality Improvement Subcommittee (SQIS) meeting minutes state that an initiative is underway to conduct quality checks of grievance letters before mailing. *Recommendation: Ensure grievance files contain enough documentation of investigation findings to verify*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resolution is correct. Ensure member letters contain language members understand easily.
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Quality Improvement Work Plan for 2018 includes a task to "analyze trends in complaints, grievances and appeals to identify opportunities of improvement in the areas of quality of care, access, attitude and services, billing/financial issues and quality of physician office sites. Identify opportunities to improve member satisfaction and present data to appropriate committee." The *Mississippi CAN 2018 Quality Improvement Program Description* states complaint/grievance data are collected, analyzed, and monitored to identify opportunities for improvement. The program description further states the SQIS monitors trends related to member complaint and grievance activities. Review of SQIS minutes confirms review and discussion of grievance process issues at the June 2018 and November 2017 meetings. Only one meeting appears to contain evidence of a report on grievance metrics (November 2017). The minutes for August 2017 and May 2017 state, "no report presented" for grievances and appeals, and the May 2017 minutes further state, "A&G performances are reviewed each month during oversight meetings." Onsite discussion revealed these oversight meetings are not a part of the SQIS and information is generally not reported to the SQIS; however, beginning 10/1/18, appeal and grievance reporting will be incorporated into the SQIS reporting.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV B. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					UHC submitted four PIPs for the CAN program. The topics included Adult, Adolescent and Childhood Obesity, Comprehensive Diabetes Care, Annual Monitoring for Patients on ACE/ARB Inhibitors, and Adult Member Satisfaction.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects".	X					The previous review noted concerns with data analysis plans and presentation of results. For the current review, those issues are corrected. All four projects received validation scores within the "High Confidence" range.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				The term "adverse benefit determination" is defined in Policy AG-02, Standard and Expedited Appeal and State Hearing Policy and Procedures (Draft 2018). However, on pages 6, 7, 9, 10, and 16 the term "action" is used instead of adverse benefit determination. The following documents also use the term "action" instead of "adverse benefit determination": •*CAN Member Handbook* (pages 59, 60, and 62) •*CAN Provider Manual* (pages 34, 35, and 40) •Policy MSCANSFH-02, Handling of Administrative and Fair Hearing Request The *CAN Provider Manual*, page 34, does not indicate that written consent from the member is required when the provider files an appeal on the members behalf. *Corrective Action: Update Policy AG-02, Standard and Expedited Appeal and State Hearing (Draft 2018), policy MSCANSFH-02, Handling of Administrative and Fair Hearing Request, the CAN Provider Manual, and the CAN Member Handbook to use the correct term of "adverse benefit determination" instead of "action." Refer to the CAN Contract, Section 6 (K) and Exhibit D. Update the CAN Provider Manual to include a statement that written consent from the member is required when the provider files an appeal on the member's behalf.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt as documented in Policy AG-02, Standard and Expedited Appeal, and State Hearing Policy and Procedures (Draft 2018).
1.6 Written notice of the appeal resolution as required by the contract;		X				The CAN BH Appeal Uphold notice indicates a State Fair Hearing must be filed within 30 days. According to the *CAN Contract, Section K*, the timeframe for filing a State Fair Hearing is 120 calendar days from the date of the appeal resolution notice. *Corrective Action: Correct the CAN BH Appeal Uphold notice to reflect Sate Fair Hearing requests must be filed within 120 calendar days from the date of the appeal resolution notice.*
1.7 Other requirements as specified in the contract.		X				The *CAN Member Handbook*, page 31, incorrectly indicates that a State Fair Hearing should be filed within 60 calendar days of final decision. Policy MSCANSFH-02, Handling of Administrative and Fair Hearing Requests, indicates a State Fair Hearing must be filed within 30 days. According to the *CAN Contract, Section K*, the timeframe for filing a State Fair Hearing is 120 calendar days from the date of the appeal resolution notice. *Corrective Action: Correct the timeframe for filing a State Fair Hearing in the CAN Member Handbook, page 31 and in policy MSCANSFH-02, Handling of Administrative and Fair Hearing Requests.*
2. The CCO applies the appeal policies and procedures as formulated.	X					During the onsite, representatives from the appeals and grievances department confirmed, member consent is required for providers to request an appeal on their behalf except for expedited requests, which do not require consent. The process for member medical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						necessity appeals was discussed during the onsite and CCME reviewed files indicating UHC is following the appeals process as outlined in policies.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy AG-02 Standard and Expedited Appeal, and State Hearing Policy and Procedures (Draft 2018) indicates appeals data and opportunities for improvement are reported quarterly to the Quality Management Committee (QMC), and this is reflected in QMC minutes. *2016* and *2017 Member Experience Reports* show results and analysis of member appeals, noting dental and pharmacy categories exceeded established thresholds.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. B Care Management						
