2020 External Quality Review

UNITEDHEALTHCARE COMMUNITY PLAN MISSISSIPPI

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Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies 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 (United). This report contains a description of the process and results of the 2020 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi (MS) Division of Medicaid (DOM) for the Mississippi Coordinated Access Network (CAN) and the Mississippi Children's Health Insurance Program (CHIP).

The goals of the review were to:

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

The EQR process is based on Centers for Medicare & Medicaid Services (CMS)-developed protocols for EQRs of Medicaid MCOs. The review includes a desk review of documents; results from a two-day virtual onsite visit; a compliance review; validation of performance improvement projects (PIPs) and performance measures, validation of network adequacy, member satisfaction and provider satisfaction surveys validations; and an Information System Capabilities Assessment (ISCA) audit.

OVERVIEW

The 2020 CAN Program EQR shows United achieved "Met" scores for 95.6% of the standards reviewed. As the following chart indicates, 4% of the standards were scored as "Partially Met" with 0.4% scoring as "Not Met." For the CHIP Program, 95.5% of the standards were scored as "Met," 4.1% of the standards were scored as "Partially Met," and 0.5% were scored as "Not Met."

Figure 1: 2020 Annual EQR Review Results for CAN & CHIP

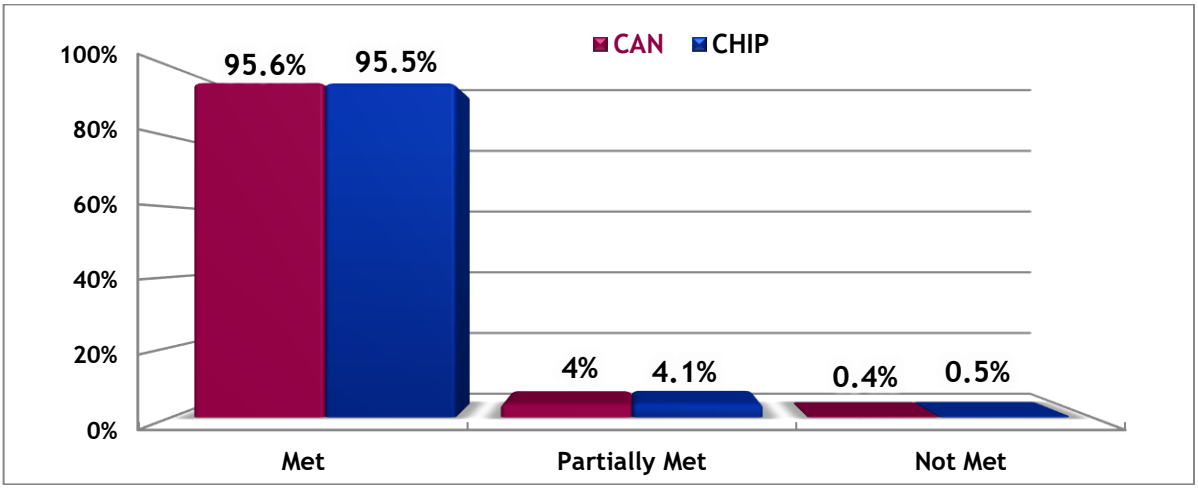


Table 1, Scoring Overview provides an overview of the scores for each review section for the CAN and the CHIP programs.

Table 1: Scoring Overview

2020	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
CAN	31	0	0	0	0	31
CHIP	31	0	0	0	0	31
Provider Services						
CAN	83	2	1	0	0	86
CHIP	81	3	1	0	0	85
Member Services						
CAN	29	4	0	0	0	33
CHIP	28	4	0	0	0	32
Quality Improvement						
CAN	19	0	0	0	0	19
CHIP	19	0	0	0	0	19
Utilization Management						
CAN	51	3	0	0	0	54
CHIP	51	2	0	0	0	53
Delegation						
CAN	2	0	0	0	0	2
CHIP	2	0	0	0	0	2

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, applicable corrective action items, and recommendations are found in the respective sections and narrative of this report.

Administration

CCME's review of United's Organizational Chart and associated discussion during the onsite confirmed adequate staffing is in place to ensure health care products and services are provided to members. Fewer than five positions are vacant and recruiting activities are in progress.

Appropriate processes are in place for annual review and approval of policies and procedures. In addition to formal policies and procedures, standard operating procedures are reviewed and revised as needed. Newly created and revised policies are reviewed by applicable committees prior to approval.

United's Information Systems Capabilities Assessment documentation reflects that United meets contractual information system requirements. Claims processing performance exceeds the State's requirements, with documentation indicating 99.89% of clean claims were paid within 30 days and 99.99% were paid within 90 days. Disaster recovery exercises are conducted twice annually.

The UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2020-2021, its Mississippi-specific addendum, and a host of policies and procedures describe processes to ensure compliance and to prevent, detect, and respond to fraud, waste, and abuse (FWA). A detailed Code of Conduct guides staff in ethical and appropriate business behavior. Initial and ongoing compliance and FWA training and education are provided to employees, and member and provider educational materials include information about FWA. Multiple reporting methods are available for reporting compliance and FWA violations. United ensures that no retaliation is taken against anyone who makes such a report.

Provider Services

The National Credentialing Committee (NCC) makes credentialing decisions and communicates the decisions to the health plan. The local Provider Advisory Committee (PAC) serves as the local Credentialing Committee and reviews credentialing and recredentialing decisions made by the NCC. Membership of the PAC includes United network providers with a variety of specialties.

The UnitedHealthcare Credentialing Plan 2019 – 2021 (Credentialing Plan), the United Behavioral Health Clinician and Organizational Provider Credentialing Plan 2020-2021,

and related policies and procedures define processes for credentialing and recredentialing of health care providers. A State and Federal Regulatory Addendum to the Credentialing Plan defines Mississippi-specific requirements.

Several issues were identified in CAN and CHIP credentialing and recredentialing files, including lack of evidence of a query of the System for Award Management (SAM), outdated signatures on Ownership Disclosure Forms (repeat finding from 2019), inability to determine the date of revision on the MS DOM Sanctioned Provider List query, undated screenshots of SAM queries and Office of Inspector General List of Excluded Individuals & Entities (OIG LEIE) queries, and lack of an OIG LEIE query.

United runs quarterly geographic access reports to evaluate and monitor the adequacy of the provider network. The policy that documents geographic access standards does not include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in the CAN and CHIP Contracts. The Managed Care Accessibility Analysis report dated July 23, 2020 uses an incorrect standard for rural emergency medicine providers. Documentation confirms there was a significant decrease of over 35% from the previous year for PCP after-hours access. Although United identified and documented barriers, it appears no action was taken to address the large decrease.

CCME noted multiple discrepancies in benefit information when comparing the CAN Care Provider Manual to the CAN Member Handbook and when comparing the CHIP Care Provider Manual to the CHIP Member Handbook. This is a repeat finding from the previous EQR.

United has implemented new methods and forums to ensure provider education continues while under COVID-19 restrictions, and its Multicultural Health Care Program includes various activities to ensure network providers can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.

Beginning in 2020, CCME initiated biannual validation of network access/availability and provider directory accuracy for Mississippi CCOs to determine if there is any improvement in the telephonic provider access study success rate and to evaluate the accuracy of the online Provider Directory. The methodology involves two phases: (1) a telephonic survey to determine if CCO-provided PCP contact information is accurate and (2) an assessment of the accuracy of United's online Provider Directories. Appointment availability for urgent and routine care is also evaluated during this process.

For this review, United submitted a total of 2,391 unique PCPs for the CAN population and a total of 2,412 unique PCPs for the CHIP population. For CAN, a random sample of 100 PCPs was drawn, and for CHIP a random sample of 104 PCPs was drawn. Phase 1 (Provider Access Study) was conducted for each. For successful calls, United's online provider directory was reviewed to determine if the information in the directory matched

the information confirmed during the provider access study phase. A summary of the results is provided in *Table 2: Summary Provider Access Study and Provider Directory Validation*.

Table 2: Summary Provider Access Study and Provider Directory Validation

Phase 1 – Provider Access Study					
	Correct Address/Phone Number	Accepted United	Accepting New Patients	Access and Availability	
				*Routine Appointments	*Urgent Appointments
CAN	72%	76%	56%	73%	69%
CHIP	61%	51%	67%	70%	58%
Phase 2 – Provider Directory Validation					
	Correct Name	Correct Phone Number	Correct Address	Correct Panel Status	
CAN	83%	79%	81%	79%	
CHIP	92%	92%	92%	67%	

* PCP met the requirements of 30-calendar days for a routine appointment and 48-hours for an urgent appointment

For the CAN population, discrepancies in the directory were most common for telephone number and status for accepting new patients (21% reported a different telephone number during the access study call in relation to the phone number provided in the directory, and 21% reported a different panel status). When compared to the access study results, 19% reported a different address in the provider directory.

The CHIP discrepancies in the directory were most common in status for accepting new patients (33% reported a different panel status). When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

Full details of the study's results, conclusions, and required corrective actions are included in the Provider Access Study and Directory Validation report.

Member Services

United has policies and procedures that define and describe member rights and responsibilities, as well as methods of notifying members of their rights and responsibilities. New members receive a New Member Packet with instructions for contacting Member Services, selecting a primary care provider (PCP), and initiating services. All members have access to information and resources in the Member Handbook, Provider Manual, on the website, and in member newsletters that can help them utilize

their benefits. The plan provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are conducted annually via a third-party vendor. The 2019 survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.

Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the QI program descriptions for the CAN and CHIP programs, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations. United's 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.

United's QI Work Plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 Work Plans included the planned activities, specific interventions, target dates for completions, responsible parties, and oversight committees. United maintains a separate work plan for the CHIP Program.

The Quality Management Committee (QMC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. Minutes are recorded for each meeting and document committee discussion points and decisions. Separate meetings were not held for the CAN and the CHIP programs. However, the minutes clearly indicated which program was being discussed.

The scope of the QI program includes monitoring of provider compliance with clinical practice guidelines. United's Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, provides the process used to monitor provider compliance with the guidelines. For CAN, United has chosen the Comprehensive Diabetes Care and Weight Assessment and Counseling for Nutrition and Physical Activity measures. The 2019 measurement year results indicated the Weight Assessment and Counseling for Nutrition and Physical Activity measure met the DOM goal; however, the Comprehensive Diabetes Care measure did not. For CHIP, United has chosen the Antidepressant Medication Management (AMM) and Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measures. The 2019 measurement year results indicated both measures showed an increase and met the established goal.

United's standard operating procedures indicate any problems identified during the EPSDT or Well-Baby and Well-Child exam that require referrals are tracked on a quarterly basis. United provided examples of the tracking reports. As noted during the previous EQR, the tracking reports failed to link the identified problem with the EPSDT or Well-

Baby/Well-Child exam and did not include or indicate the members who received additional outreach for case management referrals.

Performance Measure Validation

The purpose of the performance measure validation is to assess the accuracy of the performance measures (PMs) reported by the CCOs and to determine the extent to which the PMs follow State specifications and reporting requirements. Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the PMs identified by DOM to evaluate their accuracy as reported by United for the CAN and CHIP populations.

Performance measure validation determines the extent to which the CCO followed the specifications established for the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019. The results of the validation found that United met all the data requirements to report the PMs.

All relevant HEDIS performance measures for the CAN and CHIP populations for the current review year (MY 2019), as well as the previous year (MY 2018) and the change from 2018 to 2019 are reported in the Quality Improvement section of this report. *Table 3: CAN HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increased or decreased in rate from 2018 to 2019. Substantial increase or decrease is a change in rate of greater than 10%.

Table 3: CAN HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.99%	69.10%	14.11%
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	45.50%	58.88%	13.38%
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	65.00%	46.15%	-18.85%
Comprehensive Diabetes Care (cdc)			
HbA1c Control (<8.0%)	46.23%	34.55%	-11.68%

Table 4: CHIP HEDIS Measures with Substantial Change in Rates highlights the HEDIS measures with a substantial increase in rate from 2018 to 2019. There were no measures noted with a substantial decrease.

Table 4: CHIP HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2018	Measure Year 2019	Change from 2018 to 2019
Substantial Increase in Rate (>10% improvement)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.26%	64.96%	10.70%
Counseling for Nutrition	41.12%	55.96%	14.84%
Counseling for Physical Activity	36.50%	50.12%	13.62%

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by United for 2019 are listed in the Quality Improvement section of this report.

United did not report three of the measures for the CAN population. The three measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01), and Cesarean Birth (PC-02 CH). For CHIP, there were two measures not reported. The two measures were Live Births Weighing Less Than 2,500 grams (LBW-CW) and Cesarean Birth (PC-02 CH). It is recommended that United work proactively with DOM for clarification on measures required to be reported.

Performance Improvement Project Validation

United submitted the Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness performance improvement projects (PIPs) for validation. *Table 5: CAN Performance Improvement Project Validation Scores* provides an overview of the scores for the CAN PIPs. All PIPs scored in the "High Confidence in Reported Results" range.

Table 5: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Behavioral Health Readmissions	78/78=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results

Project	Previous Validation Score	Current Validation Score
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	62/62=100% High Confidence in Reported Results	67/72=93% High Confidence in Reported Results
Sickle Cell Disease Outcomes: Care Coordination for SCD Patients to Reduce ER Utilization	57/62=92% High Confidence in Reported Results	66/71=93% High Confidence in Reported Results
Respiratory Illness: COPD/Asthma	62/62=100% High Confidence in Reported Results	72/72=100% High Confidence in Reported Results

For the CHIP population, United submitted four projects for validation. Topics included Adolescent Well Child Visits (AWC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity), Getting Needed Care CAHPS, and Follow Up After Hospitalization for Mental Illness.

For the 2019 review, the four PIPs scored in the "High Confidence in Reported Results" range. The same PIPs were submitted and validated for the current review with all four PIPs scoring in the "High Confidence in Reported Results" range. *Table 6: CHIP Performance Improvement Project Validation Scores* provides an overview of the scores for the CHIP PIPs.

Table 6: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Adolescent Well Child Visits (AWC)	104/105=99% High Confidence in Reported Results	100/100=100% High Confidence in Report Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity)	111/111=100% High Confidence in Report Results	100/100=100% High Confidence in Report Results
Getting Needed Care CAHPS	111/111=100% High Confidence in Report Results	99/100=99% High Confidence in Report Results
Follow Up After Hospitalization for Mental Illness	84/85=99% High Confidence in Report Results	80/80=100% High Confidence in Reported Results

Utilization Management

The CAN and CHIP UM Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health services. Policies and procedures define how services are operationalized and provided to members.

Service authorization requests are conducted by appropriate reviewers utilizing internal clinical guidelines or other established criteria. The Care Management (CM) Program Description and policies appropriately document CM processes and services provided. There were issues noted related to appeals such as using outdated terminology for the term "adverse benefit determination" and lack of appeal information located on the non-secured section of the CAN and CHIP websites.

Overall, review of UM approval, denial, and appeal files provided evidence that appropriate processes are followed. Care Management files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Delegation

CCME's review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials. United reported 15 current delegation agreements.

United has policies that address the process the Plan follows to evaluate and monitor the delegated entities' capacity to perform the delegated activities. Some of the files reviewed during the monitoring noted the requirement for the Clinical Laboratory Improvement Amendments (CLIA) certificate as N/A and file review for three of the delegates was not conducted.

METHODOLOGY

On July 2, 2020 CCME sent notification to United 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 Standards for the CAN and CHIP programs.

Further, CCME invited the health plan to participate in a pre-onsite conference call with CCME and DOM to offer United an opportunity to seek clarification on the review process and ask questions about desk materials CCME requested.

The review consisted of two segments. The first was a desk review of materials and documents received from United on August 3, 2020 for review at the CCME offices (see *Attachment 1*).

The second segment was a two-day, onsite teleconference conducted on October 5, 2020 and October 6, 2020 via WebEx due to issues with COVID-19. The onsite teleconference focused on areas not covered by the desk review and areas needing clarification (see *Attachment 2*). CCME's onsite teleconference activities included the following:

- Entrance and exit conferences (open to all interested parties)
- Interviews with United'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 four federally-mandated EQR activities: compliance determination, validation of performance measures, validation of network adequacy, and validation of performance improvement projects. In addition, the review included the optional activities of member and provider satisfaction survey validations.

FINDINGS

EQR findings 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 United and DOM. Strengths, weaknesses, corrective actions, and recommendations are identified where applicable.

Areas of review are recorded in separate tabular spreadsheets for the respective CAN and CHIP programs (*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."

I. Administration

The Administration review focused on policy and procedure management, staffing, information systems, and compliance.

Jeff Wedin is the Chief Executive Officer and Mitch Morris is the Chief Operating Officer. CCME's review of United's Organizational Chart and associated discussion during the onsite confirmed adequate staffing is in place to ensure health care products and services are provided to members. United reports there are currently fewer than five open positions, and recruiting activities are in progress.

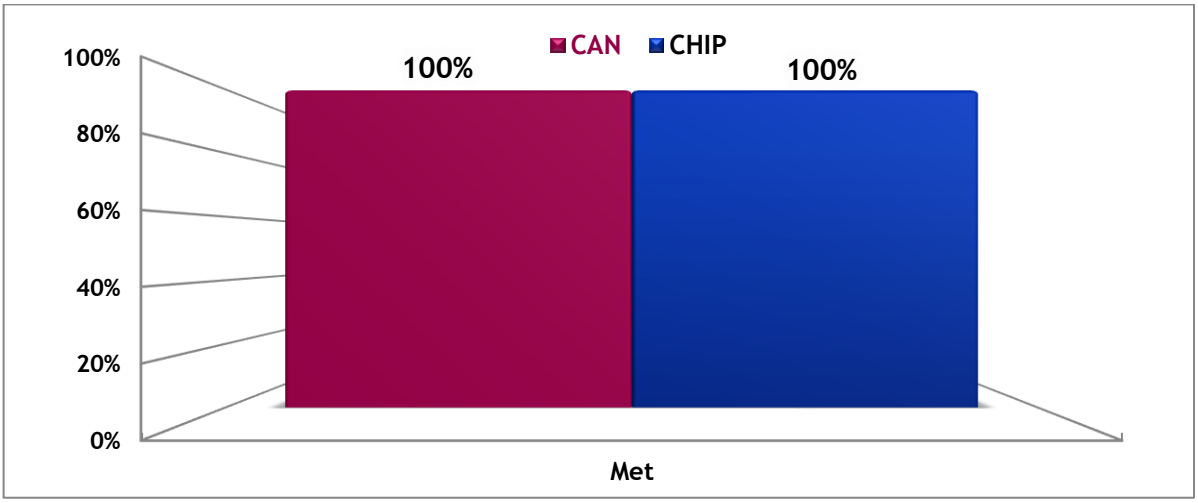
Policies and procedures are organized by department or functional area within the organization and are reviewed annually. Standard operating procedures for various business functions are maintained and are reviewed and revised as needed. Policies are accessible to all employees on a SharePoint site. Newly created and revised policies are initially reviewed by the Policy and Review Steering Committee and then presented for final review and approval by other applicable committees, such as the Health Quality Utilization Management (HQUM) Committee, Service Quality Improvement Subcommittee (SQIS), and the Quality Management Committee (QMC).

United provided data within its Information Systems Capabilities Assessment (ISCA) documentation demonstrating it can fulfill the information system requirements of the State's contract. The ISCA documentation indicates United's claims processing performance not only meets the State's requirements, but significantly exceeds those requirements. Over the 13 months of data provided, United paid 99.89% of clean claims within 30 days, and 99.99% of clean claims within 90 days. Finally, United conducts disaster recovery exercises twice annually, which is above average (once a year is most common).

The UnitedHealthcare Anti-fraud, Waste, and Abuse Program 2020-2021 (FWA Plan) provides information about the Compliance Program that applies to all businesses within the UnitedHealth Group, including UnitedHealthcare Community Plan – Mississippi. Information specific to the state of Mississippi is found in an addendum to the FWA Plan. The UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) provides guidelines for ethical behavior and includes expectations for appropriate business behavior, information about violations, and who to contact with questions and concerns. Initial and ongoing compliance and FWA training and education are provided to employees, and member and provider educational materials include information about FWA. Multiple methods are available for reporting suspected or actual compliance and FWA violations. United ensures that no retaliation is taken against anyone who makes such a report.

United received "Met" scores for 100% of the standards for both CAN and CHIP in the Administration section of the review.

Figure 2: CAN Administration Findings



Strengths

- United's monthly percent paid average for 30 and 90 days surpasses Mississippi's timeliness requirements.
- United conducts disaster recovery exercises twice annually which is above average (once a year is most common).
- The Payment Integrity Department reviews and incorporates the latest research on detecting new and emerging FWA schemes and practices.
- United's HIPAA Job Aid document provides staff with detailed authentication requirements for various callers and addresses what may be discussed on a call once authentication has taken place.

Weaknesses

- The Mississippi addendum to the corporate FWA Plan references the compliance officer by name and the information is outdated.
- The CAN and CHIP Care Provider Manuals and Member Handbooks include the telephone number for reporting to the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum (1-866-242-7727) but do not include the phone number for reporting to DOM's Office of Program Integrity (1-800-880-5920).
- The Health Talk member newsletters contain telephone numbers to report suspected fraud and abuse by providers or members to DOM's Office of Program Integrity but not to Optum's AFRS unit.
- Onsite discussion confirmed the Compliance Committee is co-chaired by the Compliance Officer and Plan CEO. However, the CAN and CHIP 2020 Quality

Improvement Program Descriptions state the Compliance Committee is chaired only by the Compliance Officer.

Recommendations

- Update the reference to the Compliance Officer in the Mississippi addendum to the FWA Plan.
- Ensure all options for reporting suspected FWA are included in the CAN and CHIP Care Provider Manuals, Member Handbooks, and Health Talk newsletters.
- Revise the CAN and CHIP 2020 Quality Improvement Program Descriptions to include correct information about the Compliance Committee chair.

II. Provider Services

CCME's review of Provider Services focused on policies and procedures, provider training and education, provider network access and availability, credentialing and recredentialing processes and files, clinical practice and preventive health guidelines, and the Provider Satisfaction Survey.

The National Credentialing Committee (NCC) makes credentialing decisions and communicates the decisions to the health plan. The NCC membership includes the health plans' Medical Directors and participating providers from the health plans' networks. A designated Medical Director serves as Chairperson. United's Provider Advisory Committee (PAC) serves as the health plan's Credentialing Committee and is chaired by Dr. Amit Prasad, United's Chief Medical Officer. The PAC reviews credentialing and recredentialing decisions of the NCC and reports to the Quality Management Committee. Membership of the PAC includes providers with specialties of pediatrics, obstetrics and gynecology, internal medicine, psychiatry, dentistry, and family medicine.

The UnitedHealthcare Credentialing Plan 2019 – 2021 (Credentialing Plan), the United Behavioral Health Clinician and Organizational Provider Credentialing Plan 2020-2021, and related policies and procedures define processes for credentialing and recredentialing of health care providers. A State and Federal Regulatory Addendum to the Credentialing Plan defines Mississippi-specific requirements.

The following issues were identified during CCME's review of CAN and CHIP credentialing and recredentialing files:

- One initial credentialing file did not contain a copy of the query of the System for Award Management (SAM).
- For one initial credentialing file, the Ownership Disclosure Form was signed and dated in 2015, more than four years prior to credentialing approval date. This is a repeat finding from the 2019 EQR.

- For three organizational files, the date the MS DOM Sanctioned Provider List was updated was not captured on the document included in the file.
- Screenshots of the System for Award Management (SAM) query in four organizational recredentialing files did not display the date the query was conducted.
- Screenshots of the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) query in three organizational recredentialing files did not display the date the query was conducted.
- One organizational recredentialing file did not contain evidence of the query of the OIG LEIE.

To evaluate and monitor the adequacy of the provider network, quarterly geographic access reports are developed. Policy PS3, Geographic Access Standards, defines the geographic access standards for primary care providers (PCPs), specialists, and other provider types in United's provider network. CCME noted the policy does not include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in *Section 7 (b) (1) of the CAN and CHIP Contracts*. United's Managed Care Accessibility Analysis (geographic access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CAN and CHIP Contracts, Section 7 (B)* is one provider within 30 miles for both urban and rural. CCME noted the goal of 90% of members with access to various specialties is not met for some specialty types. During onsite discussion, United acknowledged this finding and confirmed they continue to target and work toward securing contracts with the needed specialty types.

Policy PS2, Access Standards – Appointment Availability Requirements, defines appointment availability requirements that are compliant with contractual requirements for CAN and CHIP network providers. The Annual Assessment of Network Adequacy Report dated March 2020 documents results for 2019 assessments of practitioner accessibility and indicates there was a significant decrease of over 35% from the previous year for PCP after-hours access. Barriers were documented in the report, and the report noted that United would continue to monitor after-hours care to identify any future opportunities for improvement. However, it appears no action was taken to address the large decrease identified in the report.

Appropriate processes are in place for initial and ongoing provider education. United reported they have implemented new methods to ensure provider education continues while under restrictions resulting from COVID-19, and now conducts ongoing provider education through telephonic outreach, virtual town hall sessions, the "Ask the Advocate" Program, WebEx presentations, print publications such as newsletters, posting information to its website, etc. CCME noted multiple discrepancies in benefit information when comparing the CAN Care Provider Manual to the CAN Member Handbook and when

comparing the CHIP Care Provider Manual to the CHIP Member Handbook. This is a repeat finding from the previous EQR.

United's Multicultural Health Care Program includes various activities to ensure network providers can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations. These activities include assessments of race, ethnicity, and languages of the member population, initiatives to reduce health care disparities, and improving cultural competency in member materials and communication. A population language profile assessment and an assessment of language and cultural gaps in the practitioner network are conducted at least every three years. United also evaluates the effectiveness of interventions on the reduction of health care disparities and prioritizing opportunities to reduce disparities.

Provider Access Study and Provider Directory Validation

Beginning in 2020, CCME initiated biannual validation of network access and availability and provider directory accuracy for Mississippi CCOs. The objectives of the biannual verification activities are to determine if improvement occurred for the telephonic provider access study success rate and to evaluate the accuracy of the online Provider Directory. The methodology involves two phases:

- Phase 1: CCME conducts a telephonic survey to determine if CCO-provided PCP contact information is accurate with regard to telephone, address, accepting the CCO, and accepting new Medicaid patients. Appointment availability for urgent and routine care is also evaluated.
- Phase 2: CCME verifies the accuracy of provider directory-listed address, phone, and panel status against access-study confirmed PCP contact information. An overall accuracy rate is determined.

For Q4 2020, United submitted a total of 2,391 unique PCPs for the CAN population and a total of 2,412 unique PCPs for the CHIP population. For CAN, a random sample of 100 PCPs was drawn, and for CHIP a random sample of 104 PCPs was drawn. Phase 1 (Provider Access Study) was conducted for each. For each successful call, United's online directory was reviewed to determine if the information is the directory matched the confirmed information elicited during the provider access study phase.

CAN Summary. Phase 1 results found that 63 of 87 (72%) providers called confirmed the file contained the correct address and phone number. Of those 63, 48 (76%) confirmed they accepted UnitedHealthcare CAN. Of those 48, 27 (56%) indicated they were accepting new patients. The 48 providers considered a successful contact and were evaluated for provider directory validation in Phase 2.

Access and availability for routine appointments was 73% and availability for urgent appointments was 69%.

The 48 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found that for the 48 providers evaluated, 79% (n=38) had accurate information for all three components evaluated: address, phone number, and panel status information. There were providers with some specific elements listed accurately and with inaccuracies in other elements.

Of the 48 CAN providers evaluated in the provider directory: 40 (83%) had the provider name listed in the directory. Of the 40; 38 (79%) providers had the accurate phone number listed; 39 (81%) had the accurate address; and 38 (79%) had accurate panel status information.

Discrepancies in the directory were most common for telephone and status for accepting new patients (21% reported a different phone number during the access study call in relation to the phone number provided in the directory and 21% reported a different panel status). When compared to the access study results, 19% reported a different address in the provider directory.

CHIP Summary. Phase 1 results found that 57 of 93 (61%) providers called confirmed the file contained the correct address and phone number. Of those 57, 24 (51%) confirmed they accept United CHIP. Of those 24, 16 (67%) indicated they were accepting new patients. Access and availability for routine appointments was 70% and availability for urgent appointments was 58%.

The 24 providers considered a successful contact in Phase 1 were evaluated for provider directory validation in Phase 2. Phase 2 results found 67% (n=16) of the 24 providers that were evaluated for provider directory validation had accurate information for all three components evaluated including address, phone number, and panel status information. There were providers with specific elements listed accurately, but with inaccuracies in other elements.

Of the 24 CHIP providers evaluated in the provider directory, 22 (92%) had the provider name listed in the directory with an accurate phone number and accurate address. Sixteen of 24 (67%) had accurate panel status information.

Discrepancies in the directory were most common in status for accepting new patients (33% reported a different panel status). When compared to the access study results, only 8% reported a different address and phone number in the provider directory.

Full details of the study's results, conclusions, and required corrective actions are included in the Provider Access Study and Directory Validation report.

Provider Satisfaction Survey

Provider Satisfaction Survey validation was performed using a validation worksheet based on the CMS Survey Validation Protocol. The complete worksheet is available as an attachment in this report. The response rate in 2019 fell to 2%—only 45 completed surveys were received. United staff discussed interventions to try to improve survey response rates, including streamlining surveys to decrease the burden on providers, spreading the surveys out over 3 quarters, and focusing on email surveys. United stated the surveys are discussed with providers at each contact.

The 2019 results indicate that overall satisfaction has declined slightly since 2018, with substantially more neutral ratings when compared to 2018. However, even with the decline in overall satisfaction, 70 percent of domain item areas have favorable ratings.

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

Table 7: CAN Provider Satisfaction Survey Validation Results

Section	Reason	Recommendation
Do the survey findings have any limitations or problems with generalization of the results?	Only 45 providers (2%) completed the survey. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution.	Determine if there is an easier method to elicit responses; find methods to improve responses by providers.

As noted in *Figure 3, Provider Services Findings*, 96.5% of the Provider Services standards were scored as "Met" for both the CAN and CHIP Programs.

Figure 3: Provider Services Findings

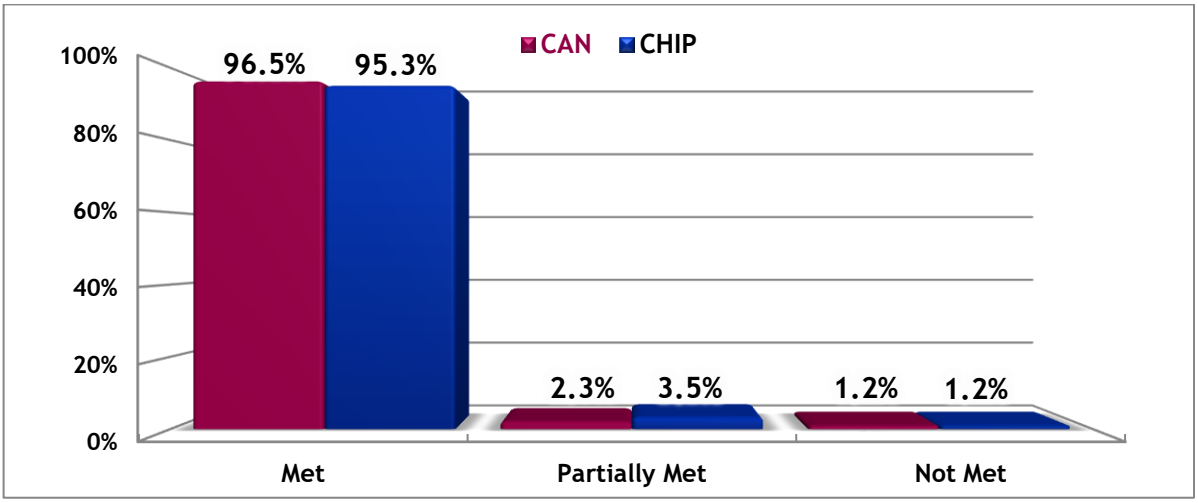


Table 8: Provider Services

Section	Standard	CAN 2019 Review	CHIP 2019 Review
Credentialing and Recredentialing	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Partially Met
Adequacy of the Provider Network	Members have access to specialty consultation from network providers located within the contract specified geographic access standards	Partially Met	Partially Met
Provider Education	CAN: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP: Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	Not Met	Not Met
	CAN: Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services CHIP: Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services	Met	Partially Met

Strengths

- United adapted to COVID-19 restrictions by implementing new methods to ensure provider education continues. Methods used for provider education now include telephonic outreach, virtual town hall sessions and presentations, the "Ask the Advocate" Program, print publications such as newsletters, and posting information to the website.
- United's Multicultural Health Care Program activities ensure network providers can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.

Weaknesses

- CCME's review of initial credentialing files revealed the following issues:
  - One initial credentialing file did not contain a copy of the query of the System for Award Management (SAM).
  - For one initial credentialing file, the Ownership Disclosure Form was signed and dated in 2015, more than four years prior to the credentialing approval date. Note: This is a repeat finding from the 2019 EQR.
- File review findings for organizational providers include:
  - For three files, the date the MS DOM Sanctioned Provider List was updated was not captured on the document included in the file. During onsite discussion, United staff stated they would follow-up with CCME, but no additional information was provided.
  - Four recredentialing files included screenshots of the SAM query; however, four of the screenshots did not display the date the query was conducted.
  - Three recredentialing files included screenshots of the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) query; however, the screenshots did not display the date the query was conducted.
  - One recredentialing file for an organizational provider did not contain evidence of the query of the OIG LEIE.
- Policy PS3, Geographic Access Standards, defines the PCP geographic access standards for United's provider network, but does not include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in the *CAN Contract, Section 7 (B) (1), Table 6* and the *CHIP Contract, Section 7 (B) (1), Table 4*.
- The most recent Managed Care Accessibility Analysis (geographic access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CAN Contract, Section 7 (B)* and the *CHIP Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural.

- The Annual Assessment of Network Adequacy Report dated March 2020 documents results for 2019 assessments of practitioner accessibility and indicates the goal for after-hours care for primary care physicians was not met. Barriers were identified in the report, but it stated United would continue to monitor after-hours care to identify any future opportunities for improvement. It appears no action was taken to address the deficiencies and identified barriers.
- During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CAN Care Provider Manual and CAN Member Handbook. For the current EQR, CCME again noted numerous discrepancies, including:
  - For Home Health Services, the CAN Care Provider Manual states there is a limit of 25 visits per calendar year for adults. The CAN Member Handbook states the limit is 36 visits per calendar year for adults.
  - For Hospice, the CAN Care Provider Manual says prior authorization is required. The CAN Member Handbook states no prior authorization is required.
  - For Medical Supplies, the CAN Care Provider Manual states medical services are covered but lists limitations and states prior authorization is required to exceed those limitations. The CAN Member Handbook states medical supplies are covered with no prior authorization required.
  - For Non-Emergency Transportation Services, the CAN Care Provider Manual states non-emergency transportation services are covered but lists limitations and states to call Member Services to arrange. The CAN Member Handbook does not include limitations and states to call MTM to arrange.
  - For Outpatient PT/OT/ST, the CAN Care Provider Manual states prior authorization is required when provided by home health agencies. The CAN Member Handbook states prior authorization is required.
  - For Transplant Services, the CAN Care Provider Manual states human solid organ (heart, lung, liver, kidney) or bone marrow/stem cell transplants are covered with prior authorization. It does not include cornea transplant, which is included in the CAN Member Handbook.
  - For Nursing Facility benefits, the CAN Care Provider Manual lists nursing facility coverage and requirements in the benefits grid. There is no information related to coverage for skilled nursing facilities in the CAN Member Handbook.
  - The CAN Care Provider Manual includes Physician Services for Long-Term Care Visits in the benefits grid, but the CAN Member Handbook does not.
  - The CAN Care Provider Manual lists Skilled Nursing Services along with Private Duty Nursing Services in the benefit grid but the CAN Member Handbook does not include Skilled Nursing Services.

- During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CHIP Care Provider Manual and CHIP Member Handbook. For the current EQR, CCME again noted numerous discrepancies, including:
  - The CHIP Care Provider Manual does not include Parenting Education as a benefit, but the CHIP Member Handbook does.
  - For Prosthetic/Orthotic Devices, the CHIP Care Provider Manual does not include the coverage restrictions for orthotic shoes that are included in the CHIP Member Handbook.
  - For Speech Therapy, the CHIP Care Provider Manual does not include the restrictions on maintenance speech therapy that are found in the CHIP Member Handbook.
- Appointment scheduling timeframes are defined in the *CHIP Contract, Section 7 (b) (2)*. The CHIP Care Provider Manual section titled "Timeliness Standards for Appointment Scheduling" does not include the requirement for routine and urgent dental providers, urgent care providers, and behavioral health/substance use disorder providers (post-discharge from an acute psychiatric hospital when the CCO is aware of the member's discharge).
- The PCP Responsibilities section of the CHIP Care Provider Manual does not clearly state the responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule. Refer to the *CHIP Contract Section 7 (H) 2 (m)*.
- Response rates to the Provider Satisfaction Surveys was very poor at only 2%.

Corrective Action

- For initial credentialing and recredentialing files, ensure:
  - The date the MS DOM Sanctioned Provider List was updated is included on screenshots captured as evidence of query.
  - Primary source verification of the SAM includes the date the query was conducted.
  - Primary source verification of the OIG LEIE is included in all files and that it includes the date the query was conducted.
- Ensure geographic access reports are run using the contractually required standard for Emergency Care Providers.
- Update the CAN Care Provider Manual and/or the CAN Member Handbook to ensure correct and consistent information about member benefits is included in both.
- Update the CHIP Care Provider Manual and/or the CHIP Member Handbook to ensure correct and consistent information about member benefits is included in both.

- Revise the CHIP Care Provider Manual to include the PCP's responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule.

Recommendations

- For credentialing files, ensure:
  - All initial credentialing files contain a screenshot showing the date the SAM was queried and results.
  - All initial credentialing files contain a screenshot showing the date the NPPES was queried and results of the query.
  - Ownership Disclosure Forms are current at the time of initial credentialing.
- Revise Policy PS3 to include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in the *CAN Contract, Section 7 (B) (1), Table 6* and the *CHIP Contract, Section 7 (B) (1), Table 4.*
- Develop and implement interventions to address any identified deficiencies when goals are not met for provider after-hours access.
- Revise the "Timeliness Standards for Appointment Scheduling" section of the CHIP Care Provider Manual to include the appointment scheduling timeframes for routine and urgent dental providers, urgent care providers, and behavioral health/substance use disorder providers (post-discharge from an acute psychiatric hospital when the CCO is aware of the member's discharge).
- Update the PCP Responsibilities section of the CHIP Care Provider Manual to include the PCP responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule.
- Continue efforts to improve response rates to Provider Satisfaction Surveys.

III. Member Services

CCME's review of United's Member Services focused on the following areas of the CAN and CHIP lines of business:

- Member rights and responsibilities
- Member program education
- Member informational materials
- Member and Provider Services Call Center
- Grievances and grievance files
- Member Satisfaction Survey

United has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. United's CAN and CHIP websites have quick links and resources for

members to access information. The onsite teleconference confirmed members can communicate with Member Services staff, view their benefit summary, and change their PCP when logged into the secure member portal. Members receive a New Member Packet with instructions for accessing the Member Handbook, Provider Directory, and member education information.

The CAN and CHIP Member Handbooks, which are also located on the website, provide useful information, are easily understood, and are written at a 6th grade reading level. The handbooks inform members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and explain how to access benefits. United ensures member program materials are written in a clear and understandable manner and meet contractual requirements. However, CCME discussed that documentation of the requirement for minimum 12-point font for regular print member materials and 18-point font for large print member materials could not be found.