1. The CCO assess the varying needs and different levels of care management needs of its member population.	X					Policy NCM 012, Risk Stratification Process, lists sources used to identify and stratify members for Care Management (CM) such as Health Risk Assessments (HRA), predictive modeling, benefit enrollment flags, and service utilization. The CM Program is communicated in the *2017 Care Management Program Description*, *CAN Member Handbook*, and *CAN Provider Manual*. Page 14 of the *CAN Member Handbook* states, "If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program." This may limit members' understanding of the scope of conditions for which Care Management may be appropriate. *Recommendation: Include examples of health conditions other than diabetes and asthma when listing diseases that may qualify for Care Management.*
2. The CCO uses varying sources to identify and evaluate members' needs for care management.	X					The Health Risk Assessment (HRA) tool is primarily used to screen and identify new members. Polices such as NCM006, Integration of Physical and Behavioral Health Through Whole Person Care, and Policy HFS002, Risk Stratification and Identification of High Risk Members for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Maternity Case Management, address identification of members into CM.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Policy MS 002 Rider 2, Case Management Process, addresses the assessment process for newly assigned high or medium risk level members. During the onsite, UHC explained risk levels are automatically assigned to members based on scores generated from the completion of the HRA and the care managers use clinical judgment to assign risk levels when needed. It was further explained that a score greater than 140 is considered high risk level. A description of risk scores with corresponding risk levels could not be identified in any of the documents. *Recommendation: Include a description of the risk-score with its corresponding risk-levels in Care Management documents such as Policy MS 002 Rider 2, Case Management Process, and the Care Management Program Description.*
4. The detailed health risk assessment includes:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan	X					CCME's review of Care Management files reflect qualified professionals conduct health risk assessments via telephone or during in-person visits; however, treatment plans are not identified. During onsite discussion,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
is completed within 30 days of completion of the health risk assessments.						representatives from the Case Management Department explained the process for completing treatment plans and additional case management files were reviewed at that time, indicating the process described is followed.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Onsite discussion revealed Health Risk Screenings and Health Risk Assessments are updated periodically as the member's condition requires, and at least annually.
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members through the following minimum functions:	X					UHC uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process as it applies to continual care, transitional care, and discharge planning.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management Team member and provided instructions on how to contract their assigned team;						
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the member requests otherwise;						
7.3 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health and those identified through EPSDT;						
7.4 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.5 Monitoring and treatment of members with ongoing medical conditions according to appropriate standards of medical practice;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						
7.8 Determination of the need for non-covered services and referral of members to the appropriate service setting, utilizing assistance as needed from the Division;						
7.9 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.10 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.11 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
arrange for the member to obtain one outside the network, at no cost to the member;						
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out of network for the member, 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;						
7.14 The Contractor must produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The member and/or authorized family member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific	X					UHC implements the Healthy First Steps (HFS) Maternity program and collaborates with the Mississippi State Department of Health (MSDH) to case manage members in the Perinatal High-Risk Management/Infant Services System (PHRM/ISS) program. Policy HFS 001, Healthy First

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
services required by the contract including high risk perinatal and infant services.						Steps Maternity Program, and the accompanied policy rider outline the processes for identifying, assessing, and providing CM services for high risk pregnant members.
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					Policy NCM 002, Case Management Process, provides case closure instructions for the CM to share care plan and historical utilization data, upon request, with the new health plan when a member transitions to another health plan.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.	X					Page 9 of the *CAN Care Management Program Description and Addendum* lists conditions included in the core disease management programs available to members, but the list does not include hypertension, obesity, and organ transplants. Onsite discussion confirms these conditions are included in disease management. *Recommendation: Update the list of conditions included in the disease management program on page 9 of the CAN Care Management Program Description and Addendum to include hypertension, obesity, and organ transplants.*
V C. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and other service providers.	X					The *CAN Care Management Program Description and Addendum* indicates the Care Team manages care transitions from hospital to home within 30 days of discharge with the goal of providing members with tools and skills to support their transition between settings. Policy NCM 002, Case Management Process, describes how CM supports pediatric members transitioning from pediatric to an adult care provider.
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					The *CAN Care Management Program Description and Addendum* lists general requirements for Transitional Care Management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					When applicable, appropriate transitional care requirements are identified.

CCME CHIP Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CHIP**
Review Performed:	2018

I. MANAGEMENT INFORMATION SYSTEMS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I A. Information Systems Capabilities Assessment (ISCA)						
1. The CCO processes provider claims in an accurate and timely fashion.		X				UHC did not provide actual monthly clean claim payment statistics and internal per-month goals/benchmarks for review. UHC notes, "Completeness is estimated using claims completion models that account for trend, seasonality, unit cost changes, special adjustments and claims payment speed. Claim completeness varies by month and by category. In general, claims are 85% to 90% complete after 3 months." These claim completion estimates fall below the requirement for 99% of clean claim payments completed within 90 days. Refer to the *CHIP Contract, Section J (1).* *Corrective Action: Implement processes to ensure UHC meets the contractual requirement to pay 99% of clean claims within 90 days.*
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					UHC uses the state assigned Medicaid ID to uniquely identify enrollees. Additionally, UHC's systems can track member and encounter data across product lines. To identify newborn enrollees, UHC relies on the newborn data included within the state's 834 files to correlate newborns with an existing Medicaid member. Finally, member and encounter demographics are monitored and reviewed for accuracy regularly.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					UHC uses General Dynamics Information Technology's (GDIT's) MedMeasures software for HEDIS and state reporting. MedMeasures is a National Committee for Quality Assurance (NCQA) accredited solution for analyzing and reporting performance and effectiveness data. Dedicated data warehouse reporting is validated against the source data for accuracy.
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					ISCA documentation demonstrates UHC has sound backup and disaster recovery plans in place. To test these plans, UHC performs regular table-top recovery exercises that track the areas of success and any areas that need remediation.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II A. Credentialing and Recredentialing						
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					The *UnitedHealthcare Credentialing Plan 2017-2019* defines the procedures for credentialing and recredentialing licensed independent practitioners and facilities in to the network. Specific credentialing criteria for Mississippi are detailed in an addendum to the credentialing plan. Primary source verification is conducted by Aperture. The *United Behavioral Health Clinician and Facility Credentialing Plan 2017-2018* defines processes for behavioral health and the *Optum Physical Health Credentialing Risk Management Plan 2018* defines processes for physical medicine providers, including chiropractic, physical therapy, occupational therapy and speech therapy. Onsite discussion confirmed that UHC is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						integrating these credentialing programs into one credentialing process.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO.	X					The Provider Advisory Committee (PAC) is chaired by Dr. Lionel Fraser, Chief Medical Officer. Additional voting members of the committee include ten network providers with specialties in pediatrics, psychiatry, dentistry, OB/GYN, internal medicine, family medicine and emergency medicine. The committee chair votes in case of a tie, and a quorum is met with 51% of voting members in attendance. The committee meets at least quarterly, and a report of providers credentialed by the National Credentialing Committee (NCC) is presented at each meeting. The *PAC Charter* states it is the local Credentialing Committee. The PAC acts as the health plan's Credentialing Committee, reviews the NCC recommendations and has the authority to approve, deny, or suspend the recommendations made by NCC related to the Mississippi Medicaid network. The NCC reviews all credentialing/recredentialing decisions. Onsite discussion confirmed the MS Chief Medical Officer attends the meetings frequently. The NCC voting members include 16 network physicians from local plans and Mississippi is represented by Dr. George Russell, Orthopedic Surgeon. A quorum is met with 51% of the voting members in attendance.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
General (OIG) List of Excluded Individuals & Entities (LEIE));						
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF)		X				One credentialing file did not show proof the Social Security Death Master File (SSDMF) was queried. Per onsite discussion, effective 6/1/17, UHC implemented a national process to check the SSDMF and no longer uses Aperture to perform the checks. UHC Policy Social Security Death Master File Database Cleanse defines the protocol for identifying and taking action with provider data when the provider information appears on the Social Security Administration Death Master (SSDMF) file. Providers within the UHC National Database (NDB) are compared to the SSDMF weekly. If the provider information is found on the Death Master File, the provider is removed from UHC directories, outbound verification may occur to confirm the provider is deceased, and UHC databases are updated accordingly. Ongoing weekly validation of UHC NDB provider records against the SSDMF, will identify any provider in the enrollment and re-enrollment process as being deceased. However, it does not appear that UHC has implemented a process to ensure the credentialing files reflect proof of query of the SSDMF. *Corrective Action Plan: Ensure evidence of the SSDMF query is included in the credentialing/recredentialing files.*
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;		X				One credentialing file for a psychiatrist did not address the hospital plan on the application or the checklist. UHC responded that hospital admitting privileges are not required for this type of provider; however, the *CHIP Contract, Section 7 B*, states, "Each network physician shall maintain hospital admitting privileges with a network hospital as required for the performance of his or her practice or have a written agreement with a network physician who has hospital admitting privileges." For psychiatrists, UHC needs to consider whether the MD has a plan for hospital admittance if they do not have hospital admitting privileges. *Corrective Action Plan: Ensure credentialing and recredentialing files address a hospital admitting plan for psychiatrists if they do not have hospital admitting privileges.*