The toll-free Member Services telephone number routes calls to reach appropriate staff during the hours of 7:30 a.m. to 5:30 p.m. CT, Monday through Friday. Callers also have the option to transfer to the 24-hour NurseLine. However, CCME identified several instances where the toll-free telephone numbers and Call Center hours of operation in various member materials were incorrect, omitted, or had discrepancies.

Policies define requirements and processes for handling member grievances and complaints. In addition to policies, grievance information is found in the CAN and CHIP Member Handbooks and Care Provider Manuals. During the onsite teleconference, United staff confirmed grievance information is located on the member portal and not on the non-secured public website. However, the *CHIP Contract, Section 6 (H)* requires the plan to provide specific, up-to-date grievance information on a non-secure section of the website.

The CAN and CHIP 2019 Quality Improvement Program Descriptions indicate the Service Quality Improvement Committee's (SQIC's) responsibilities include monitoring member complaint and grievance trends.

Overall, the majority of United's Member Services standards follow *CAN and CHIP Contract* requirements and state and federal guidelines. CCME provides recommendations and advises on corrective actions for identified issues.

Member Satisfaction Survey Validation

Member Satisfaction Survey validation for United CAN and CHIP was performed based on the CMS Survey Validation Protocol. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. United contracts with DSS Research, a certified Consumer Assessment of Healthcare Providers and Systems survey vendor, to conduct the Adult and Child Surveys.

The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS.

For United CAN Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (19.1%). For the Child CCC survey, generalizability of the survey results is also difficult to discern due to low response rates for general population and total population. General Population Survey Responses: 395 completed (17.72% responses rate). Total Population Survey Responses: 883 (18.18% response rate).

For United CHIP, the generalizability of the Child CCC survey results is difficult to discern due to low response rate for total sample 21.11% and 20.45% for general population. This is a decrease from last year's response rates although it was higher than the average United CHIP general population response rate of 17.62%.

As noted in *Figure 4: Member Services Findings*, United achieved "Met" scores for 87.9% of the Member Services Standards for CAN and 87.5% of the standards for CHIP.

Figure 4: Member Services Findings

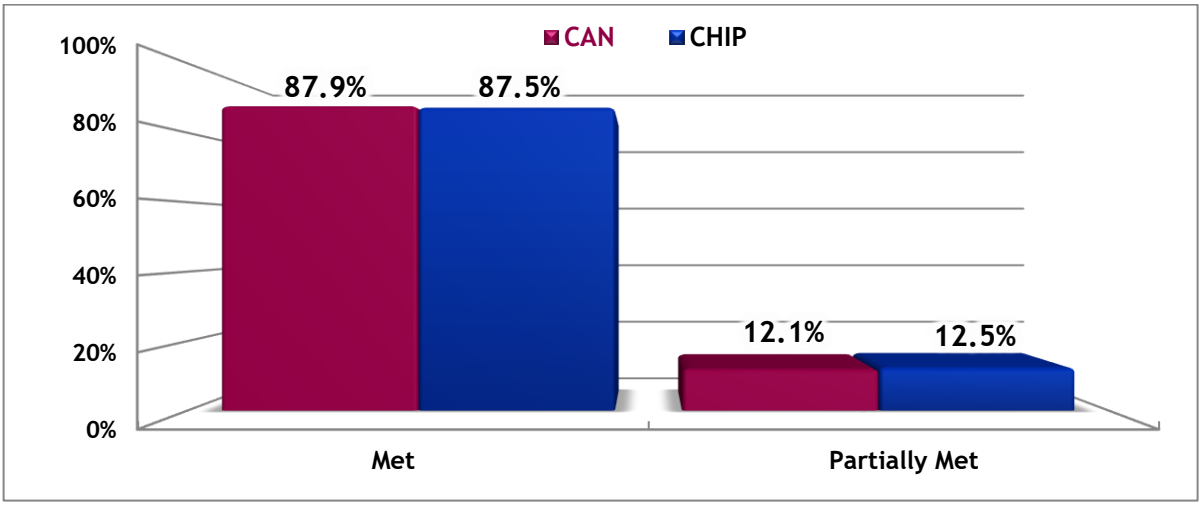


Table 9: Member Services

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Member Program Education	Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract	Partially Met	Partially Met
Call Center	The CCO maintains a toll-free dedicated Member Services and Provider Services call	Partially Met	Partially Met

Section	Standard	CAN 2020 Review	CHIP 2020 Review
	center to respond to inquiries, issues, or referrals		
Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: The procedure for filing and handling a grievance	Partially Met	Partially Met
	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	Partially Met	Partially Met

Strengths

- Staff implemented COVID-related strategies to continue member education programs and community engagement activities.

Weaknesses

- For CAN and CHIP, there is no documentation of the requirement for member materials to use a minimum 12-point font for regular print items and 18-point font for large print items.
- Several documentation issues were noted with CAN and CHIP toll-free telephone numbers and member and provider Call Center hours of operation:
  - The Member Services toll-free number on the CAN member website is not the same number listed in the CAN Member Handbook. The requirement in the *CAN Contract Section 6 (A)* is that members will be provided with one toll-free number.
  - The hours of operation for Member Services and Provider Services Call Centers are inconsistently listed or omitted from documents.
  - The CHIP website informs members to call Member Services and the NurseLine but does not provide the telephone number to call.
- Grievance procedures and instructions are not on the CAN and CHIP non-secured areas of the respective websites.
- For CAN and CHIP, Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, incorrectly states grievances will be acknowledged in writing within 10 calendar days.

- Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, does not specify that CAN and CHIP grievance records will be retained "during the entire term of the Contract and for a period of 10 years thereafter", as noted in *CAN Contract, Section 11 (A)*.
- CAN and CHIP Care Provider Manuals do not have adequate instructions on how members can obtain a Living Will or Medical Power of Attorney.
- For adult and child CAHPS surveys, the generalizability of the survey results is difficult to discern due to low response rate.

Corrective Actions

- Document the requirement to print written material using a minimum 12-point font and using a minimum 18-point font for large print member materials.
- Edit the CAN and CHIP Member Handbooks, Care Provider Manuals, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services Call Centers as required in CAN Contract
- Include information on grievance procedures on the non-secured section of the CAN and CHIP websites, as required in the *CAN and CHIP Contract, Section 6 (H)*.
- Edit Policy POL2015-01 Member Appeal, State Fair Hearing, External Appeal and Grievance, to correctly state grievances will be acknowledged in five calendar days.
- Edit Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, to include the complete grievance requirement, as noted in the *CAN Contract, Section 11(A)*.

Recommendations

- Edit the CAN and CHIP Care Provider Manuals to include information on where members can obtain Advance Directive forms.
- Continue working with DSS Research to increase response rates for Adult and Child surveys.

IV. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the QI program descriptions for the CAN and CHIP programs, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations. United's 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.

United's QI Work Plan identifies activities related to program priorities aimed at addressing and improving the quality and safety of clinical care and services. The 2019 and 2020 Work Plans included the planned activities, specific interventions, target dates

for completion, responsible parties, and oversight committee(s). United maintains a separate work plan for the CHIP Program.

The Quality Management Committee (QMC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The QI Program Description, page 11, clearly outlines the responsibilities of the QMC. Minutes are recorded for each meeting and document committee discussion points and decisions. The minutes provided with the desk materials indicate the required quorums were met for each meeting. Separate meetings were not held for the CAN and the CHIP Programs. However, the minutes clearly indicate which program was being discussed. The QMC is chaired by the Chief Medical Officer and membership includes United's senior leaders, department directors, and other health plan staff. A variety of network providers are included on the Provider Advisory Committee.

The scope of the QI program includes monitoring of provider compliance with clinical practice guidelines. United's Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, provides the process used to monitor provider compliance with guidelines. For CAN, United chose the Comprehensive Diabetes Care and Weight Assessment and Counseling for Nutrition and Physical Activity measures. The 2019 measurement year results indicated the Weight Assessment and Counseling for Nutrition and Physical Activity measure met the DOM goal. However, the Comprehensive Diabetes Care measure did not. For CHIP, United chose the Antidepressant Medication Management (AMM) and Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measures. The 2019 measurement year results indicated both measures showed an increase and met the established goal.

United's standard operating procedures indicate any problem identified during the EPSDT or Well-Baby and Well-Child exam requiring referrals are tracked on a quarterly basis. United provided examples of the tracking reports. Similar to the reports provided during the previous EQR, the tracking reports failed to link the identified problem with the EPSDT or Well-Baby and Well-Child exam and did not include or indicate the members who received additional outreach for case management referrals

Performance Measure Validation

Aqurate Health Data Management, Inc. (Aqurate) conducted a validation review of the performance measures (PMs) identified by DOM to evaluate their accuracy as reported by United for the CAN and CHIP populations. DOM has selected a set of PMs to evaluate the quality of care and services delivered by United to its members. Performance measure validation determines the extent to which the CCO followed the specifications established for the NCQA Healthcare Effectiveness Data Informational Set (HEDIS®) measures as well as the Adult and Child Core Set measures when calculating the PM rates. Aqurate conducted validation of the performance measure rates following the CMS-

developed protocol for validating performance measures. The final PM validation results reflected the measurement period of January 1, 2019 through December 31, 2019.

Per the contract between the CCOs and DOM, the CCOs are required to submit HEDIS data to NCQA. To ensure HEDIS rates were accurate and reliable, DOM also required each CCO to undergo an NCQA HEDIS Compliance Audit. United contracted with an NCQA-licensed organization to conduct the HEDIS audit. Aqurate reviewed United's final audit reports, information systems compliance tools, and Interactive Data Submission System files approved by United's NCQA licensed organization. Aqurate found that United's information systems and processes were compliant with the applicable information system standards and the HEDIS reporting requirements for HEDIS 2020.

In addition, Aqurate conducted additional source code review, medical record review validation, and primary source verification to ensure accuracy of rates submitted for the CMS Adult and Child Core Set measures. Several aspects crucial to the calculation of PM data reviewed included: data integration, data control, and documentation of PM calculations. The following are some of the main steps conducted during the validation process:

- Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. Aqurate validated the data integration process used by United, which included a review of file consolidations, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Aqurate determined the data integration processes for United was acceptable.
- Data Control—United's organizational infrastructure must support all necessary information systems. Its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. Aqurate validated United's data control processes and determined that the data control processes in place were acceptable.
- Performance Measure Documentation—Interviews and system demonstrations provide supplementary information and validation review findings were also based on documentation provided by United. Aqurate reviewed all related documentation, which included the completed HEDIS Roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. Aqurate determined that the documentation of PM generation by United was acceptable.

All relevant HEDIS performance measures for United CAN for the current review year (MY 2019), as well as the previous year (MY 2018) and the change from 2018 to 2019 are reported in *Table 10: CAN HEDIS Performance Measure Results*. The change in rates

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

Table 10: CAN HEDIS Performance Measure Results

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	88.75%	90.75%	2.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.99%	69.10%	14.11%
Counseling for Nutrition	50.85%	54.74%	3.89%
Counseling for Physical Activity	46.23%	54.99%	8.76%
Childhood Immunization Status (cis)			
DTaP	83.21%	77.62%	-5.59%
IPV	94.65%	93.43%	-1.22%
MMR	93.67%	89.54%	-4.13%
HiB	91.24%	88.08%	-3.16%
Hepatitis B	94.65%	90.27%	-4.38%
VZV	92.94%	91.48%	-1.46%
Pneumococcal Conjugate	86.86%	83.70%	-3.16%
Hepatitis A	81.27%	76.16%	-5.11%
Rotavirus	81.27%	79.08%	-2.19%
Influenza	31.63%	32.85%	1.22%
Combination #2	80.78%	72.75%	-8.03%
Combination #3	79.32%	72.26%	-7.06%
Combination #4	69.59%	62.77%	-6.82%
Combination #5	70.07%	66.18%	-3.89%
Combination #6	27.49%	29.93%	2.44%
Combination #7	62.04%	57.91%	-4.13%
Combination #8	26.03%	28.22%	2.19%
Combination #9	24.33%	27.01%	2.68%
Combination #10	23.36%	25.30%	1.94%
Immunizations for Adolescents (ima)			
Meningococcal	54.26%	58.64%	4.38%
Tdap	77.13%	78.10%	0.97%
HPV	18.98%	24.57%	5.59%
Combination #1	51.34%	56.93%	5.59%
Combination #2	17.27%	22.87%	5.60%
Lead Screening in Children (lsc)	72.51%	72.81%	0.30%
Breast Cancer Screening (bcs)	48.49%	46.17%	-2.32%

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
Cervical Cancer Screening (ccs)	54.90%	56.69%	1.79%
Chlamydia Screening in Women (chl)			
16-20 Years	46.84%	46.92%	0.08%
21-24 Years	59.53%	59.70%	0.17%
Total	49.04%	48.74%	-0.30%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	68.64%	70.48%	1.84%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	32.89%	28.30%	-4.59%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	41.33%	42.24%	0.91%
Bronchodilator	76.77%	74.96%	-1.81%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	48.92%	55.25%	6.33%
5-11 Years: Medication Compliance 75%	23.29%	26.43%	3.14%
12-18 Years: Medication Compliance 50%	50.35%	48.87%	-1.48%
12-18 Years: Medication Compliance 75%	22.75%	24.08%	1.33%
19-50 Years: Medication Compliance 50%	57.73%	58.79%	1.06%
19-50 Years: Medication Compliance 75%	30.41%	31.32%	0.91%
51-64 Years: Medication Compliance 50%	57.89%	62.86%	4.97%
51-64 Years: Medication Compliance 75%	31.58%	40.00%	8.42%
Total: Medication Compliance 50%	50.47%	53.21%	2.74%
Total: Medication Compliance 75%	23.91%	26.36%	2.45%
Asthma Medication Ratio (amr)			
5-11 Years	82.28%	81.04%	-1.24%
12-18 Years	67.85%	68.84%	0.99%
19-50 Years	48.75%	44.66%	-4.09%
51-64 Years	44.83%	50.00%	5.17%
Total	71.62%	70.70%	-0.92%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	53.53%	53.53%	0.00%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	65.00%	46.15%	-18.85%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy: 21-75 Years (Male)	67.14%	71.16%	4.02%
Statin Adherence 80%: 21-75 Years (Male)	45.42%	52.49%	7.07%
Received Statin Therapy: 40-75 Years (Female)	66.17%	68.42%	2.25%
Statin Adherence 80%: 40-75 Years (Female)	35.98%	42.31%	6.33%

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
Received Statin Therapy: Total	66.67%	69.80%	3.13%
Statin Adherence 80%: Total	40.88%	47.53%	6.65%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.43%	84.18%	-0.25%
HbA1c Poor Control (>9.0%)	45.50%	58.88%	13.38%
HbA1c Control (<8.0%)	46.23%	34.55%	-11.68%
HbA1c Control (<7.0%)	NR	NR	NR
Eye Exam (Retinal) Performed	55.72%	57.42%	1.70%
Medical Attention for Nephropathy	89.78%	91.24%	1.46%
Blood Pressure Control (<140/90 mm Hg)	52.31%	49.39%	-2.92%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	49.62%	54.66%	5.04%
Statin Adherence 80%	34.61%	41.04%	6.43%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	39.66%	41.72%	2.06%
Effective Continuation Phase Treatment	21.59%	25.64%	4.05%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	58.11%	53.69%	-4.42%
Continuation and Maintenance (C&M) Phase	69.09%	66.81%	-2.28%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	66.04%	62.00%	-4.04%
6-17 years - 7-Day Follow-Up	41.03%	38.82%	-2.21%
18-64 years - 30-Day Follow-Up	53.09%	52.33%	-0.76%
18-64 years - 7-Day Follow-Up	29.59%	27.77%	-1.82%
65+ years - 30-Day Follow-Up	100.00%*	0.00%	0.00%*
65+ years - 7-Day Follow-Up	0.00%*	0.00%	0.00%
Total 30-Day Follow-Up	60.37%	57.92%	-2.45%
Total 7-Day Follow-Up	35.94%	34.17%	-1.77%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	42.79%	51.09%	8.30%
6-17 years - 7-Day Follow-Up	30.77%	31.52%	0.75%
18-64 years - 30-Day Follow-Up	41.34%	39.39%	-1.95%
18-64 years - 7-Day Follow-Up	25.05%	25.42%	0.37%
65+ years - 30-Day Follow-Up	NR	NA	NA
65+ years - 7-Day Follow-Up	NR	NA	NA

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
Total - 30-Day Follow-Up	41.78%	43.36%	1.58%
Total- 7-Day Follow-Up	26.78%	27.49%	0.71%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	9.09%	3.57%	-5.52%
7-Day Follow-Up: 13-17 Years	9.09%	0.00%	-9.09%
30-Day Follow-Up: 18+ Years	8.41%	6.06%	-2.35%
7-Day Follow-Up: 18+ Years	5.53%	3.64%	-1.89%
30-Day Follow-Up: Total	8.46%	5.87%	-2.59%
7-Day Follow-Up: Total	5.79%	3.35%	-2.44%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	70.53%	73.09%	2.56%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	68.60%	67.91%	-0.69%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	70.59%	72.22%	1.63%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (saa)	55.79%	55.13%	-0.66%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	23.91%	NA	NA
6-11 Years	18.36%	NA	NA
1-11 Years	NA	23.22%	NA
12-17 Years	24.38%	24.46%	0.08%
Total	21.80%	23.92%	2.12%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.49%	1.09%	-0.40%
Appropriate Treatment for Upper Respiratory Infection (uri)	65.15%	69.24%	4.09%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	37.09%	44.42%	7.33%
Use of Imaging Studies for Low Back Pain (lbp)	66.67%	71.45%	4.78%
Use of Opioids at High Dosage (hdo)	1.45%	1.50%	0.05%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	19.74%	18.37%	-1.37%
Multiple Pharmacies	5.82%	3.74%	-2.08%
Multiple Prescribers and Multiple Pharmacies	3.16%	2.07%	-1.09%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	10.31%	7.38%	-2.93%
18-64 years - >=31 Days covered	4.39%	3.87%	-0.52%
65+ years - >=15 Days covered	11.11%*	12.50%	1.39%

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
65+ years - >=31 Days covered	11.11%*	0.00%	-11.11%
Total - >=15 Days covered	10.31%	7.39%	-2.92%
Total - >=31 Days covered	4.39%	3.87%	-0.52%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.84%	86.13%	-0.71%
45-64 Years	90.88%	90.08%	-0.80%
65+ Years	93.62%	86.84%	-6.78%
Total	88.54%	87.82%	-0.72%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.72%	97.59%	-0.13%
25 Months - 6 Years	90.12%	91.07%	0.95%
7-11 Years	92.10%	92.15%	0.05%
12-19 Years	90.90%	90.52%	-0.38%
Annual Dental Visit (adv)			
2-3 Years	53.87%	55.01%	1.14%
4-6 Years	75.63%	76.47%	0.84%
7-10 Years	76.75%	77.51%	0.76%
11-14 Years	73.46%	74.23%	0.77%
15-18 Years	64.53%	64.17%	-0.36%
19-20 Years	45.90%	43.71%	-2.19%
Total	70.20%	70.67%	0.47%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	79.41%	83.87%	4.46%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	2.94%	0.00%	-2.94%
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years	66.67%*	50.00%	-16.67%
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years	0.00%*	0.00%	0.00%
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	63.68%	63.59%	-0.09%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	9.45%	4.35%	-5.10%
Total: Initiation of AOD Treatment: 13-17 Years	62.15%	63.37%	1.22%
Total: Engagement of AOD Treatment: 13-17 Years	8.88%	3.96%	-4.92%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	42.20%	43.95%	1.75%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	4.46%	5.16%	0.70%

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	20.54%	26.11%	5.57%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	6.55%	9.76%	3.21%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	40.70%	41.42%	0.72%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	5.61%	4.96%	-0.65%
Total: Initiation of AOD Treatment: 18+ Years	32.41%	35.88%	3.47%
Total: Engagement of AOD Treatment: 18+ Years	5.86%	6.10%	0.24%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	43.71%	45.45%	1.74%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	4.39%	4.97%	0.58%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	20.81%	26.25%	5.44%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	6.51%	9.70%	3.19%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	43.45%	44.08%	0.63%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	6.07%	4.88%	-1.19%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	34.37%	37.88%	3.51%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.06%	5.94%	-0.12%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	88.29%	92.21%	3.92%
Postpartum Care	68.29%	73.24%	4.95%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	36.00%*	NA	NA
6-11 Years	63.05%	NA	NA
1-11 Years	NA	63.39%	NA
12-17 Years	63.43%	66.67%	3.24%
Total	62.68%	65.33%	2.65%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.00%	1.46%	1.46%
1 Visit	3.06%	2.92%	-0.14%
2 Visits	5.36%	3.65%	-1.71%
3 Visits	4.59%	5.35%	0.76%
4 Visits	7.91%	10.46%	2.55%
5 Visits	19.64%	16.06%	-3.58%
6+ Visits	59.44%	60.10%	0.66%

Measure/Element	MY2018 (HEDIS 2019)	MY2019 (HEDIS 2020)	Change
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	54.98%	57.66%	2.68%
Adolescent Well-Care Visits (awc)	45.50%	49.64%	4.14%

NA: Indicates denominator was too small or data were not available; NR: Not reported. *Indicates rate was calculated with small denominator

As shown, two measures had substantial improvement of greater than 10%. Those included Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile, and Comprehensive Diabetes Care HbA1c Poor Control. The measures with a substantial decrease in rate were Persistence of Beta-Blocker Treatment After a Heart Attack and Comprehensive Diabetes Care HbA1c Control.

All relevant CHIP HEDIS performance measures for United CHIP in MY 2019, the previous year (2018), and the change from 2018 to 2019 are reported in the table that follows.

Table 11: CHIP HEDIS Performance Measure Results

Measure/Data Element	HEDIS 2019 (MY 2018) CHIP Rates	HEDIS 2020 (MY 2019) CHIP Rates	Change
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	54.26%	64.96%	10.70%
Counseling for Nutrition	41.12%	55.96%	14.84%
Counseling for Physical Activity	36.50%	50.12%	13.62%
Childhood Immunization Status (cis)			
DTaP	85.89%	85.89%	0.00%
IPV	93.92%	93.92%	0.00%
MMR	93.67%	93.67%	0.00%
HiB	90.75%	90.75%	0.00%
Hepatitis B	94.40%	94.40%	0.00%
VZV	92.94%	92.94%	0.00%
Pneumococcal Conjugate	86.86%	86.86%	0.00%
Hepatitis A	79.81%	79.81%	0.00%
Rotavirus	84.43%	84.43%	0.00%
Influenza	39.90%	39.90%	0.00%
Combination #2	84.91%	84.91%	0.00%
Combination #3	83.45%	83.45%	0.00%
Combination #4	72.26%	72.26%	0.00%
Combination #5	76.40%	76.40%	0.00%

Measure/Data Element	HEDIS 2019 (MY 2018) CHIP Rates	HEDIS 2020 (MY 2019) CHIP Rates	Change
Combination #6	36.74%	36.74%	0.00%
Combination #7	67.15%	67.15%	0.00%
Combination #8	34.55%	34.55%	0.00%
Combination #9	34.55%	34.55%	0.00%
Combination #10	32.60%	32.60%	0.00%
Immunizations for Adolescents (ima)			
Meningococcal	54.26%	56.20%	1.94%
Tdap/Td	82.48%	80.78%	-1.70%
HPV	16.30%	19.71%	3.41%
Combination #1	53.04%	55.96%	2.92%
Combination #2	14.36%	18.73%	4.37%
Lead Screening in Children (lsc)	63.99%	65.94%	1.95%
Chlamydia Screening in Women (chl)			
16-20 Years	37.13%	39.78%	2.65%
21-24 Years	NA*	NA	NA
Total	37.13%	39.78%	2.65%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	71.99%	75.74%	3.75%
Medication Management for People with Asthma (mma)			
5-11 Years: Medication Compliance 50%	59.48%	63.24%	3.76%
5-11 Years: Medication Compliance 75%	30.48%	29.90%	-0.58%
12-18 Years: Medication Compliance 50%	54.59%	58.42%	3.83%
12-18 Years: Medication Compliance 75%	26.09%	25.26%	-0.83%
Total Medication Compliance 50%	57.23%	60.96%	3.73%
Total Medication Compliance 75%	28.51%	27.96%	-0.55%
Asthma Medication Ratio (amr)			
5-11 Years	87.73%	86.85%	-0.88%
12-18 Years	74.55%	73.68%	-0.87%
Total	81.87%	80.47%	-1.40%
Effectiveness of Care: Cardiovascular conditions			
Controlling High Blood Pressure (cbp)	60.00%*	12.00%	-48.00%
Effectiveness of Care: Behavioral			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	32.35%	41.94%	9.59%
Effective Continuation Phase Treatment	17.65%	19.35%	1.70%
Follow-up care for children prescribed ADHD Medication (add)			

Measure/Data Element	HEDIS 2019 (MY 2018) CHIP Rates	HEDIS 2020 (MY 2019) CHIP Rates	Change
Initiation Phase	50.00%	52.09%	2.09%
Continuation and Maintenance (C&M) Phase	58.51%	66.00%	7.49%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	63.44%	65.58%	2.14%
6-17 years - 7-Day Follow-Up	36.02%	37.67%	1.65%
18-64 years - 30-Day Follow-Up	37.50%*	20.00%	-17.50%
18-64 years - 7-Day Follow-Up	25.00%*	20.00%	-5.00%
Total-30-day Follow-Up	61.39%	64.55%	3.16%
Total-7-day Follow-Up	35.15%	37.27%	2.12%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	68.42%*	56.00%	-12.42%*
6-17 years - 7-Day Follow-Up	26.32%*	28.00%	1.68%
18-64 years - 30-Day Follow-Up	75.00%*	33.33%	-41.67%
18-64 years - 7-Day Follow-Up	50.00%*	33.33%	-16.67%
Total-30-day Follow-Up	69.57%*	53.57%	-16.00%
Total-7-day Follow-Up	30.43%*	28.57%	-1.86%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	100.00%*	NA	NA
6-11 Years	21.43%	NA	NA
1-11 Years	NA	25.00%	NA
12-17 Years	23.33%	25.58%	2.25%
Total	23.04%	25.41%	2.37%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.77%	0.78%	0.01%
Appropriate Treatment for Upper Respiratory Infections (uri)	58.21%	67.13%	8.92%
Use of Imaging Studies for Low Back Pain (lbp)	76.92%*	59.38%	-17.54%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	3.39%	1.23%	-2.16%
18-64 years - >=31 Days covered	0.00%	0.00%	0.00%
Total - >=15 Days covered	3.39%	1.23%	-2.16%
Total - >=31 Days covered	0.00%	0.00%	0.00%
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	98.56%	98.73%	0.17%
25 Months-6 Years	92.30%	92.96%	0.66%
7-11 Years	95.51%	94.79%	-0.72%

Measure/Data Element	HEDIS 2019 (MY 2018) CHIP Rates	HEDIS 2020 (MY 2019) CHIP Rates	Change
12- 19 Year	93.13%	92.42%	-0.71%
Annual Dental Visit (adv)			
2-3 Years	55.52%	57.12%	1.60%
4-6 Years	77.98%	77.54%	-0.44%
7-10 Years	83.04%	82.81%	-0.23%
11-14 Years	79.34%	78.34%	-1.00%
15-18 Years	70.37%	69.80%	-0.57%
19-20 Years	58.65%	55.20%	-3.45%
Total	75.75%	75.25%	-0.50%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Total: Initiation of AOD Treatment: 13-17 years	56.25%	64.44%	8.19%
Total: Engagement of AOD Treatment: 13-17 years	3.13%	8.89%	5.76%
Total: Initiation of AOD Treatment: 18+ years	NA	20.00%*	NA
Total: Engagement of AOD Treatment: 18+ years	NA	0.00%*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total	51.02%	58.33%	7.31%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	2.04%	8.33%	6.29%
Total: Initiation of AOD Treatment: Total	45.61%	53.33%	7.72%
Total: Engagement of AOD Treatment: Total	1.75%	6.67%	4.92%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	50.00%*	76.92%	26.92%
Postpartum Care	50.00%*	23.08%	-26.92%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	100.00%*	NA	NA
6-11 Years	42.86%	NA	NA
1-11 Years	NA	60.53%	NA
12-17 Years	54.69%	58.33%	3.64%
Total	51.00%	59.09%	8.09%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.31%	0.97%	0.66%
1 Visit	2.18%	1.46%	-0.72%
2 Visits	1.56%	3.16%	1.60%
3 Visits	2.49%	2.68%	0.19%
4 Visits	9.03%	5.35%	-3.68%

Measure/Data Element	HEDIS 2019 (MY 2018) CHIP Rates	HEDIS 2020 (MY 2019) CHIP Rates	Change
5 Visits	13.71%	12.90%	-0.81%
6+ Visits	70.72%	73.48%	2.76%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	62.50%	62.50%	0.00%
Adolescent Well-Care Visits (awc)	48.18%	50.36%	2.18%

NA: Indicates denominator was too small or data were not available; NR: Not reported. * indicates rate was calculated with small denominator

There were three measures having substantial improvement of greater than 10%. Those included BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity under the Weight Assessment, and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) measure.

DOM requires the CCOs to report all Adult and Child Core Set measures annually. The measure rates for the CAN population reported by United for 2019 are listed in *Table 12*: *CAN Non-HEDIS Performance Measure Rates*. The table for the CHIP population follows (*Table 12: CHIP Non-HEDIS Performance Measure Rates)*.

Table 12: CAN Non-HEDIS Performance Measure Rates

Measure	MY 2019 Rate
Adult Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-AD)	
Ages 18-65	0.34%
Ages 65+	0.00%
Total	0.34%
Maternal and Perinatal Health	
PC-01: ELECTIVE DELIVERY (PC-01)	
Women with elective vaginal deliveries or elective cesarean sections	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)	
Most or moderately effective contraception – 3 days	15.35%
Most or moderately effective contraception – 60 days	52.01%
LARC - 3 Days	0.61%
LARC - 60 Days Reported	9.45%
CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)	
Most or moderately effective contraception – 3 days	27.91%

Measure	MY 2019 Rate
Most or moderately effective contraception – 60 days	0.00%
LARC - 3 Days	3.53%
LARC - 60 Days Reported	0.00%
Care of Acute and Chronic Conditions	
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)	
Ages 18-65	25.72
Ages 65+	106.27
Total	25.87
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI-05)	
Ages 40-64	62.78
Ages 65+	0.00
Total	62.49
HEART FAILURE ADMISSION RATE **(PQI-08)**	
Ages 18-65	45.73
Ages 65+	212.54
Total	46.03
ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI 15-AD)	
Ages 18-39	3.39
HIV VIRAL LOAD SUPPRESSION (HVL - AD)	
Ages 18-65	18.46%
Ages 65+	0.00%
Total	18.11%
USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)	
Ages 18-65	1.55%
Ages 65+	0.00%
Total	1.55%
CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)	
Ages 18-65	6.81%
Ages 65+	0.00%
Total	6.80%
USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)	
Overall	57.14%
Prescription for Buprenorphine	57.14%
Prescription for Oral Naltrexone	3.57%
Prescription for Long-acting, injectable naltrexone	1.79%

Measure	MY 2019 Rate
Prescription for Methadone	0.00%
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-CH)	
Ages 12-17	0.68%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	28.58%
Age 2 Screening	43.85%
Age 3 Screening	39.43%
Total Screening	35.16%
Maternal and Perinatal Health	
PC-02: CESEAREAN BIRTH (PC02-CH)	
Ages 9-17	NR
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CW)	
Deliveries covered by MD/CHP	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or moderately effective contraception – 3 days	2.74%
Most or moderately effective contraception – 60 days	53.06%
LARC - 3 Days	1.29%
LARC - 60 Days Reported	13.87%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception – 3 days	32.91%
Most or moderately effective contraception – 60 days	0.00%
LARC - 3 Days	3.05%
LARC - 60 Days Reported	0.00%
Dental and Oral Health Services	
DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)	
Ages 6-9	21.22%
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	
Ages 1-20	54.94%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting

United did not report three of the measures for the CAN population. The three measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01), and Cesarean Birth (PC-02 CH).

Table 13: CHIP Non-HEDIS Performance Measure Rates

Measure	MY 2019 Rate
Child Core Set Measures	
Primary Care Access and Preventative Care	
SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER (CDF-CH)	
Ages 12-17	0.51%
DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)	
Age 1 Screening	33.33%
Age 2 Screening	53.09%
Age 3 Screening	44.46%
Total Screening	48.36%
Maternal and Perinatal Health	
PC-02: CESEAREAN BIRTH (PC02-CH)	
Ages 9-17	NR
AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)	
Total (Newborn < 91 Days at Dx)	NA
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CW)	
Deliveries covered by MD/CHP	NR
CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP-CH)	
Most or moderately effective contraception – 3 days	0.00%
Most or moderately effective contraception – 60 days	38.46%
LARC - 3 Days	0.00%
LARC - 60 Days Reported	7.69%
CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW-CH)	
Most or moderately effective contraception – 3 days	33.14%
Most or moderately effective contraception – 60 days	0.00%
LARC - 3 Days	2.45%
LARC - 60 Days Reported	0.00%
Dental and Oral Health Services	
DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)	
Ages 6-9	22.40%
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES (PDENT-CH)	

Measure	MY 2019 Rate
Ages 1-20	59.86%

NR: Indicates the rate was not reported by the health plan; NA: not enough data were available for reporting

United did not report two non-HEDIS measures for the CHIP population. The two measures were Live Births Weighing Less Than 2,500 grams (LBW-CW) and Cesarean Births (PC-02 CH). It is recommended that United work proactively with DOM for clarification on measures that are required to be reported.

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

The DOM-required topics for PIPs include: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). United submitted the Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness for validation. *Table 14: CAN Performance Improvement Project Validation Scores* provides an overview of the previous validation scores with the current scores for the CAN PIPs.

Table 14: CAN Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Behavioral Health Readmissions	78/78=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	62/62=100% High Confidence in Reported Results	67/72=93% High Confidence in Reported Results
Sickle Cell Disease Outcomes: Care	57/62=92%	66/71=93%

Project	Previous Validation Score	Current Validation Score
Coordination for SCD Patients to Reduce ER Utilization	High Confidence in Reported Results	High Confidence in Reported Results
Respiratory Illness: COPD/Asthma	62/62=100% High Confidence in Reported Results	72/72=100% High Confidence in Reported Results

All the PIPs scored in the "High Confidence in Reported Results" range. There are three recommendations for the Improved Pregnancy Outcomes, Sickle Cell, and the Behavioral Health Readmission PIPs. They are displayed in *Table 15: CAN Performance Improvement Project Recommendations*.

Table 15: CAN Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Improved Pregnancy Outcomes: Care Management to reduce preterm deliveries	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are reported for baseline. The goal is listed as 83.76% for benchmark on page 7; DOM goal as 89.2% on page 7; and 88.29% on page 3.	Clarify which rate is the baseline goal rate and which is the benchmark target rate for the PIP report.
Sickle Cell Disease Outcomes	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results in Findings Tables are noted to be per 1000 member months but then a percentage is documented.	Organize the results to reflect per 1,000 member months instead of a percentage per 1000 member months. The data reported on page 9 is an informative way to present the results that is focused on SCD patients, therefore, that is another option for presenting the findings.
Behavioral Health Readmissions	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is to reduce the readmission rate 5% from baseline to remeasurement 1. The annual report shows an increase from 18% to 19.2% for the first remeasurement period.	The current interventions may need to be revised for continued implementation in dealing with COVID-19. An analysis of most impactful interventions may need to be performed, and then re-focusing on those interventions until the rate decreases toward the goal

Project	Section	Reason	Recommendation
			rate. Workgroup can continue to assess and work on revising initiatives.

For the CHIP population, United submitted four projects for validation. Topics included Adolescent Well Child Visits (AWC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity), Getting Needed Care CAHPS, and Follow Up After Hospitalization for Mental Illness.

For the 2019 review, the four PIPs scored in the "High Confidence in Reported Results" range. The same PIPs were submitted and validated for the current review, and all four PIPs again scored in the "High Confidence in Reported Results" range. *Table 16: CHIP Performance Improvement Project Validation Scores* provides an overview of the scores for the CHIP PIPs.

Table 16: CHIP Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Adolescent Well Child Visits (AWC)	104/105=99% High Confidence in Reported Results	100/100=100% High Confidence in Report Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity)	111/111=100% High Confidence in Report Results	100/100=100% High Confidence in Report Results
Getting Needed Care CAHPS	111/111=100% High Confidence in Report Results	99/100=99% High Confidence in Report Results
Follow Up After Hospitalization for Mental Illness	84/85=99% High Confidence in Report Results	80/80=100% High Confidence in Reported Results

The Adolescent Well Child Visits PIP showed improvement in the rate from last year to this year (HEDIS 2020). The rate improved from 48.18% to 50.36%. For the Getting Needed Care CAHPS PIP, the goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from

90% in 2018 to 88.54% in 2019. This rate was higher than the NCQA rate but lower than the United plan goal rate. The Follow-Up After Hospitalization PIP showed that the 30-day follow up rate improved from 61.39% to 64.55%, which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.1.5% to 37.27%, which is above the goal rate of 36.20%. The obesity PIP has three HEDIS indicators: BMI percentile, counseling for nutrition, and counseling for physical activity. All rates improved from the previous measurement period and are above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate.

The recommendation for the Getting Needed Care CAHPS are displayed in *Table 17: CHIP Performance Improvement Project Recommendations*.

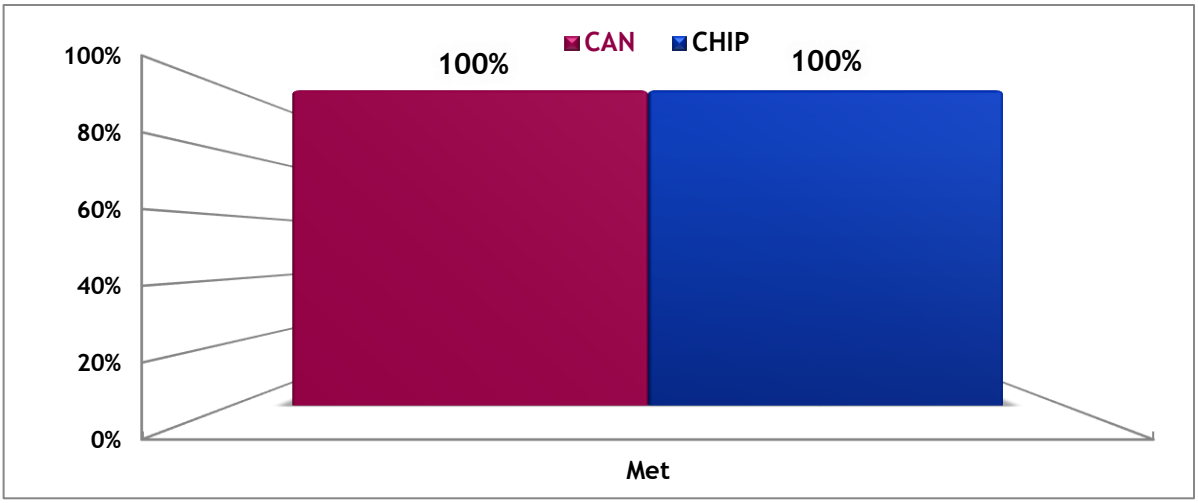
Table 17: CHIP Performance Improvement Project Recommendations

Project	Section	Reasoning	Recommendation
Getting Needed Care CHAPS	Was there any documented, quantitative improvement in processes or outcomes of care?	The goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019. This rate was higher than the NCQA rate but lower than the UNITED plan goal rate.	Work with survey vendor to improve response rate, which will assist in making sure the indicator rate is more representative of the population. Continue working on provider and member interventions focusing on education and awareness.