3.1.14 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					
3.1.15 Ownership Disclosure Form.	X					
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					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed in the section that follows.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery the System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Query of the Social Security Administration's Death Master File (SSDMF);		X				Three recredentialing files did not show proof the SSDMF had been queried. Per onsite discussion, effective 6/1/17 UHC implemented a national process to check the SSDMF and no longer uses Aperture to perform the checks. UHC Policy Social Security Death Master File Database Cleanse defines the protocol for identifying and taking action with provider data when the provider information appears on the Social Security Administration Death Master (SSDMF) file. Providers within the UHC National Database (NDB) are compared to the SSDMF weekly. If the provider information is found in the Death Master File, the provider is removed from UHC directories, outbound verification may occur to confirm the provider is deceased, and UHC databases are updated accordingly. Ongoing weekly validation of UHC NDB provider records against the SSDMF, will identify any provider in the enrollment and re-enrollment process as being deceased. However, it does not appear that UHC has implemented a process to ensure the recredentialing files reflect proof of query of the SSDMF. *Corrective Action Plan: Ensure evidence of the SSDMF query is included in the recredentialing files.*
4.2.11 Query of the National Plan and Provider Enumeration (NPPES);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 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					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure form.	X					
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					
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					UnitedHealthcare Services Policy, Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy & Procedure, defines the process for investigating and evaluating quality of care concerns which includes Medical Director review and peer committee review as appropriate. If adverse disciplinary action such as suspension or termination is taken against a physician or health care professional as a result of a QOC investigation, a notice about the opportunity for a fair hearing is provided.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.	X					The *UnitedHealthcare Credentialing Plan 2017-2019* defines the procedures for credentialing and recredentialing facilities in to the network. Specific credentialing criteria for Mississippi are detailed in an addendum to the credentialing plan. Primary source verification is conducted by Aperture.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The file review reflected one recredentialing file where Aperture verified the SAM electronically, but a copy of the query was not in the file. *Recommendation: Ensure copies of the queries for the SAM are placed in the organizational credentialing/recredentialing files.*
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 members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					Policy PS10a, PCP Panel Notification, states 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 UHC receives the Member Listing Report from DOM. The policy details the process, which includes making information available to all participating PCPs via the secure provider portal. Changes in member panels are communicated via post card notification. The Provider Services call center is available for questions.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment, states it is the policy of UHC that out-of-network providers are able to verify the enrollment of an enrollee. All providers, including out-of-network providers, may call the telephone number on the back of the member ID card to verify member enrollment.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					Policy PS10a, PCP Panel Notification, states during initial credentialing and/or contracting setup, PCPs may communicate desired restrictions regarding member panel composition to UHC. For closed panels, no members are assigned to them. If no restrictions are requested, it is understood that the PCP agrees to accept all members as assigned. PCPs can request changes to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						their panel profile information at any time, and this information is updated in the provider data and applied to member assignment processes. UHC makes member panel details available to all participating PCPs via the secure provider portal to notify providers of panel composition and keep them informed of any changes to their member panels. The online *Provider Directory* specifies whether the provider is accepting new patients.
1.4 Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties.	X					The geographic access standards for primary care providers for the CAN and CHIP programs are defined in Policy PS3, Geographic Access Standards. The standards for urban and rural measurement comply with contract guidelines. GEO access reports show the standards are measured appropriately. The *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report reflected PCPs for CAN and CHIP (Family/General Practice, Internal Medicine, and Pediatrics) met the goal of 90% compliance to the defined standards. In fact, all categories were 100% compliant to the urban and rural standards.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy PS3, Geographic Access Standards, defines the geographic standards for evaluating specialists, and the information complies with contract guidelines. UHC provided GEO Access reports for review and CCME noted that Emergency Care providers were run as “one within 60 miles” for Rural, when the guideline is “one within 30 miles” for Rural. The *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report reflected measurement of high volume/high impact specialties such as Cardiology, Oncology, Allergy & Immunology, OB/GYN, ENT Otolaryngology, and Orthopedics. All specialties met the goal of 90% compliance for CAN and CHIP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the quarterly GEO Access reports reflect the correct mileage parameter for Rural Emergency Care providers.