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

For this review period, United met all the requirements in the Quality Improvement section for the CAN and CHIP populations as noted in *Figure 5: Quality Improvement Findings*.

Figure 5: Quality Improvement Findings



Strengths

- The performance measure validation found that United was fully compliant with all information system standards and determined that United submitted valid and reportable rates for all HEDIS measures in scope of this audit.
- There were no concerns with United's data processing, integration, and measure production for the CMS Adult and Child Core Set measures reported. Aqurate determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation.
- The following CAN HEDIS measure rates were strengths for United since their rates had a greater than 10% improvement:
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), the BMI percentile indicator improved by 10 percentage points.
  - Comprehensive Diabetes Care (CDC), the HbA1c Poor Control (>9.0%) indicator improved by 10 percentage points.
- The following CHIP HEDIS measure rates were strengths for United since their rates had a greater than 10% improvement:
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), the BMI percentile, Counseling for Nutrition and Counseling for Physical Activity indicators improved by 10 percentage points.
- All the performance improvement projects received a validation score in the "High Confidence Range."

Weaknesses

- The EPSDT and the Well-Baby and Well-Child tracking reports for any problems identified during the exams failed to link the identified problems with the EPSDT or Well-Baby and Well-Child service and did not include or indicate the members who received additional outreach for case management referrals.
- The following CAN HEDIS measure rates were determined to be areas of opportunities for United since their rates had a greater than 10% decline:
  - Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) declined by over 10 percentage points.
  - Comprehensive Diabetes Care (CDC), the HbA1c Control (<8.0%) indicator declined by over 10 percentage points.
- One numerator compliant chart for the Cervical Cancer Screening (CCS) measure was not consistent with NCQA guidelines. Processes used for reviewing and conducting the overread of medical record abstractions must follow the most current NCQA guidelines.
- United was unable to provide proof of service documentation for one sample supplemental data record for the Well Child Visits in the First 15 Months of Life (W15) measure. Processes used for reviewing accuracy of supplemental data sources may need to be improved to ensure only appropriate services are included for measure calculation.
- United did not report three non-HEDIS measures for the CAN population. The three measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01) and Cesarean Birth (PC-02 CH).
- For CHIP, two non-HEDIS measures were not reported. The two measures were Live Births Weighing Less Than 2,500 grams (LBW-CW) and Cesarean Birth (PC-02 CH).

Recommendations

- The EPSDT and Well-Baby and Well-Child tracking reports should include the date the exams were provided, ICD 10 or CPT codes, treatment/referral, if any provided, and members who received additional outreach for case management referrals.
- Request clarification from NCQA each year for any medical record abstraction guidance since measure specifications and related guidance can change each year. Also, pay special attention to supplemental data received from aggregated data vendors to confirm that data reflects services provided.
- Work proactively with DOM for clarification of core set measures that are required to be reported.
- United must continue to follow NCQA guidelines for chart abstraction and supplemental data.

V. Utilization Management

CCME's review of United's CAN and CHIP Utilization Management (UM) Programs include various UM documents, medical necessity determination processes, pharmacy requirements, the Care Management Program, and approval, denial, appeal, and care management files.

The UM Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services for members in Mississippi. Additionally, they outline the program's structure, lines of responsibility, and standards used to make UM decisions. CCME identified documentation issues with timeliness requirements for requesting additional information from providers and incorrectly referencing working days instead of calendar days.

Service authorization requests are reviewed by appropriate staff using an established clinical hierarchy. United assesses consistency in criteria application and decision-making through annual inter-rater reliability testing of both physician and non-physician reviewers. Review of CAN and CHIP approval and denial files reflect consistent decision-making using approved criteria.

OptumRx is the pharmacy benefit manager (PBM) and is responsible for implementing pharmaceutical services. United uses the most current version of the MS Medicaid Program Preferred Drug List (PDL) to fulfill pharmacy requirements which is accessible from both CAN and CHIP websites. The Care Management Program and Population Health Management (PHM) Program promote access and delivery of physical and behavioral health services to identified members. Review of CM files reflected that staff are providing the appropriate level of care according the member's risk level.

CCME's review of appeal files confirmed timely acknowledgement, resolution, and notification of resolution. The CAN and CHIP policies contain appeal definitions, procedures, and other requirements. Some of the issues regarding appeals included:

- Lack of a definition of the term "adverse benefit determination" in the UM Program Description.
- Overall, the CAN and CHIP websites lack information on the appeal process, such as definitions of an appeal and describing who can file an appeal.

The CAN and CHIP UM Programs are evaluated at least annually to assess strengths and effectiveness. The evaluations are presented to the Healthcare Quality and Utilization Committee (HQUM) and the Quality Management Committee (QMC) for approval.

As noted in *Figure 6: Utilization Management Findings*, United achieved "Met" scores 94.4% for CAN and 96.2% for CHIP for the UM standards. The plan received "Partially Met" scores of 5.6% for CAN and 3.8% for CHIP.

Figure 6: Utilization Management Findings

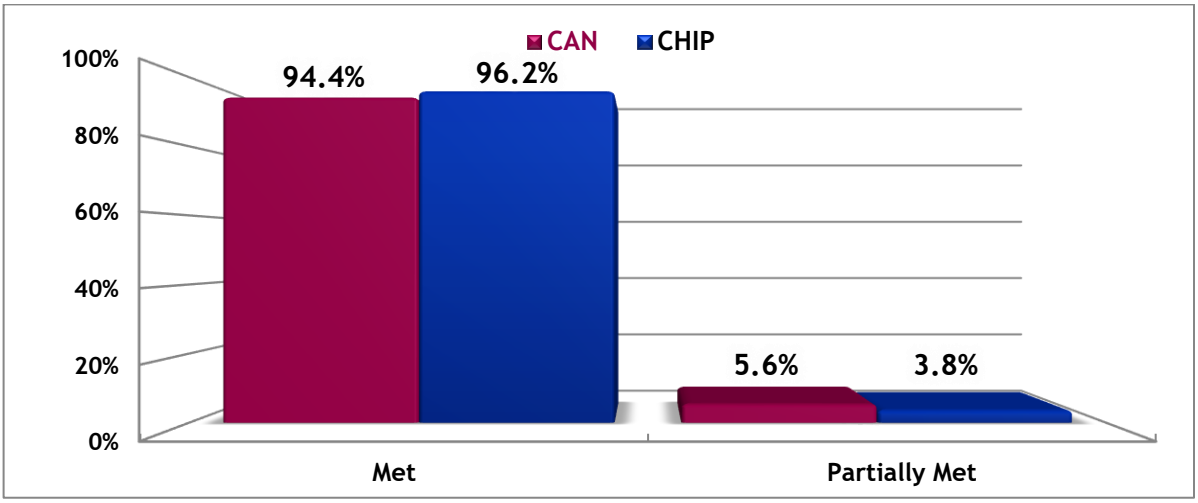


Table 18: Utilization Management

Section	Standard	CAN 2020 Review	CHIP 2020 Review
Utilization Management	The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Partially Met
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including: The procedure for filing an appeal	Partially Met	Partially Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Met

Strengths

- Member files reflect individual circumstances are taken into consideration during review of service authorizations.

Weaknesses

- CCME identified the following CAN documentation issues with UM timeframes:

  - The 2020 CAN and CHIP UM Program Description Addendums omitted the authorization timeframe requirement that the CCO will notify the requesting providing if additional medical information is needed to make a decision as noted in *CAN Contract, Section 5 (J) (6)* and the *CHIP Contract, Section 5 (I) (4)* .

- Policy UCSMM.06.16, Initial Review Timeframes, omitted the timeframe requirement for denial notices which states "For termination, suspension or reduction of previously authorized Medicaid-covered services, within 10 calendar days of the date of the Action for previously authorized services as permitted under 42 C.F.R. § 431, Subpart E", as noted in the *CAN Contract, Section 5 (L) (1)* and the *CHIP Contract, Section 5 (K)*.
- CCME identified the following CAN documentation issues:
  - The CAN and CHIP UM Program Descriptions do not define the term "adverse benefit determination".
  - The non-secured section of the CAN and CHIP websites lack information on appeal processes and procedures, such as the definition of an appeal and describing who can file an appeal.
  - The CAN and CHIP Member Handbooks and the CAN Care Provider Manual do not clearly describe the requirement that a member's legal guardian (for a minor or an incapacitated adult) or a representative of the member as designated in writing may file an appeal. Refer to the *CAN Contract, Exhibit D* and the *CHIP Contract, Exhibit D*.
- The CAN Care Provider Manual, on page 35, incorrectly notes an appeal acknowledgment letter is generated within 10 working days for standard appeals instead of 10 calendar days.
- The CHIP Care Provider Manual omits the requirement that verbal appeals must be followed by a written appeal signed by the member within 30 calendar days of the oral filing date. Refer to the *CHIP Contract, Exhibit E (D)*.
- The CAN appeal resolution notice letter template, MS Member Admin or Clinical Uphold, incorrectly states members can file an independent external review. CAN members are allowed State Fair Hearings rather than independent external reviews. Refer to the *CAN Contract, Exhibit D*.
- Policy MS021, Transitional Care Management and Policy HFS 003, Covered Services and Continuity of Benefit Coverage for Pregnant Members do not completely document the continuity of care requirement that members are allowed continued access to their prenatal care provider and any provider currently treating the members chronic, acute, medical, or behavioral health/substance use disorder through the postpartum period. Refer to the *CAN Contract, Section 8 (B) (5)*.

Corrective Actions

- Edit the CAN and CHIP UM Program Descriptions to include all service authorization timeframe requirements noted in the *CAN Contract, Section 5 (J) (6)*, the *CHIP Contract, Section 5 (I) (4)*, and to be consistent with Policy UCSMM.06.16, Initial Review Timeframes.
- Edit Policy UCSMM.06.16, Initial Review Timeframes, to include all timeframe requirements for denial notices stated in the *CAN Contract, Section 5 (L) (1)* and the *CHIP Contract, Section 5 (K)*.
- Include information on appeal processes and procedures on the non-secured section of the CAN and CHIP websites as required in the *CAN Contract, Section 6 (H)* and *CHIP Contract, Section 6 (H)*.
- Correct the CAN appeal resolution notice template, MS Member Admin or Clinical Uphold, to reflect members can request a State Fair Hearing instead of an independent external review.

Recommendations

- Revise the CAN and CHIP UM Program Descriptions to include the definition of the term adverse benefit determination, to be consistent with the POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and other UM documents.
- Edit the CAN and CHIP Member Handbooks and Provider Manuals to describe the full requirement that a member's legal guardian or representative can file an appeal.
- Include the definition or description of who can file an appeal on the CAN and CHIP websites.
- Correct the CAN Care Provider Manual to reflect that an appeal request is acknowledged in 10 calendar days instead of 10 working days.
- Edit the Can Care Provider Manual to include the requirement that a verbal appeal must be followed by a written appeal signed by the member within 30 calendar days of the oral filing date.
- Edit CAN Policy MS021, Transitional Care Management, and Policy HFS 003, Covered Services and Continuity of Benefit Coverage for Pregnant Members, to include the complete transition of care requirement for members in their second and third trimesters, as noted in the *CAN Contract, Section 8 (B) (5)*.

VI. Delegation

CCME's review of Delegation functions included the submitted Delegate List, delegation contracts, and delegation monitoring materials.

United reported 15 current delegation agreements, as shown in *Table 19: Delegated Entities and Services*.

Table 19: Delegated Entities and Services

Delegated Entities	Delegated Services
OptumHealth	Behavioral Health Case Management, Utilization Management, Quality Management, Network Contract Management, and Claims Processing
Dental Benefit Providers	Dental Network Services and 3rd Party Dental Administrator
eviCore National	Radiology and Cardiology Management Services
MARCH Vision Care	Vision and Eye Care Benefit Administration Services, Vision Network Contract Management, Call Center Operations, Claims Processing
Optum Rx	Pharmacy Benefit Administration Services
Medical Transportation Management	Non-Emergency Transportation
Hattiesburg Clinic River Region Health System HubHealth University Physicians, PLLC HCA Physician Services Health Choice, LLC North Mississippi Medical Center Ochsner Premier Health	Credentialing

Policy UCSMM 03.14, Delegated Credentialing Oversight Policy & Procedure, provides the process the Plan follows to evaluate and monitor the delegated entities' capacity to perform the delegated activities.

In addition to delegated credentialing, other health plan functions are delegated. Processes for pre-delegation assessment, ongoing monitoring, and annual oversight are documented in Policy DOV-01, Delegated Vendor Oversight Strategy. Copies of the annual oversight monitoring were provided for all delegated entities.

The monitoring tools used for the annual oversight included all Mississippi credentialing requirements. The query of the social security death master file, the requirement for the Ownership Disclosure form, and the monitoring of practitioner quality concerns (recredentialing) are not delegated functions and scored as N/A on the monitoring tools.

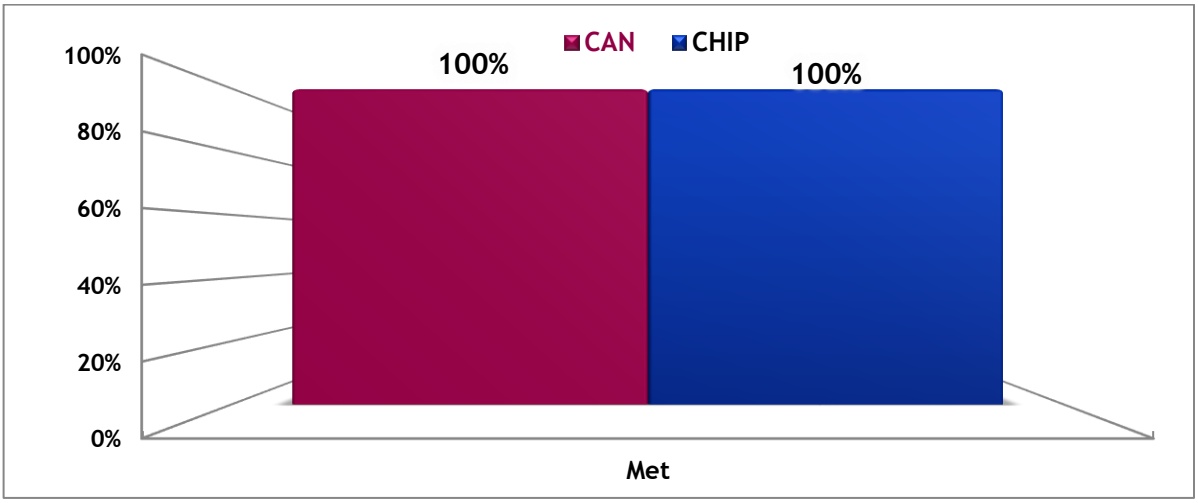
Several of the credentialing and recredentialing files reviewed during the monitoring of the credentialing/recredentialing delegates noted the requirement for the Clinical Laboratory Improvement Amendments (CLIA) certificate was marked as "N/A" with an

explanation noted as "Doesn't have a CLIA". It was unclear from the explanation if the provider did not provide laboratory services or the file did not contain the required CLIA certificate.

Also, the monitoring for OptumHealth, Dental Benefit Providers, and MARCH Vision Care did not include a file review of the delegates' credentialing and recredentialing files.

As indicated in *Figure 7: Delegation Findings*, 100% of the standards in the Delegation section were scored as "Met" for CAN and CHIP.

Figure 7: Delegation Findings



Weaknesses

- The CLIA was marked as "N/A" on several of the credentialing and recredentialing files reviewed during the monitoring of credentialing/recredentialing delegates.
- The monitoring for OptumHealth, Dental Benefit Providers, and MARCH Vision Care did not include a file review of the delegates' credentialing and recredentialing files.

Recommendations

- Include in the delegation monitoring oversight a sample of credentialing and recredentialing files and ensure the CLIA certificate is included in the credentialing and recredentialing files for practitioners providing laboratory services.

ATTACHMENTS

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

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

The Carolinas Center *for* Medical Excellence
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July 2, 2020

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 2020 External Quality Review (EQR) of UnitedHealthcare Community Plan – Mississippi is being initiated. The review will include the MississippiCAN Program (MSCAN) and MississippiCHIP Program (MSCHIP) and will be conducted by The Carolinas Center for Medical Excellence (CCME).

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME) and an 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 via teleconference on **October 5, 2020** through **October 6, 2020** for the MississippiCAN and Mississippi CHIP Programs.

In preparation for the desk review, the items on the enclosed **Mississippi CAN Materials Request for Desk Review** and **Mississippi CHIP Materials Request for Desk Review** lists should be provided to CCME no later than **August 3, 2020**.

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

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

We would be happy to schedule an education session (via webinar) on how to utilize the file transfer site. We will also send written desk instructions on how to use the file transfer site. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support. Of course, additional information and technical assistance will be provided as needed.

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

Please contact me directly at 803-212-7586 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you!

Sincerely,

Wendy Johnson
Project Manager

Enclosure(s)
cc: DOM

External Quality Review 2020 for MississippiCAN

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures for the MississippiCAN (MSCAN) program, as well as a complete index 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 (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the MSCAN program. Please include any provider identified limitations on panel size considered in the network assessment.

5. Submit a complete list of network providers from the current provider directory for the MSCAN members. The list should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for MississippiCAN Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Type/Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions
Medicaid ID	Tax ID
NPI	Contract Date Spans

Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information. (Note: this information will be requested quarterly.)

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 copy of the current Fraud, Waste & Abuse/Compliance plan for the MSCAN programs and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for MSCAN. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

10. The Quality Improvement work plans for MSCAN for 2019 and 2020.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the MSCAN program 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.

13. Minutes of <u>all committee meetings</u> in the past year 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.

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

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

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

17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews for MSCAN providers.

18. Provide reports for measuring provider adherence to medical record standards for 2019 and 2020.

19. A complete list of all MSCAN members enrolled in the Care Management program from June 2019 through June 2020. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

20. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the MSCAN program and changes.

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

22. 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.

23. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on MSCAN program.

24. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on the MSCAN program.

25. A copy of the Grievance, Complaint, and Appeal logs for the MSCAN program for the months of June 2019 through June 2020.

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

27. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the MSCAN program. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment and after-hours access monitoring.

28. Preventive health practice guidelines recommended by the CCO for use by practitioners for MSCAN members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

29. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for MSCAN members, including references used in

their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

30. For the MSCAN program, a list of physicians currently available for utilization consultation/review and their specialty.

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

32. A sample provider contract for the MSCAN program.

33. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    h. A copy of the Information Security Plan & Security Risk Assessment.
    i. A copy of the claims processing monitoring reports covering the period of June 2019 through June 2020.

34. For the MSCAN program, a listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

35. Contracts for all delegated entities.

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

37. Please provider the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS 2020 (Measurement Year 2019) Roadmap (Record of Administration, Data Management and Processes) (Roadmap)	• Please submit the same Roadmap your CCO completed for the 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for MSCAN	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for MSCAN.
c.	HEDIS 2020 Final Audit Report (from Licensed Organization) for MSCAN	Please submit the MSCAN Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM], to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that EQR reviewer may contact the vendor to review source code/process flow for measure production.
f.	List of measures rotated for HEDIS 2020 due to COVID-19 impact	Please submit a table/list of measures that were rotated for HEDIS 2020 due to COVID-19 impact.
g.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37g) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite visit.*
h.	List of exclusions and numerator positive hits	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will*

Folder	Requested Document	Description
	via medical record review (MRR) for the HEDIS measures	*send a second request with selected measures and request the CCO upload (via CCME portal, folder 37. h) a list of the first 100 hits that are identified through medical record review. CCME will select a random sample to conduct the medical record review validation.*
i.	Reporting template populated with data for Non-HEDIS measure rates	CCME will provide the reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.

1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
2. HEDIS Certified Measures [SM] is a service mark of the NCQA.

38. 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 network hospitals; and
        v. 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 network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the MSCAN program made in the months of June 2019 through June 2020. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
    d. Twenty-five utilization approval files (acute care and behavioral health) for the MSCAN made in the months of June 2019 through June 2020, including any medical information and approval criteria used in the decision.

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

These materials:

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

External Quality Review 2020 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 (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base for the CHIP program. Please include any provider identified limitations on panel size considered in the network assessment.

5. Submit a complete list of network providers from the current provider directory for the CHIP members. The lists should be submitted as an excel spreadsheet and include the following information:

List of Network Providers for Mississippi CHIP Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Type/Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions
Medicaid ID	Tax ID
NPI	Contract Date Spans

Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization. The provider list should include the most current provider contact information. (Note: this information will be requested quarterly.)

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 copy of the current Fraud, Waste & Abuse/Compliance plan for the CHIP program and any code of conduct for staff, etc. Please include any Compliance and Program Integrity policies and procedures, if not included in item 1 above.

9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy programs for CHIP. Please also submit the Credentialing Program Description and all health plan and corporate credentialing policies and procedures for all provider types.

10. The Quality Improvement work plans for CHIP for 2019 and 2020.

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

12. Documentation of all Performance Improvement Projects (PIPs) for the CHIP program that have been planned and completed during the previous year and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).

    d. For all projects with NON-HEDIS measures:
        - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.
    e. For projects with measures derived from medical record abstraction:
        - full documentation of the abstraction process and tool used during abstraction, and
        - 15 sample records from those abstracted charts.
    f. For projects with measures derived from administrative electronic systems:
        - full source code documentation of how the measure was processed and calculated for the PIP, and
        - any validity testing done from the programing of the measure to ensure the measure is capturing the populations of interest.

13. Minutes of all committee meetings in the past year 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.

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

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

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

17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews for CHIP providers.

18. Provide reports for measuring provider adherence to medical record standards for 2019 and 2020.

19. A complete list of all CHIP members enrolled in the Care Management program from June 2019 through June 2020. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.

20. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel. Evidence of any training provided to call center staff on the CHIP program and changes.

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

22. 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.

23. A copy of any member newsletters, educational materials, and/or other mailings. Any training plans for educating providers on the CHIP program.

24. A copy of any provider newsletters, educational materials, and/or other mailings. Any training plans, including initial provider orientation, for educating providers on the CHIP program.

25. A copy of the Grievance, Complaint, and Appeal logs for the CHIP program for the months of June 2019 through June 2020.

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

27. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards for the CHIP program. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment and after-hours access monitoring.

28. Preventive health practice guidelines recommended by the CCO for use by practitioners for CHIP members, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

29. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners for CHIP, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.

30. For the CHIP program, a list of physicians currently available for utilization consultation/review and their specialty.

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

32. A sample provider contract for the CHIP program.

33. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    h. A copy of the Information Security Plan & Security Risk Assessment.
    i. A copy of the claims processing monitoring reports covering the period of June 2019 through June 2020.

34. For the CHIP program, a listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.

35. Contracts for all delegated entities.

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

37. Please provider the following information for Performance Measure validation:

Folder	Requested Document	Description
a.	HEDIS 2020 (Measurement Year 2019) Roadmap (Record of Administration, Data Management and Processes) (Roadmap)	• Please submit the same Roadmap your CCO completed for the 2020 [1]NCQA HEDIS Compliance Audit™, that was conducted by your NCQA-licensed organization (LO). Include all attachments for each section. • Section 5 and all attachments are required for each supplemental data source that are utilized for measures included under PMV review. If you did not use supplemental data for the measures under scope, please replace this section with a note indicating this.
b.	IDSS (CSV and Excel workbooks) for CHIP	Please submit auditor locked Interactive Data Submission System (IDSS) workbooks for CHIP.
c.	HEDIS 2020 Final Audit Report (from Licensed Organization) for CHIP	Please submit the CHIP Final Audit Report that was issued by the NCQA HEDIS Licensed Organization.
d.	Source code (programming code) used to generate each of the HEDIS measures that are produced using non-certified code, if any	• If your CCO used non-certified code for any of the HEDIS measures, please submit the source code for each measure. • If your CCO used [2]HEDIS Certified Measures [SM,] to produce the HEDIS measures under scope, please provide a copy of your software vendor's NCQA final measure certification report in lieu of source code.
e.	Source code used to generate each of the non-HEDIS performance measures	• Please submit source code for each measure. • If non-HEDIS performance measures were calculated by a vendor, please provide vendor name and contact information so that EQR reviewer may contact the vendor to review source code/process flow for measure production.
f.	List of measures rotated for HEDIS 2020 due to COVID-19 impact	Please submit a table/list of measures that were rotated for HEDIS 2020 due to COVID-19 impact.
g.	Numerator positive case listings for the HEDIS and non-HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 g) a list of the first 100 hits that are identified through claims data. CCME will select a random sample from this list of 100 to conduct primary source verification (PSV) on your CCO's claims and enrollment system(s) that will occur during the onsite visit.*
h.	List of exclusions and numerator positive hits via medical record review (MRR) for the HEDIS measures	*Note: After completing the HEDIS Roadmap and IDSS review from the first desk materials request, CCME will send a second request with selected measures and request the CCO upload (via CCME portal, folder 37 h) a list of the first 100 hits that are identified through medical*

Folder	Requested Document	Description
		record review. CCME will select a random sample to conduct the medical record review validation.
i.	Reporting template populated with data for Non-HEDIS measure rates	CCME will provide the reporting template for non-HEDIS measures which must be populated with final data (denominators, numerators, and rates) for each measure.

1. NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
2. HEDIS Certified Measures [SM] is a service mark of the NCQA.

38. 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 network hospitals; and
        v. 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 network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files for the CHIP program made in the months of June 2019 through June 2020. Of the 25 requested files, include five for behavioral health and five for pharmacy medical necessity denial decisions. Include any medical information and physician review documentation used in making the denial determination for each file.
    d. Twenty-five utilization approval files (acute care and behavioral health) for the CHIP program made in the months of June 2019 through June 2020, including any medical information and approval criteria used in the decision.

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

These materials:

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

II. Attachment 2: Materials Requested for Onsite Review

UnitedHealthcare Community Plan – MississippiCAN and Mississippi CHIP

External Quality Review 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity

3. Policies, procedures, or other documentation describing exclusion and sanction monitoring activities for employees and delegated entities

4. A copy of the EPSDT Compliance report and the quarterly tracking report of problems and referrals identified during the EPSDT exam. (reference - EPSDT Services – Tracking Process Standard Operating Procedure)

5. A copy of the CHIP Standard Operating Procedure titled Well Child Services – Tracking Process.

6. Copies of the Well-Child Compliance report and the quarterly tracking reports of problems and referrals identified during the Well Child exam.

7. A copy of all policies, procedures, letter templates, etc. for the Pharmacy Lock-in Program.

8. P&P documents for the Member Services/Call Center and the Provider Services/Call Center (staffing, hours of operations, monitoring, etc.) for CHIP & CAN.

9. Copies of all policies, process and requirements for member disenrollment for CHIP & CAN.

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 CCC)
- Member Satisfaction Survey Validation CHIP (Child CCC)
- HEDIS PM Validation CAN
- HEDIS PM Validation CHIP
- CAN CMS Adult Core Set Measures
- CAN CMS Child Core Set Measures
- CHIP CMS Child Core Set Measures
- PIP Validation CAN
- PIP Validation CHIP

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare CAN/CHIP**
Survey Validated	**PROVIDER SATISFACTION**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

	Survey Element	Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose was documented in the report. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019 UnitedHealthcare Provider Satisfaction Specifications
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective was documented in the report. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019 UnitedHealthcare Provider Satisfaction Specifications
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience was identified in the report. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019 UnitedHealthcare Provider Satisfaction Specifications

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

	Survey Element	Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
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:* UnitedHealthcare Provider Satisfaction Survey Results-2019

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that covers the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019 UnitedHealthcare Provider Satisfaction Specifications
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Only 45 providers (2%) completed the survey. This is a very low response rate and may not reflect the population of providers. Thus, results should be interpreted with great caution. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019 ***Recommendation****: Determine if there is an easier method to elicit responses; find methods to improve responses by providers.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* UnitedHealthcare Provider Satisfaction Survey Results-2019

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

	Survey Element	Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose was documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective was documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience was identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

	Survey Element	Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that covers the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,350. The total completed surveys was 313 for a 23% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019 *Recommendation: Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.*

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare CAN**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose was documented in the report. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective was documented in the report. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience was identified in the report. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
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 Member Satisfaction Report-Child CCC 2019

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that covers the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results was difficult to discern due to low response rates for general population and total population. General Population Survey Responses: 395 completed surveys, with a 17.2% response rate- sample of 2310. This is slightly lower than last year's response rate of 17.72%. The Total Population Survey Responses: Response rate was 18.18% with 883 completed surveys; sample of 4886. This year's response rate is slightly lower than last year's rate 18.84%. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019 *Recommendation: Continue to work on interventions to increase response rates (e.g. website banners, reminders on call center scripts).*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019

CCME EQR Survey Validation Worksheet

Plan Name	**UnitedHealthcare CHIP**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2019
Review Performed	2020

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (Updated based on October 2019 version of EQR protocol 6)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

	Survey Element	Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose was documented in the report. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective was documented in the report. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience was identified in the report. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019

ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

	Survey Element	Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
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 Member Satisfaction Report-Child CCC 2019

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that covers the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* DSS Research Member Satisfaction Report-Child CCC 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The generalizability of the survey results is difficult to discern due to low response rate for total sample 21.11% and 20.45% for general population. This is a decrease from last year's response rates although it was higher than the average United response rate of 17.62%. The sample size was 4,886 with 1,023 completed surveys. The response rates are below the NCQA target rate is 40%. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019 *Recommendation: Determine if there are any new barriers that occur for completion of surveys for the Child CCC member population. Continue to work with DSS Research to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* DSS Research Member Satisfaction Report- Child CCC 2019

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	United was unable to provide proof of service documentation for one sample supplemental data record for W15. Processes used for reviewing accuracy of supplemental data sources may need to be improved to ensure only appropriate services are included for measure calculation.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	One numerator compliant chart for the CCS measure was not consistent with NCQA guidelines. Processes used for reviewing and conducting the overread of medical record abstractions must follow the most current NCQA guidelines.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	9
N2	5	Met	5
N3	5	Met	5
N4	5	Met	4
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	73
Measure Weight Score	75
Validation Findings	97.33%

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	United was unable to provide proof of service documentation for one sample supplemental data record for W15. Processes used for reviewing accuracy of supplemental data sources may need to be improved to ensure only appropriate services are included for measure calculation.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	One numerator compliant chart for the CCS measure was not consistent with NCQA guidelines. Processes used for reviewing and conducting the overread of medical record abstractions must follow the most current NCQA guidelines.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	9
N2	5	Met	5
N3	5	Met	5
N4	5	Met	4
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	73
Measure Weight Score	75
Validation Findings	97.33%

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44 (CCP-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44 (CCW-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN AGE 18 AND OLDER (CDF – AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**HIV VIRAL LOAD SUPPRESSION (HVL-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMA Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER (OHD-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER (OUD-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare- MSCAN**
Name of PM:	**ELECTIVE DELIVERY (PC01 – AD)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Not Applicable**	This measure was not reported.

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.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
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).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
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.	**Not Applicable**	This measure was not reported.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Not Applicable**	This measure was not reported.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Not Applicable**	This measure was not reported.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Not Applicable**	
D1	**10**	**Not Applicable**	
D2	**5**	**Not Applicable**	
N1	**10**	**Not Applicable**	
N2	**5**	**Not Applicable**	
N3	**5**	**Not Applicable**	
N4	**5**	**Not Applicable**	
N5	**5**	**Not Applicable**	
S1	**5**	**Not Applicable**	
S2	**5**	**Not Applicable**	
R1	**10**	**Not Applicable**	

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	**M/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

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:	**UnitedHealthcare - MSCAN**
Name of PM:	**DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE (PQI01-AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE (PQI05 – AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**HEART FAILURE ADMISSION RATE (PQI08 – AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**ASTHMA IN YOUNGER ADULTS ADMISSION RATE (PQI15 – AD)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Adult Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specification

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP – CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW – CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)**
Reporting Year:	**2020**
Review Performed:	**10/05/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	This hybrid measure was reported using only administrative methodology.
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	This hybrid measure was reported using only administrative methodology.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare- MSCAN**
Name of PM:	**LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CH)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Not Applicable**	This measure was not reported.

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.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
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).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
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.	**Not Applicable**	This measure was not reported.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Not Applicable**	This measure was not reported.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Not Applicable**	This measure was not reported.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Not Applicable	
D1	10	Not Applicable	
D2	5	Not Applicable	
N1	10	Not Applicable	
N2	5	Not Applicable	
N3	5	Not Applicable	
N4	5	Not Applicable	
N5	5	Not Applicable	
S1	5	Not Applicable	
S2	5	Not Applicable	
R1	10	Not Applicable	

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	**M/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

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:	**UnitedHealthcare- MSCAN**
Name of PM:	**CESAREAN BIRTH (PC-02)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Not Applicable**	This measure was not reported.

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.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
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).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
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.	**Not Applicable**	This measure was not reported.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Not Applicable**	This measure was not reported.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Not Applicable**	This measure was not reported.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Not Applicable	
D1	10	Not Applicable	
D2	5	Not Applicable	
N1	10	Not Applicable	
N2	5	Not Applicable	
N3	5	Not Applicable	
N4	5	Not Applicable	
N5	5	Not Applicable	
S1	5	Not Applicable	
S2	5	Not Applicable	
R1	10	Not Applicable	

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	**M/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

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:	**UnitedHealthcare - MSCAN**
Name of PM:	**PRECENTAGE OF ELIGIBLES WHO RECEIVED PREVENTATIVE DENTAL SERVICES (PDENT-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Met**	**10**
D1	**10**	**Met**	**10**
D2	**5**	**Met**	**5**
N1	**10**	**Met**	**10**
N2	**5**	**Met**	**5**
N3	**5**	**Met**	**5**
N4	**5**	**Met**	**5**
N5	**5**	**Met**	**5**
S1	**5**	**Met**	**5**
S2	**5**	**Met**	**5**
R1	**10**	**Met**	**10**

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCAN**
Name of PM:	**DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE (AUD-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20 (CCP – CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20 (CCW – CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17 (CDF-CH)**
Reporting Year:	**2020**
Review Performed:	**10/05/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**DEVELOPMENTAL SCREENING IN THE FIRST 3 YEARS OF LIFE (DEV-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**N/A**	This hybrid measure was reported using only administrative methodology
S2 Sampling	Sample size and replacement methodologies met specifications.	**N/A**	This hybrid measure was reported using only administrative methodology

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare- MSCHIP**
Name of PM:	**LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS (LBW-CH)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Not Applicable**	This measure was not reported.

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.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
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).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
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.	**Not Applicable**	This measure was not reported.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Not Applicable**	This measure was not reported.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Not Applicable**	This measure was not reported.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Not Applicable**	
D1	**10**	**Not Applicable**	
D2	**5**	**Not Applicable**	
N1	**10**	**Not Applicable**	
N2	**5**	**Not Applicable**	
N3	**5**	**Not Applicable**	
N4	**5**	**Not Applicable**	
N5	**5**	**Not Applicable**	
S1	**5**	**Not Applicable**	
S2	**5**	**Not Applicable**	
R1	**10**	**Not Applicable**	

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	**M/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

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:	**UnitedHealthcare- MSCHIP**
Name of PM:	**CESAREAN BIRTH (PC-02-CH)**
Reporting Year:	**2020**
Review Performed:	**Not Applicable**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**Not Applicable**	This measure was not reported.

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.	**Not Applicable**	This measure was not reported.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Not Applicable**	This measure was not reported.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Not Applicable**	This measure was not reported.
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).	**Not Applicable**	This measure was not reported.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Not Applicable**	This measure was not reported.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Not Applicable**	This measure was not reported.
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.	**Not Applicable**	This measure was not reported.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample treated all measures independently.	**Not Applicable**	This measure was not reported.
S2 Sampling	Sample size and replacement methodologies met specifications.	**Not Applicable**	This measure was not reported.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Not Applicable**	This measure was not reported.
Overall assessment			

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	**10**	**Not Applicable**	
D1	**10**	**Not Applicable**	
D2	**5**	**Not Applicable**	
N1	**10**	**Not Applicable**	
N2	**5**	**Not Applicable**	
N3	**5**	**Not Applicable**	
N4	**5**	**Not Applicable**	
N5	**5**	**Not Applicable**	
S1	**5**	**Not Applicable**	
S2	**5**	**Not Applicable**	
R1	**10**	**Not Applicable**	

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	**M/A**
Measure Weight Score	**N/A**
Validation Findings	**N/A**

AUDIT DESIGNATION
NOT REPORTED

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:	**UnitedHealthcare - MSCHIP**
Name of PM:	**PRECENTAGE OF ELIGIBLES WHO RECEIVED PREVENTATIVE DENTAL SERVICES (PDENT-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PM Validation Worksheet

Plan Name:	**UnitedHealthcare - MSCHIP**
Name of PM:	**DENTAL SEALANTS FOR 6-9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK (SEAL-CH)**
Reporting Year:	**2020**
Review Performed:	**10/5/2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
CMS Child Core Set Measure Specifications

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	
Overall assessment			**Met**

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CAN**
Name of PIP:	**BEHAVIORAL HEALTH READMISSIONS (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

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 noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement period one was reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is to reduce the readmission rate 5% from baseline to remeasurement 1. The annual report shows an increase from 18% to 19.2% for the first remeasurement period. *Recommendation: The current interventions may need to be revised for continued implementation in dealing with COVID-19. An analysis of most impactful interventions may need to be performed, and then re-focusing on those interventions until the rate decreases toward the goal rate. Workgroup can continue to assess and work on revising initiatives.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported.

Component / Standard (Total Points)	Score	Comments
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement recorded.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CAN**
Name of PIP:	**RESPIRATORY ILLNESS**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Childhood asthma is a major concern in MS. COPD is the fourth leading cause of death.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined. Using HEDIS measures: Pharmacotherapy of COPD Exacerbation and Medication Management for People with Asthma.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measured changes in health status.

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 noted.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of rate in comparison to benchmarks.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	NA	NA
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	72
Project Possible Score	72
Validation Findings	100%
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CAN**
Name of PIP:	**SICKLE CELL DISEASE OUTCOMES (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Results in Findings Tables were noted to be per 1000 member months but then a percentage was documented. *Recommendation: Organize the results to reflect per 1,000 member months instead of a percentage since it is labeled as per 1000 member months. The data reported on page 9 is an informative way to present the results that if focused on SCD patients, therefore, that is another option for presenting the findings.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline data only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**NA**	Baseline data only.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement reported
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement reported.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	5
7.3	NA	NA
7.4	NA	NA
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	66
Project Possible Score	71
Validation Findings	93%
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CAN**
Name of PIP:	**IMPROVING PREGNANCY OUTCOMES (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Results were reported for baseline. The goal is listed as 83.76% for benchmark on page 7; DOM goal as 89.2% on page 7; and 88.29% on page 3. *Recommendation: Clarify which rate is the baseline goal rate and which is the benchmark target rate for PIP in report.*
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline rate reported only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of baseline in relation to benchmark rates.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only. Already above goal rate at baseline.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	5
7.3	NA	NA
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**67**
Project Possible Score	**72**
Validation Findings	**93%**
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CHIP**
Name of PIP:	**ADOLESCENT WELL CARE VISITS (CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The goal is to improve AWC rate. The rate improved from 48.18% to 50.36%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to continued intervention efforts.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; only one period with improvement, after the rate declined from HEDIS 2018 to HEDIS 2019

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	**100**
Project Possible Score	**100**
Validation Findings	**100%**
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CHIP**
Name of PIP:	**FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	FUH rate was below the target rate of 66.6% for 3-day follow up and 45.11% for 7-day follow up.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The goal is to improve FUH rate for 30-day and 7-day follow up. The 30-day follow up rate improved from 61.39% to 64.55% which is above the goal rate of 63.23%. The 7-day follow up rate improved from 35.1.5% to 37.27% which is above the goal rate of 36.20%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to continued intervention efforts.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; rate has improved after a decline from HEDIS 2018 to HEDIS 2019.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	80
Project Possible Score	80
Validation Findings	100%
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CHIP**
Name of PIP:	**MEMBER SATISFACTION**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	There was a downward trend from 2016 to 2017 for getting needed care.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS survey sampling specifications were used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS survey sampling specifications were used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS survey sampling specifications were used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods and interim rates were monitored.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	The goal is to improve the rate to the NCQA quality compass percentile rate. There was a slight decline in the rate for the most recent measurement period from 90% in 2018 to 88.54% in 2019. This rate was higher than the NCQA rate but lower than the United plan goal rate. *Recommendation: Work with survey vendor to find ways to improve response rate, which will assist in making sure the indicator rate is more representative of the population. Continue working on provider and member interventions focusing on education and awareness*.