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Geographic access reports are developed quarterly to assess network compliance as defined in Policy PS3, Geographic Access Standards. The reports are delivered each quarter to DOM, as well as the Service Quality Improvement Subcommittee for reporting, tracking, and trend analysis.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report reflected UHC's assessment of cultural, ethnic, racial and linguistic availability. The data related to UHC practitioner network, including member complaint and survey data, indicated there were no gaps related to language and cultural/ethnicity.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Appointment availability standards are defined in Policy PS2, Access Standard – Appointment Availability Requirements. The standards comply with contract requirements and are listed in the *Provider Manual* and reinforced through provider education. Quarterly assessments are performed to gauge the level of compliance among PCPs, OB/GYNs, and Behavioral Health providers. Quarterly and annual assessments are performed to gauge level of compliance among high-volume specialty providers. These results are submitted to DOM and the UHC Service Quality Improvement Subcommittee for monitoring, tracking, trending, and to support identification of improvement opportunities and development of corrective action initiatives.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME reviewed the *UnitedHealthcare Community Plan of Mississippi Annual Assessment of Network Adequacy May 2017* report and determined it is a comprehensive report that reflects UHC's efforts to ensure member access to their providers. UHC utilizes Dial America to make calls to PCP offices to assess appointment availability (urgent, routine, well care visits) and after-hours access. Results for CHIP and CAN for 2017 showed the goal of 80% was met for all three categories: urgent care (82.84%); routine care (85.99%); and after-hours care (95.23%).
II C. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.	X					CCME performed Provider Satisfaction Survey validation using a validation worksheet based on the CMS Survey Validation Protocol. The survey had a low response rate (4.7%). The low response rate may impact the generalizability of the survey. The complete worksheet is available as an attachment in this report. *Recommendation: Focus on strategies that help increase response rates for this population. Solicit the help of the survey vendor.*
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The survey was analyzed by the plan.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					Results were presented to the QMC committee in March 2018.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The generalizability of the survey results is difficult to discern due to low response rates of 28.49% total and 26.97% for the general population. *Recommendation: Focus on strategies that help increase response rates for this population. Set an internal response rate goal (such as receiving a 2% increase over the previous year's response rate) as opposed to the target rate set by AHRQ.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Results are presented and analyzed to assess barriers and create interventions regarding the satisfaction results in September 2017.
3. The CCO reports the results of the member satisfaction survey to providers.	X					The 2017 CHIP CAHPS results were shared with providers in a provider newsletter.
4. The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
III B. Complaints/Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy AG-03, Complaint and Grievance Policy and Procedures, and the Optum's Mississippi CHIP Addendum to Enrollee Grievances define processes for receipt, handling, and resolution of CHIP grievances.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;		X				Policy AG-03 defines a grievance as an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action. The word "action" is outdated based on *42 CFR §*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						438.400 (b)—the current term is "adverse benefit determination." Issues noted in the *CHIP Member Handbook* include: •The heading for the section on page 48 is "Appeals and Complaints." Throughout the section the terms "complaint" and "grievance" seem to be used interchangeably, which may be confusing for members since separate processes exist for complaints and grievances. •Page 49 defines a grievance as "when you are not happy with UnitedHealthcare benefits, services, policies or providers," and page 50 defines the term "complaint" as "When a member expresses dissatisfaction with any part of his/her care." There is no mention on either page that grievances and complaints exclude dissatisfaction with an adverse benefit determination. The term "grievance" is not defined in the *CHIP Provider Manual*. UHC's CHIP website glossary defines a grievance as a "statement of dissatisfaction with any part of your care." It does not include that grievances are unrelated to an adverse benefit determination. *Corrective Action: Update the definitions of complaints and grievances in the CHIP Member Handbook and in UHC's CHIP website glossary to include that complaints and grievances are unrelated to an adverse benefit determination. Define the term "grievance" in the CHIP Provider Manual.* *Recommendation: Revise policy AG-03 to use the current terminology of "adverse benefit determination" rather than "action." Update the heading on page 48 of the CHIP Member Handbook to include grievances and revise this section of the CHIP Member Handbook to clearly*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						define the differences between complaints and grievances and to explain the processes for both.