Component / Standard (Total Points)	Score	Comments
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to continued intervention efforts.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; rate improved but have not achieved United goal rate.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	**99**
Project Possible Score	**100**
Validation Findings	**99%**
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

CCME EQR PIP Validation Worksheet

Plan Name:	**UnitedHealthcare CHIP**
Name of PIP:	**REDUCING ADOLESCENT AND CHILDHOOD OBESITY**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	MS obesity rate is 18.9% for youth and 21.9% for children, making this population at-risk for chronic issues.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims of the study were stated clearly.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This project addressed aspects of enrollee care.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	This project included all relevant populations.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS sampling specifications were used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS sampling specifications were used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS sampling specifications were used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were clearly defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in health status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were noted.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Methods were documented as valid and reliable.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments provided consistent and accurate data collection.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis plans were noted.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualifications of personnel were listed.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Data were reported for one year measurement periods and interim rates were monitored.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were reported clearly.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement periods were reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Report included analysis of change in rate between measurement periods and qualitative analysis of the results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions already undertaken to address barriers were documented in report.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The goal is to improve BMI percentile, nutrition, and physical activity counseling. HEDIS rates were reported. All rates improved from the previous measurement period and were above the comparison goal rate of 3% improvement, but still fall below the benchmark NCQA rate.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to continued intervention efforts.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical testing was documented.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge; rate has improved but have not achieved benchmark yet.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	5	5
4.2	10	10
4.3	5	5
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	1
9.2	5	5
9.3	1	1
9.4	NA	NA

Project Score	100
Project Possible Score	100
Validation Findings	100%
AUDIT DESIGNATION	
HIGH CONFIDENCE IN REPORTED RESULTS	

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

IV. Attachment 4: Tabular Spreadsheet

CCME CAN Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CAN**
Review Performed:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, defines processes for policy review and revision. Policies and SOPs must be current, reviewed annually, and accessible to all employees. Onsite discussion confirmed policies are housed on a SharePoint site for staff access. Newly created and revised policies are reviewed by the policy and review Steering Committee prior to review and approval by other applicable committees, such as the Health Quality Utilization Management (HQUM) Committee, Service Quality Improvement Subcommittee (SQIS), and the Quality Management Committee (QMC). National policies that do not include state-specific requirements will have a rider or addendum. When possible, United creates Standard Operating Procedures (SOPs) to outline processes and provide

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						detailed instructions for staff. The SOPs are reviewed and updated on an as-needed basis by the applicable department head.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						Current staffing appears to be adequate for ensuring health care products and services are provided to members. United reports there are currently fewer than five open positions, and recruiting activities are in progress.
1.1 *Chief Executive Officer;	X					Jeff Wedin is the Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Douglas "Mitch" Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Heath Seaman is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Mike Rogers is the Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Shandrika Sutton is the Claims Administrator
1.6 *Provider Services Manager;	X					Nicole Tucker is the Provider Services Manager and Tamara Keane is the Provider Relations Manager.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					Kenisha Potter is Director of Member Services. Marianne Bullian is Member Services Manager and Kobie Wells is Member Outreach Manager.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7.1 Member services and education;	X					
1.8 Complaint/Grievance Coordinator;	X					Sheree Thompson is the Appeals and Grievances Coordinator.
1.9 Utilization Management Coordinator;	X					Kimberly Bollman is the Health Services / Population Health Director. She is supported by a Prior Authorization Manager, IP Case Manager, and Case Management Managers.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Quality Management Director and Lynn Mitchell is Quality Management Manager.
1.11 *Marketing, member communication, and/or public relations staff;	X					
1.12 *Medical Director;	X					Amit Prasad, MD, is the Chief Medical Officer.
1.13 *Compliance Officer.	X					Juan Rodas is serving as Interim Compliance Officer since the position became vacant in August 2020. United has three current candidates for the position and expects to have the position filled within three to four weeks.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					United's Information Systems Capabilities Assessment (ISCA) documentation included a detailed breakdown of the percent of clean claims paid for the last 13 months. United's monthly percent paid average for 30 and 90 days surpasses Mississippi's timeliness requirements. Over the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						13 months of data provided, United paid 99.89% of clean claims within 30 days, and 99.99% of clean claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United collects enrollment and member demographic data in CSP-Facets, its member/encounter/claims system. United uses the member ID provided in the State's 834 file to identify enrollees in its systems. Those systems are capable of tracking members across multiple product lines while retaining the histories associated with each. On a weekly basis, United runs a report to identify members with duplicate records. Duplicate records are voided with a note to the correct subscriber ID. Finally, United provided a short history of updates to its member/encounter/claims system which shows the yearly upgrades and maintenance occurring on a scheduled basis.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					United uses NCQA-certified software, MedMeasures, for HEDIS and HEDIS-like reporting. The MedMeasures software is updated by United's vendor annually, and the updates are validated by United to ensure successful operation. HEDIS and HEDIS-like reports are sourced from data that is reviewed by a HEDIS auditor and stored in a dedicated data warehouse.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United has a disaster recovery (DR) plan in place for systems which service its Medicaid and Medicare operations. Documentation indicates there are sound business continuity practices in place to avoid outages, and an impact analysis process prioritizes recovery if there is an outage. Finally, United conducts tabletop DR exercises twice annually to review and revise the DR plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The corporate UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2020 – 2021 (FWA Plan) along with the UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program 2020 – 2021 addendum were submitted for review. The FWA Plan addendum describes United's commitment "to providing Mississippi members with access to high-quality medical care while protecting the ethical and fiscal integrity of the program by operating a Fraud, Waste and Abuse (FWA) program that includes: prevention, detection, reporting, corrective action and best practices." The UnitedHealthcare FWA Plan describes the comprehensive FWA program and the addendum includes expectations specific to the state of Mississippi.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					Any issues identified are described in the standards that follow.
2.1 Standards of conduct;						The UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) provides guidelines for ethical behavior for staff. The Code of Conduct addresses expectations for ethical work behavior, information about violations of the Code of Conduct and policies, and who to contact with questions and concerns.
2.2 Identification of the Compliance Officer;						The corporate FWA Plan provides information about the overarching Compliance Program that applies to all businesses within the UnitedHealth Group, including UnitedHealthcare Community & State plans. The FWA Plan briefly describes the role of the UnitedHealthcare

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program Integrity Chief Compliance Officer and Vice President, Payment Integrity. The Mississippi addendum to the FWA Plan references the Compliance Officer and briefly describes the role of the Compliance Officer. CCME noted the Mississippi addendum references the compliance officer by name and the information is outdated. *Recommendation: Update the reference to the Compliance Officer in the Mississippi addendum to the FWA Plan.*
2.3 Information about the Compliance Committee;						The corporate FWA Plan discusses the UnitedHealthcare Compliance Program Integrity Oversight Committee. CCME received minutes for the UnitedHealthcare Community Plan of Mississippi Compliance Oversight Committee. The 2020 Quality Improvement Program Description, page 15, includes detailed information about the health plan's Compliance Committee.
2.4 Compliance training and education;						The corporate FWA Plan provides an overview of Compliance training for employees, internal and external vendors/contractors, and network providers. The CAN 2020 Care Provider Manual (Provider Manual) provides thorough information about FWA (including definitions, examples, reporting methods), ethics and integrity, and the Compliance Program. United distributes educational materials to its members regarding FWA detection through written communications designed to raise awareness of how to identify potential FWA and how to report suspected FWA. The CAN Member Handbook includes a brief explanation of FWA, provides examples of FWA, and information about reporting FWA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 Lines of communication;						As stated in the FWA Plan, employees are expected to report and/or provide information about compliance violations and suspected FWA. United takes precautions to maintain the confidentiality of those who report and prohibits retaliatory actions against anyone who, in good faith, reports or provides information about suspected violations. Reporting methods include designated web portals, call centers, databases, and anonymous hotlines. The CAN Care Provider Manual and Member Handbook include the telephone number for reporting to the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum (1-866-242-7727) but do not include the phone number for reporting to DOM's Office of Program Integrity (1-800-880-5920). The Health Talk member newsletters contain telephone numbers to report suspected fraud and abuse by providers or members to DOM's Office of Program Integrity but not to Optum's AFRS unit. *Recommendation: Ensure all options for reporting suspected FWA are included in the CAN Care Provider Manual and Member Handbook, as well as in the Health Talk newsletters.*
2.6 Enforcement and accessibility;						The Code of Conduct informs staff that all violations will be taken seriously and may result in discipline, up to and including termination of employment and possible legal action, including referral to law enforcement. The CAN Member Handbook informs members that "Committing fraud or abuse is against the law." The handbooks further state that making an intentional false statement or claim to receive or increase benefits can

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						result in criminal charges, prosecution, and loss of benefits. The CAN 2020 Care Provider Manual includes information about the expectation that providers notify United about any suspicions of or actual FWA, cooperate with initiatives to detect, prevent and combat FWA, and cooperate with any review of such a situation.
2.7 Internal monitoring and auditing;						The FWA Plan addresses monitoring and auditing activities, including: •Prospective detection (pre-payment data analysis, data mining, and analysis of abnormal billing patterns) •Retrospective detection (post-payment data and payment error analytics) •Industry trend analysis •Exclusion and sanction monitoring •Monitoring and oversight of delegated entities, providers, and related entities •Provider audits •FWA Program compliance and performance audits
2.8 Response to offenses and corrective action;						The FWA Plan and its related Mississippi Addendum state investigations of FWA are conducted by the Special Investigations Unit (SIU). The SIU staffing includes investigators with experience in health care and prescription drug FWA, industry business practices and systems, and infrastructure. The Payment Integrity Department reviews and incorporates the latest research on detecting new and emerging FWA schemes and practices. Actions taken in response to detected offenses include, but are not limited to:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Provider notification and education •Recovery efforts •Termination of network participation •Referral to law enforcement, regulatory, and administrative agencies
2.9 Exclusion status monitoring.						Policy ID-5881, New Hire and Periodic Employee Sanction Review states, "UnitedHealth Group will not knowingly hire, continue to employ, or contract with someone of law or contract prohibits the person from providing services for our customers." The policy defines the monitoring conducted and the frequency of the monitoring. Policy ID-5787, Practitioner Sanctions Monitoring, describes sanctions monitoring of network providers.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The 2020 Quality Improvement Program Description, page 15, includes detailed information about the health plan's Compliance Committee. The committee meets at least quarterly and as needed, and its quorum is defined as 51% of membership. Members may designate surrogate attendees with voting privileges. Responsibilities of the local Compliance Committee include: •Supporting the prevention, detection, and correction of legal and regulatory risks and promoting compliance. •Ensuring accountability throughout the organization for compliance with legal and business requirements. •Identifying and promoting best practices, resources, and operational efficiencies. •Reviewing regulatory concerns and status of corrective action plan(s).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Reviewing and suggesting changes to key policies and procedures as indicated. •Reviewing results of internal and external audits, reports, and compliance indicators . •Providing CCO leadership and appropriate internal and corporate departments with key information and updates about CCO compliance activities. The Compliance Committee Charter states the Compliance Committee is co-chaired by the Compliance Officer and Plan CEO. However, the QI Program Description, pages 15 and 16, states the Compliance Committee is chaired only by the Compliance Officer. Onsite discussion confirmed the documentation in the Compliance Committee Charter is correct. *Recommendation: Ensure the QI Program Description includes correct information about the Compliance Committee chair.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Optum's Prospective Investigation and Clinical Review Policy and Procedure provides the activities conducted throughout the pre-payment investigation of detected claims. Additional information about conducting investigations of reported incidents is found in the FWA Plan and its associated Mississippi Addendum.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

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 credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The UnitedHealthcare Credentialing Plan 2019-2021 (Credentialing Plan), the United Behavioral Health Clinician and Organizational Provider Credentialing Plan 2020-2021, and related policies and procedures define processes for credentialing and recredentialing of health care providers. Attachment E of the Credentialing Plan, State and Federal Regulatory Addendum, defines Mississippi-specific requirements.
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 National Credentialing Committee (NCC) makes credentialing decisions and communicates the decisions to the health plan. The NCC membership includes the health plans' Medical Directors and participating providers from the health plans' networks.. The health plan's Provider Advisory Committee (PAC) is chaired by United's Chief Medical Officer and is responsible for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviewing credentialing and recredentialing decisions of the NCC. Membership of the PAC includes providers with specialties of pediatrics, obstetrics and gynecology, internal medicine, psychiatry, dentistry, and family medicine. The PAC reports to the Quality Management Committee.
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						Identified issues are discussed in standards 3.1.1 through 3.1.15.
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					
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice insurance coverage / claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting the ability to provide health care, any history of chemical	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					One initial credentialing file did not contain a copy of the query of the System for Award Management (SAM). *Recommendation: Ensure all initial credentialing files contain a screenshot showing the date the SAM was queried and results of the query.*
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					One initial credentialing file did not contain a copy of the query of the National Plan and Provider Enumeration System (NPPES).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure all initial credentialing files contain a screenshot showing the date the NPPES was queried and results of the query.
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
3.1.15 Ownership Disclosure form.	X					For one initial credentialing file, the Ownership Disclosure Form was signed and dated in 2015, more than four years prior to credentialing approval date. Note: This is a repeat finding from the 2019 EQR. During the 2019 EQR, CCME noted some files contained outdated Ownership Disclosure Forms. United presented a response in the corrective action documentation for the 2019 EQR that "UnitedHealthcare Community Plan will continue to collect at the time of contracting and maintaining to the 3 year signature date policy." *Recommendation: Ensure Ownership Disclosure Forms are current at the time of initial credentialing.*
3.2 Site assessment.	X					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. Recredentialing processes include all elements required by the contract and by the CCO's internal policies.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						Issues are addressed in standards 4.2.1 through 4.2.14.
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 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.14 Ownership Disclosure form.	X					
4.3 Provider office site reassessment, when applicable.	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					The Credentialing Plan defines the process for evaluating potential quality of care concerns which may result in a network provider's suspension, restriction, or termination. This process includes review by the Medical Director, and if the Medical Director determines action is necessary, and in collaboration with the Regional Peer Review Committee chairperson and the regional chief medical officer, a network provider's network participation may be restricted or suspended. If immediate action is not warranted, the information is referred to the Peer Review Committee, and possibly to the National Peer Review and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Credentialing Policy Committee. Providers are notified in writing of any suspension, restriction, or termination for cause.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				File review findings for organizational providers include: •All initial credentialing files for organizational providers contained evidence that the MS DOM Sanctioned Provider List was checked, but for three of the files, the date the MS DOM Sanctioned Provider List was updated was not captured on the document included in the file. During onsite discussion, United staff stated they would follow-up with CCME, but no additional information was provided. •All recredentialing files for organizational providers contained screenshots of the SAM query; however, four of the screenshots did not display the date the query was conducted. •Three recredentialing files for organizational providers included screenshots of the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) query; however, the screenshots did not display the date the query was conducted. •One recredentialing file for an organizational provider did not contain evidence of the query of the OIG LEIE. *Corrective Action: Ensure the date the MS DOM Sanctioned Provider List was updated is included on screenshots captured as evidence of query. Ensure primary source verification of the SAM includes the date the query was conducted. Ensure primary source verification of the OIG LEIE is included in all files and that it includes the date the query was conducted.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.						Policy PS3, Geographic Access Standards, defines the PCP geographic access standards for United's provider network. Standards listed in the policy comply with contract requirements; however, the table on page two of the policy does not include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in the *CAN Contract, Section 7 (B) (1), Table 6*. Onsite discussion revealed this was on oversight when the policy was last revised. Geo access reports confirm these provider types are included in the assessment of network adequacy. *Recommendation: Revise Policy PS3 to include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in the CAN Contract, Section 7 (B) (1), Table 6.*
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As stated in Policy PS10, PCP Panel Notification, United makes member panel information available to all participating PCPs via the secure provider portal. United identifies PCPs with changes in member panels and mails post card notification about these changes within five days of receiving the Member Listing Report from DOM.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, describes processes to verify member enrollment status. Network providers can access enrollment information via the secure provider portal. Out of network providers can verify enrollment by calling the telephone number on the member ID card.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					During initial credentialing and contracting, PCPs inform the health plan of any member panel restrictions, as defined in Policy PS10, PCP Panel Notification. If no panel restrictions are communicated, it is understood that the PCP agrees to accept all members as assigned. The Provider Directory explains indicates if providers are not accepting new patients. Onsite discussion confirmed United runs quarterly reports of providers who are not accepting new patients and have a standing monthly meeting to review and ensure there are enough providers in the network who are accepting new patients to meet member needs.
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Quarterly geographic access reports are developed to assess compliance with the contractual standards for PCP access. The Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 displays standards for some rural family medicine, internal medicine, pediatricians, and nurse practitioners as 1 provider within 60 miles. The standard noted in the report for some urban family medicine, internal medicine, pediatrics, and nurse practitioners as 1 within 30 miles. Onsite discussion revealed the providers assessed under these standards may not act as PCPs, e.g. those working in urgent care centers, etc.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.		X				Policy PS3, Geographic Access Standards, defines the specialist geographic access standards for United's provider network. The most recent Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						within 60 miles. However, the standard stated in the *CAN Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural. CCME noted the goal of 90% of members with access to various specialties is not met for some specialty types. During onsite discussion, United acknowledged this finding and confirmed they continue to target and work toward securing contracts with the needed specialty types. *Corrective Action: Ensure Geo access reports are run using the contractually-required standard for Emergency Care Providers.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					The Annual Assessment of Network Adequacy Report dated March 2020 states: "The goal is for 90 percent of members to have access to the specific practitioner types within the miles designated based on the population of the geographic area." During onsite discussion, United confirmed the established goal is that 90% of members have access to PCPs. Geo access reports are run quarterly and evaluated to determine the adequacy of the provider network. The Geo access report dated July 23, 2020 confirms adequate access for PCPs for members across the state.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					United's Multicultural Health Care Program activities include: •Assessing race/ethnicity and languages of members and providers and focusing on initiatives to reduce health care disparities, improve cultural competency in member materials and communication, and to advance network adequacy to address the needs of a diverse membership. United conducts a population language

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						profile assessment at least every three years, and an assessment of the practitioner network to identify language or cultural gaps is conducted at least every three years. •Measuring activities to reduce disparities. •Evaluating the effectiveness of interventions on the reduction of disparities and prioritizing opportunities to reduce health care disparities and improve CLAS. •Embracing diversity by creating a continuum of culturally sensitive initiatives that promote health and prevent avoidable health care cost.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy PS2, Access Standards – Appointment Availability Requirements, defines appointment availability requirements for providers who provide services to CAN and CHIP members. The appointment availability standards listed in the policy are compliant with contractual requirements. Provider education includes information about appointment availability standards. The policy states, "Quarterly assessments are performed to gauge 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, as well as to support