1.2 The procedure for filing and handling a complaint/grievance;		X				When discussing the grievance filing timeframe during the onsite visit, UHC staff stated CHIP members may file grievances within 30 days of the event causing dissatisfaction. This 30-day filing timeframe is also stated on page 4 of Policy AG-03, Complaint and Grievance Policy and Procedures. *42 CFR §438.402 (c) (2) (i)* allows grievances to be filed at any time. The following resources do not define the timeframe to file a grievance: •Optum's Mississippi CHIP Addendum to Enrollee Grievances, however, the timeframe is defined in the National Optum Enrollee Grievances: Medicaid policy •*CHIP Member Handbook* •*CHIP Provider Manual* The *CHIP Member Handbook* contains very little information on grievances and the grievance filing process and does not indicate that UHC assists members in the grievance filing process, if needed. Onsite discussion confirmed written grievances are acknowledged in writing within five calendar days of receipt of the grievance; however, the following documents indicate the acknowledgement timeframe for written grievances is five business days: •Policy AG-03, Complaint and Grievance Policy and Procedures •Optum's Mississippi CHIP Addendum to Enrollee Grievances *Corrective Action: Revise Policy AG-03, the CHIP Member Handbook, and the CHIP Provider Manual to state that member grievances can be filed at any time. Revise the CHIP Member Handbook to contain a complete overview*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of the grievance process and include that assistance with the grievance filing process is provided to members if needed. Correct the timeframe for acknowledgement of written grievances in Policy AG-03 and in Optum's Mississippi CHIP Addendum to Enrollee Grievances. *Recommendation: Update the Optum Mississippi CHIP Addendum to Enrollee Grievances to indicate grievances may be filed at any time.*
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;		X				Policy AG-03, Complaint and Grievance Policy and Procedures, appropriately defines the resolution timeframes for complaints and for both standard and expedited grievances. Information is included about extensions of the resolution timeframes. Issues with documentation of resolution timeframes include: •Optum's Mississippi CHIP Addendum to Enrollee Grievances and National Optum Enrollee Grievances: Medicaid policy do not address the resolution timeframe for complaints and expedited grievances. •Optum's Mississippi CHIP Addendum to Enrollee Grievances does not include information about extensions of grievance resolution timeframes; however, information about extensions is found in the National Optum Enrollee Grievances: Medicaid policy. •The *CHIP Member Handbook* does not include resolution timeframes for expedited grievances and does not include information about extensions of grievance resolution timeframes. •The *CHIP Provider Manual* does not define the complaint and grievance resolution timeframe or provide information about extensions of grievance resolution timeframes. *Recommendation: Update the Optum Mississippi CHIP Addendum to Enrollee Grievances to include information about extensions of grievance resolution timeframes.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Corrective Action: Update Optum's Mississippi CHIP Addendum to Enrollee Grievances to include resolution timeframes for complaints and expedited grievances. Revise the CHIP Member Handbook to include resolution timeframes for expedited grievances and information on extensions of grievance resolution timeframes. Revise the CHIP Provider Manual to include complaint and grievance resolution timeframes as well as information on extensions of grievance resolution timeframes.
1.4 Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract.	X					
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					Review of CHIP grievance files reveals the following: •One acknowledgement letter was sent after the required timeframe for acknowledgement •One file reflects discrepancies in documentation of the receipt date of the grievance •One file has insufficient documentation regarding the services for which the member was billed, resulting in the inability to determine if the resolution is appropriate *Recommendation: Ensure acknowledgement letters are sent within the required timeframe and that receipt date is consistently documented throughout the file. Ensure grievance files contain enough documentation of the grievance and/or investigation findings to verify resolution is correct.*
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality	X					The *2018 QI Program Description* indicates all grievances are tracked and data is reported to and analyzed by the QIC to identify trends and to recommend performance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
improvement opportunities, and reported to the Quality Improvement Committee.						improvement activities. Grievance reports are submitted to the QIC at least quarterly along with recommendations for QI activities based on results. Review of QIC minutes confirm grievance data is reported and discussed.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					
IV B. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM.	X					UHC submitted four projects for desk material review. As per the contract, a PIP regarding obesity should be selected annually for continuous evaluation. The topics are Adolescent Well Child Visits, Follow Up after Hospitalization for Mental Illness, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, and Getting the Care Needed CAHPS, which is still awaiting state approval to replace the ASM PIP.

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 "Validating Performance Improvement Projects".	X					In the previous EQR, the issues for the PIPs involved clarification of the research question, data analysis plan, actual analysis, and improvement in rates for the follow-up after hospitalization PIP. For the current review, those issues are corrected. All projects received a score of "High Confidence in Reported Results.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including:	X					Policy AG-04, Standard and Expedited Appeal Process and Procedures, describes the appeal process for CHIP members. Optum's Enrollee Appeals of Adverse Benefits Determinations: Medicaid policy, along with the Optum Mississippi CHIP Addendum to Enrollee Appeals of Adverse Benefit Determinations, Provider Appeals and Independent External Process policy, address behavioral health appeals.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Issues with definitions of appeal terminology include: •Policy AG-04, Standard and Expedited Appeal Process and Procedures and the *CHIP Member Handbook* define the term "action" but do not use the current terminology of "adverse benefit determination" as found in *42 CFR §438.400 (b)* •Pages 29 through 31 of the *CHIP Provider Manual* use the terms "action" and "adverse action" *Corrective Action: Correct Policy AG-04, Standard and Expedited Appeal Process and Procedures, the CHIP*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member Handbook, and the CHIP Provider Manual to use the current terminology of "adverse benefit determination" instead of "action" or "adverse action."
1.2 The procedure for filing an appeal;		X				Instructions for filing an appeal are listed in the *CHIP Member Handbook*, *CHIP Provider Manual*, Policy AG-04, Standard and Expedited Appeal Process and Procedures, and *Optum's Enrollee Appeals of Adverse Benefits Determinations: Medicaid* policy. *42 CFR §438.406 (b) (1)* requires acknowledgement of each appeal, and onsite discussion revealed UHC sends appeal acknowledgment letters to members within 10 days of receiving the request. CCME identified the following issues: •Policy AG-04 does not include processes or timeframes for acknowledging appeals. •The *CHIP Member Handbook* does not inform members that appeals are acknowledged. •Page 30 of the *CHIP Provider Manual* indicates appeals will be acknowledged in one working day for expedited appeals and within five working days for standard appeals. However, as noted above, UHC staff indicates acknowledgement is provided within 10 days of receipt of an appeal. The instructions for filing an appeal in the *CHIP Provider Manual* interchangeably use the terms "appeal" and "grievance." A *Grievance and Appeal Form* is located on page 53 of the *CHIP Member Handbook*; however, there is no reference to this form or instructions for the use of the form elsewhere in the *CHIP Member Handbook*. *Corrective Action: Revise Policy AG-04 to include processes and timeframes for acknowledging appeals. Update the CHIP Member Handbook to inform members that appeals are acknowledged and the timeframe for*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						acknowledgement. Update the CHIP Provider Manual to include the correct timeframe for appeal acknowledgement. *Recommendation: Revise the CHIP Provider Manual to remove the interchangeable use of the words "appeal" and "grievance" in the appeals section. Communicate in the appeals section of the CHIP Member Handbook that a grievance and appeals form is available on page 53 and provide instructions for its use to file an appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				As documented in Policy AG-04, Standard and Expedited Appeal Process and Procedures, the *2018 CHIP Member Handbook*, and the *2017 CHIP Provider Manual*, each level of standard appeals is resolved within 15 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt. Page 4 of *Optum's Enrollee Appeals of Adverse Benefits Determinations: Medicaid* policy defines resolution timeframes for appeals as 30 calendar days for standard appeals and 72 hours for expedited appeals. Optum's Mississippi CHIP Addendum to Enrollee Appeals of Adverse Benefit Determinations, Provider Appeals and Independent External Process addendum also states the appeal resolution timeframe is 30 calendar days from receipt. During onsite discussion, UHC staff confirmed all

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						levels of appeals are responded to within 15 calendar days with a possible extension of up to 14 calendar days. UHC staff confirms the medical and behavioral health appeals processes should mirror each other. *Corrective Action: Ensure timeframes for resolution of behavioral health appeals are documented in the Optum Mississippi CHIP Addendum to Enrollee Appeals of Adverse Benefit Determinations, Provider Appeals and Independent External Process according to guidelines in the CHIP Contract, Exhibit E.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The CCO applies the appeal policies and procedures as formulated.	X					Appeal files reflected timely acknowledgements, decisions, and notifications. All were reviewed by the appropriate physicians, and appeal notices contained appropriate information.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy AG-04, Standard and Expedited Appeal Process and Procedures indicates appeals data is tracked and reported to QMC quarterly. Review of QMC minutes confirms CHIP appeals are reported and discussed.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. B Care Management						
1. The CCO assess the varying needs and different levels of care management needs of its member population.	X					The *Mississippi Addendum to the 2017 Care Management Program Description* defines the program's goals, objectives, lines of responsibility, and operations. Policy NCM 012, Risk Stratification Process lists sources used to identify and stratify members for Care Management (CM) such as a Health Risk Assessments (HRA), predictive modeling, benefit enrollment flags, and service

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						utilization. The CM Program is communicated in the *CHIP Member Handbook* and the *CHIP Provider Manua*l. Page 14 of the CHIP Member Handbook states, "If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program." This might limit members' understanding of the scope of conditions for which Care Management may be appropriate. *Recommendation: In the statement on page 14 of the CHIP Member Handbook, include examples of health conditions other than diabetes and asthma that may qualify for Care Management, so members know broader case management services are available.*
2. The CCO uses varying sources to identify and evaluate members' needs for care management.	X					Policy NCM 001, Identification of High Risk Members for Case Management, the CM Program Description and Addendum, and the *CHIP Provider Manual* describe various methods for which eligible CHIP members can be referred into Care Management. The HRA tool is primarily utilized to screen and identify new members. Activities such as data mining, provider or member referrals, and medical management program referrals are utilized for ongoing identification of members for CM. Additionally, Policy NCM 006, Integration of Physical and Behavioral Health Through Whole Person Care, addresses identification of members for CM.
3. A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level.	X					Policy NCM 002 Rider 1, Case Management Process addresses the assessment process for newly assigned high or medium risk level CHIP members and indicates the health risk assessment is completed within 30 calendar days. The policy does not include a description of the risk score associated with the documented risk levels. Risk scores are not included in the *2017 Care Management Program Description and Addendum*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The *CHIP Provider Manual* gives a description of the low, moderate, and high-risk levels to which a member can be assigned based on the HRA results. *Recommendation: Include a description of the risk score with corresponding risk levels in Policy NCM 002 Rider 1, Case Management Process, and the Care Management Program Description and Addendum so that readers can objectively recognize a member's risk level.*
4. The detailed health risk assessment includes:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments.	X					Policy NCM 002 Rider 1, Case Management Process, defines the timeframe for completing treatment plans as within 30 days of the HRA. Sampled care management files reflect qualified professionals complete health risk assessments via telephone or in-person visits; however, treatment plans could not be identified. During onsite discussion, representatives from the Care Management department explained the process for completing treatment plans.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					Policy NCM 002, Case Management Process appropriately addresses the requirement to periodically update risk level assignment. Onsite discussion revealed health risk screenings and health risk assessments are updated intermittently as the member's condition requires, and at least annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all members through the following minimum functions:	X					Care Management techniques are utilized for CHIP members to ensure comprehensive, coordinated care in various risk levels according to a standard outreach process as it applies to continual care, transitional care, and discharge planning.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management Team member and provided instructions on how to contract their assigned team;						
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the member requests otherwise;						
7.3 Appropriate referral and scheduling assistance for Members needing specialty health care services, including behavioral health, and those identified through Well-Baby and Well-Child screening;						
7.4 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.5 Monitoring and treatment of members with ongoing medical conditions according to appropriate standards of medical practice;						
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.8 Determination of the need for non-covered services and referral of members to the appropriate service setting, utilizing assistance as needed from the Division;						
7.9 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.10 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.11 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular member, the Contractor must adequately and timely cover these services out of network for the member, 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;						
7.14 The Contractor must produce a treatment plan for members determined to need a course of treatment or regular care monitoring. The member and/or authorized family member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract.	X					UHC provides services to members assigned to medium and low risk levels as described in Policy NCM 002 Rider 1, Case Management Process.
9. The CCO provides members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					Policy NCM 001, Identification of High Risk Members for Case Management describes methods utilized to identify high risk members. Policy NCM 002, Case Management Process, describes the assessment process for high risk members. Policy NCM 002 Rider 1, Case Management Process identifies the Care Management services provided to all

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members in Care Management as well as to members assigned to the medium risk level. CCME is unable to determine specifically the care management services provided to members in the high-risk level. *Recommendation: Update Policy NCM 002 Rider 1, Case Management Process, to clearly identify the services provided to members assigned to the high-risk level.*
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					The *2017 Care Management Program Description and Addendum* indicates member information is forwarded to the MS Division of Medicaid when a member disenrolls from the health plan. Policy NCM 002, Case Management Process provides case closure instructions for the care manager to share care plan and historical utilization data with the new health plan when a member transitions to another health plan upon request.
11. The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.	X					Page 9 of the *CHIP Care Management Program Description and Addendum* lists conditions included in the core disease management programs available to members, but the list does not include obesity, attention deficit hyperactivity disorder, and organ transplants. *Recommendation: Update the list of conditions included in the disease management program on page 9 of the CHIP Care Management Program Description and Addendum to include obesity, attention deficit hyperactivity disorder, and organ transplants.*
V C. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between the PCPs and other service providers.	X					The *2017 Care Management Program Description and Addendum* indicates the Care Team manages care transitions from hospital to home within 30 days of discharge with the goal of providing members with tools and skills to support their transition between settings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy NCM 002, Case Management Process notes that Care Managers support pediatric members transitioning from pediatric to adult care providers.
2. The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					The *Care Management Program Description and Addendum* lists general requirements for Transitional Care Management.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					When applicable, appropriate transitional care requirements are identified during.