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identification of improvement opportunities and development of corrective action initiatives." The Annual Assessment of Network Adequacy Report dated March 2020 documents results for 2019 assessments of practitioner accessibility. The document states, "Assessment of the 2019 PCP practitioner survey for after-hours care for primary care physicians demonstrate the goal was not met. The 2019 after-hours care (60.94) decreased by 35.28 percentage points over the 2018 year (96.22). The barriers found include inappropriate PCP responses for after-hours needs: 1) the clinic does not have an answering service 2) clinic has answering machine with message stating a) go to the nearest ER or b) leave message after the tone 3) generic answering machine message with no after-hours information. The plan will continue to monitor after-hours care to identify any future opportunities for improvement." *Recommendation: When goals are not met for provider after-hours access, develop and implement interventions to address any identified deficiencies.*
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy PS14, Provider Orientation Plan, and its associated Standard Operating Procedure (SOP-PS14) describe the orientation process for newly contracted providers. New providers are contacted within 30 days of their contract effective date to schedule orientation. An on-site orientation meeting is scheduled at when convenient for the provider.
2. Initial provider education includes:						Identified issues are addressed in standards 2.1 through 2.18.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;			X			During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CAN Care Provider Manual and CAN Member Handbook. When comparing the CAN Care Provider Manual and CAN Member Handbook information for the current EQR, CCME again noted numerous discrepancies, including: •For Home Health Services, the CAN Care Provider Manual states there is a limit of 25 visits per calendar year for adults. The CAN Member Handbook states the limit is 36 visits per calendar year for adults. •For Hospice, the CAN Care Provider Manual says prior authorization is required. The CAN Member Handbook states no prior authorization is required. •For Medical Supplies, the CAN Care Provider Manual states medical services are covered but lists limitations and states prior authorization is required to exceed those limitations. The CAN Member Handbook states medical supplies are covered with no prior authorization required. •For Non-Emergency Transportation Services, the CAN Care Provider Manual states non-emergency transportation services are covered but lists limitations and states to call Member Services to arrange. The CAN Member Handbook does not include limitations and states to call MTM to arrange. •For Outpatient PT/OT/ST, the CAN Care Provider Manual states prior authorization is required when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provided by home health agencies. The CAN Member Handbook states prior authorization is required. •For Transplant Services, the CAN Care Provider Manual states human solid organ (heart, lung, liver, kidney) or bone marrow/stem cell transplants are covered with prior authorization. It does not include cornea transplant, which is included in the CAN Member Handbook. •For Nursing Facility benefits, the CAN Care Provider Manual lists nursing facility coverage and requirements in the benefits grid. There is no information related to coverage for skilled nursing facilities in the CAN Member Handbook. •The CAN Care Provider Manual includes Physician Services for Long-Term Care Visits in the benefits grid, but the CAN Member Handbook does not. •The CAN Care Provider Manual lists Skilled Nursing Services along with Private Duty Nursing Services in the benefit grid but the CAN Member Handbook does not include Skilled Nursing Services. *Corrective Action: Update the 2020 CAN Care Provider Manual and/or the CAN Member Handbook to ensure correct and consistent information about member benefits is included in both.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with members who are non-compliant with EPSDT screenings and services;	X					
2.8 Medical record handling, availability, retention, and confidentiality;	X					
2.9 Provider and member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The CAN Care Provider Manual includes information about pharmacy services, including prior authorizations, prescription limitations, the Preferred Drug List (PDL), and the availability of a 72-hour emergency supply of medication.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with contract requirements.	X					United maintains a Provider Directory that is available in a printable format as well as an online searchable directory that is available on the health plan's website. Onsite discussion confirmed Provider Directories are available in State Medicaid Regional Offices, United's office, Women Infant and Children offices, libraries, etc. The Provider Directory is available upon member request. Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing, confirms the web-based Provider Directory must be updated within five business days upon changes to the provider network.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					United ensures ongoing education for network providers continues, despite the restrictions resulting from the COVID-19 pandemic. The health plan has adjusted to those restrictions and now conducts ongoing provider education through alternative formats including telephonic outreach, virtual town hall sessions, the "Ask the Advocate" Program, WebEx presentations, print publications such as newsletters, and by posting information to its website.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					United's Preventive Health Guidelines (PHGs) include the American Academy of Pediatrics/Bright Futures guidelines as well as multiple recommendations from the US Preventive Services Task Force. The Provider Advisory Committee (PAC) reviews and approves the PHGs annually. They were most recently approved during the May 2020 PAC meeting.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Preventive health guidelines are available on United's website. The CAN Care Provider Manual includes a link for providers to access the guidelines. The CAN Member Handbook includes a statement that United uses preventive care guidelines from the U.S. Preventive Services Task Force and includes preventive health guidelines for adults and children. Members and providers can request a printed copy of the guidelines, and information about the guidelines is included as needed in newsletters.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					United uses evidenced-based Clinical Practice Guidelines (CPGs) to monitor and improve the quality of care provided by participating providers. The Provider Advisory Committee (PAC) reviews and approves nationally endorsed Clinical Practice Guidelines (CPGs), providing input as appropriate. PAC decisions are reviewed by the Quality Management Committee (QMC).
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO members to providers.	X					Clinical practice guidelines (CPGs) are available on United's website. The CAN Care Provider Manual include a link for providers to access the guidelines. Members and providers can request a printed copy of the guidelines, and information about the guidelines is included as needed in newsletters.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy NQM-025, Ambulatory Medical Record Review Process, states documentation standards and record review tools are developed to comply with state and federal regulations and accreditation standards. Practitioners are informed of medical record standards in the Provider Administrative Manual and via other communication documents.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The National Quality Oversight Committee (NQOC) reviews and approves documentation standards and Medical Record Documentation Standards/Tools annually. United may include additional medical record requirements that are state-specific to the state and the PAC approves the documentation standards and review tools. The CAN Care Provider Manual provides information about the Medical Record Review Process and includes specific requirements for member medical record confidentiality, organization, and documentation standards. A copy of the Medical Record Documentation Standards Audit Tool is also included.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with providers.	X					Policy NQM-025, Ambulatory Medical Record Review Process, states United requires member medical records to be maintained in a current, detailed, and organized manner that permits effective and confidential patient care and quality review. Medical record reviews (MRR) are completed annually. Improvement action plans are implemented if standards are not met. For scores below the established threshold of 85%, the provider is notified of the failing score and documentation deficiencies and informed that a follow-up review will be conducted in six months. If the score falls below the threshold on follow-up review, action may be taken by the Medical Director, PAC, or QMC. Actions may include education and counseling, additional reviews, and/or recommendation for termination of contract due to non-compliance with Medical Record Documentation Standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Aggregate results are presented annually to the PAC and QMC and included in the Quality Improvement Annual Evaluation. The 2019 Medical Record Review results indicated many providers did not pass because the requested records were not submitted, even after multiple follow-up requests. A small percentage of providers did not pass due to actual documentation issues. For all providers falling under the threshold, notification was sent, and the provider was informed a follow-up review would be conducted within 6 months. However, due to COVID-19, the follow-up review has been delayed and is expected to begin shortly.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and met all requirements of the CMS Survey Validation Protocol.	X					A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems. Evidence of this was noted in the UnitedHealthcare Provider Satisfaction Survey Results report for 2019 and in the 2019 MSCAN QI Program Evaluation report.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified. Results were presented to the QMC in the March 2020 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					United CAN ensures member rights and responsibilities as described in Policy MBR4a Notification of Rights and Policy NQM-051, Members Rights and Responsibilities. Members are informed of their rights in the CAN Member Handbook and providers are notified of member rights and responsibilities in the CAN Care Provider Manual, and information is posted on the website.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in Policy MBR4a, Notification of Rights, CAN Member Handbook, CAN Care Provider Manual, and the CAN member website. Policy MBR15a, Advanced Directives, describes members are advised on 2 types of advanced directives, a Living Will and a Medical Power of Attorney.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To access medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and to be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Member responsibilities are correctly listed in Policy MBR4a, Notification of Rights, and communicated in the CAN Member Handbook, CAN Care Provider Manual, and the member website.
3.1 To pay for unauthorized health care services obtained from non-participating providers and to know the procedures for obtaining authorization for such services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member CCO Program Education						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which enrollment starts, of all benefits to which they are entitled, including:	X					Policy MBR 2a, Information Packets to Members (Prior to the first day of the month of their enrollment), describes members are provided, via priority or first class mail, a New Member Packet within 14 days after United receives the member's enrollment data from MS DOM. Discussions during the onsite teleconference confirmed the packet includes all contract required information such as, an introduction letter, CAN ID card, a Get Started Guide, and instructions to access the CAN Member Handbook and the CAN Care Provider Directory.
1.1 Full disclosure of benefits and services included and excluded in coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits, including that no cost is passed on to the member for out-of-network services;						The CAN Member Handbook provides instructions for and limits on accessing care from an out-of-network provider. Members are informed that they may have to cover costs for unauthorized services from out-of-network providers.
1.3 Requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						The processes and requirements for prior approval of medical, behavioral health (BH), and pharmaceutical services is described in the CAN Member Handbook. Services that require prior approval are indicated in the benefits grid. Prior approval is not required for family planning services, emergency visits, or BH. Additionally, services requiring prior authorization are clearly listed in the CAN Care Provider Manual.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook and United's website provide clear and specific information instructing members on the appropriate level of care for a routine, urgent, or emergent healthcare need for medical, dental, and behavioral health services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable co-payments and formulary restrictions;						The CAN Member Handbook includes information about obtaining prescription medications and durable medical equipment. Members are directed to the website to view

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Preferred Drug List and find participating pharmacies or contact Member Services to obtain this information.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						United notifies members of changes to the CAN program no later than 30 calendar days prior to implementation and 15 days written notice of termination of a provider, as described in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, Policy MBR8b, 15-Day Written Notices of Termed Provider, and noted in the CAN Member Handbook. Updates to the Preferred Drug List (PDL) are maintained by DOM, appropriately dated to indicate the effective date, and is accessible on United's website.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, call center, nurse advice line, and member portal;						The CAN Member Handbook provides telephone numbers and descriptions for Member Services, the 24-Hour NurseLine, and information to access the secure Member Portal on the website. As discussed during the onsite teleconference, members can communicate with Members Services staff, view their benefit summary, and change their PCP when logged into the secure member portal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 A description of EPSDT services;						The CAN Member Handbook provides adequate information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). Additionally, standard operating procedures address that United conducts written, telephonic and in-person outreach to inform members of EPSDT services. Detailed EPSDT information and a current Bright Futures immunization schedule are available on the website.
1.14 Procedures for disenrolling from the CCO;						The CAN Member Handbook provides information on the requirements for disenrollment and instructs members to make requests directly to DOM either in writing or by phone.
1.15 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						The CAN Member Handbook informs members to contact Member Services or use the Provider Directory to select and obtain specific information about providers. Additionally, the provider directory lists whether a provider will accept new patients and whether the office/facility has accommodations for people with physical disabilities including offices, exam rooms, and equipment.
1.17 Instructions for reporting suspected cases of fraud and abuse;						Fraud and abuse are defined and appropriately described in the CAN Member Handbook and on the website. Instructions are provided for members to anonymously report fraud and abuse to United and DOM.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						United's Care Management Program is described in the CAN Member Handbook and on the website. Members are instructed to contact Member Services for information on the various disease and care management programs

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						offered for chronic health conditions, such as asthma, diabetes, weight loss. smoking cessation, Healthy First Steps™, Social service programs for WIC, and special education services.
1.19 Information about advance directives;						A Living Will and Medical Power of Attorney are two types of Advanced Directives described in the CAN Member Handbook, website, and CAN Care Provider Manual.
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					United notifies members by mail of significant changes in benefits 30 days prior to the effective date as described in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, and in the CAN Member Handbook. The Enrollment Department sends a written notice of any provider terminations within 15 days after the notification of the termination, as indicated in Policy MBR8b, 15 Day Written Notices of Termed Provider. During the onsite teleconference, United provided a copy of the Provider Termination Letter – MEMBER template, which addresses the requirements.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.		X				Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension and Policy MBR1b2, Notification of Oral Interpretation Services describe and outline the processes United uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME could not identify documentation of the requirement for member materials to have a minimum 12-point font for regular print items and 18-point font for large print items. During the onsite teleconference, United staff explained this requirement in documented in Policy MBR11a, Marketing Material. Upon review CCME still could not identify documentation of this requirement. This requirement was discussed during the 2019 EQR and a recommendation was made to address it. *Corrective Action Plan: Document the requirement to print written material using a minimum 12-point font and items requiring large print are completed in 18-point font.*
4. The CCO maintains and informs members how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Interpreter and translation services are provided free of charge to non-English speaking members, members who have limited English proficiency, and members who are deaf or hearing impaired as described in the CAN Member Handbook and Policy MBR1b2, Notification of Oral Interpretation Services. Additionally, contact information for Member Services, the NurseLine, and Relay 711 for members with hearing and speech limitations are noted on the website, in member materials, and on the member's ID card.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members.	X					
III C. Call Center						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.		X				United maintains a Member Services Call Center, Provider Services Call Center, and 24-Hour NurseLine. In addition, members can access a 24-hour behavioral health hotline staffed with mental health professionals, and Relay 711 is communicated in several areas. During the onsite teleconference, CCME discussed the following documentation issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services Call Centers: •The Member Services toll-free telephone number on the member website is not the same number that is listed in the CAN Member Handbook (1-877-743-8731) and in other materials. The CAN Contract, Section 6 (A) requires states that, "Members will be provided with one (1) toll free number, and the Contractor's automated system and call center staff will route calls as required to meet Members' needs." •The Member Services hours in the Wellness Mailer are not consistent with hours in the Member Handbook on page 13. •The Provider Services hours on the CAN website are not consistent with operating hours in the CAN Member Handbook on page 13. •The Provider Services hours on page 5 of the CAN Care Provider Manual are not correct. •The Provider Services number in the Provider Manual (877-743-8734) is different than the number listed in the Spring 2020 Practice Matters newsletter (800-557-9933). *Corrective Action Plan: Edit the CAN Member Handbook, CAN Care Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						call centers as required in the CAN Contract, Section 6 (A) and Section 7 (H) (1), and ensure consistent documentation of such across the respective areas.
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					Training logs confirm Call Center staff receive training at least quarterly, as required. United has several scenarios of Call Center scripts in place, such as Coordination of Benefits and Member Materials Requests.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about the preventive health and chronic disease management services available to them and encourages members to utilize these benefits.	X					Information about scheduled preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services is included in the CAN Member Handbook and on the CAN website. United's website provides information on a variety of health topics. Additionally, the plan sends targeted mailers, such as an EPSDT brochure and member newsletters, and makes calls to eligible members reminding them of screenings and well visits.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting;	X					The Healthy First Steps™ (HFS) Program Description outlines United's approach for identifying pregnant members, stratifying them by risk level, and providing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and tracks participation of pregnant members in recommended care, including participation in the WIC program.						care management and health education services for all enrolled pregnant members. HFS provides participants with the education and tools to reduce their risk of adverse pregnancy outcomes. Member engagement in the HFS program is tracked and monitored by various methods, such as communication with the OB provider. Additionally, United tracks timeliness of prenatal care by Healthcare Effectiveness Data Information Set (HEDIS) monitoring of pregnant members, and participation in HFS program. The 2019 CAN Quality Improvement Program Evaluation reports a 43% decline in pregnant members since October 2018.
3. The CCO tracks children eligible for recommended EPSDT services and immunizations and encourages members to utilize these benefits.	X					United has several policies in place to ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services for members through the month of their 21st birthday. The policies describe processes and methods for notification, tracking, and follow-up of the EPSDT program and addressing barriers by creating interventions to encourage members to use the services.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The CCO conducts a formal annual assessment of member satisfaction that meets all requirements of the CMS Survey Validation Protocol. United contracts with DSS Research, a certified Consumer Assessment of Healthcare Providers and Systems Survey vendor, to conduct the Adult and Child Surveys.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS. For United CAN Adult CAHPS, the generalizability of the survey results is difficult to discern due to low response rates (19.1%). For the Child CCC survey, generalizability of the survey results is also difficult to discern due to low response rates for general population and total population. General Population Survey Responses: 395 completed (17.72% responses rate). Total Population Survey Responses: 883 (18.18% response rate). *Recommendation: In addition to the other ongoing interventions, continue working with DSS Research to increase response rates for Adult and Child surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					United analyzes data obtained from the Member Satisfaction Survey to identify quality problems, as noted in the 2019 MS CAN QI Program Evaluation.
3. The CCO reports results of the member satisfaction survey to providers.	X					The plan reports the results of the Member Satisfaction Survey to providers as seen in the Practice Matters 2019 Newsletter.
4. The CCO reports results of the member satisfaction survey and the impact of measures taken to address any quality problems that were identified to the appropriate committee.	X					The CCO reports results of the Member Satisfaction Survey, and the impact of measures taken to address any quality problems that were identified, to the correct committee as noted in the September 2019 QMC Committee Minutes, and the MSCAN Adult CAHPs Survey results document.
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with	X					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, describes United's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
contract requirements, including, but not limited to:						processes for receiving, processing, and responding to member requests for complaints and grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance is correctly defined in the POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, the CAN Member Handbook, CAN Care Provider Manual and on the website glossary.
1.2 The procedure for filing and handling a grievance;		X				The procedure for filing a grievance is correctly described in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CAN Member Handbook, and CAN Care Provider Manual. CCME did not identify grievance procedures and instructions on the CAN website. During the onsite teleconference, United staff confirmed that grievance information is located on the Member Portal and not on the public website. However, the *CAN Contract, Section 6 (H)* requires the plan to provide specific up-to-date grievance information on a non-secure section of the website. The CAN Member Handbook and CAN Care Provider Manual correctly states grievances will be acknowledged in writing within 5 calendar days, however the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) indicates acknowledgement in 10 calendar days. Members must give written permission for someone else to file a grievance on their behalf and are instructed to contact Member Services or access the Grievance and Appeal Form in the Member Handbook. *Corrective Action Plan: Include information on grievance procedures on the non-secured section of the CAN website, as required in the CAN Contract, Section 6*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(H). Correct the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) to indicate that grievances will be acknowledged in 5 calendar days.
1.3 Timeliness guidelines for resolution of grievances as specified in the contract;	X					Timeliness for grievance resolution is correctly documented in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy. The CAN Member Handbook and the CAN Care Provider Manual do not specify that "members will receive written notice of the reason for the extension within two (2) calendar days of the decision to extend the time frame."
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.		X				The POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, indicates grievance records are retained for a minimum of 10 years, however it does not specify that grievance records will be retained, "during the entire term of this Contract and for a period of 10 years thereafter," as required by the *CAN Contract Section 11 (A).* *Corrective Action Plan: Edit the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy to include the complete grievance requirement in the CAN Contract, Section 11(A).*
2. The CCO applies the grievance policy and procedure as formulated.	X					Review of grievance files confirmed timely acknowledgements, resolution, and notification of determinations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the appropriate Quality Committee.	X					United tracks, trends ,and analyzes grievances for medical and behavioral health services, and reports results to the Service Quality Improvement Subcommittee (SQIS) quarterly, as described in the Utilization Management and Quality Improvement Program Description documents. The SQIS monitors trends related to member grievance activities and the quality of other non-clinical services. The 2019 CAN Quality Improvement Program Evaluation provides a summary of the annual grievance analysis for six key member experience categories with improvement opportunities identified. The results indicate the rate of 2019 CAN grievances (2.16/1000 members) exceeded the threshold of 1.5/1000 members and remained the same from the previous year.
4. Grievances are managed in accordance with CCO confidentiality policies and procedures.	X					
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if the change is due to dissatisfaction.	X					Policy MBR3a, Assignment of Primary Care Provider, describes Member Services staff assist members with PCP change requests for any reason including dissatisfaction.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The 2020 Quality Improvement Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					The QI Program Description provides a description of United's Multicultural Health Care Program. This program is designed to address special health care needs and support efforts to reduce health disparities.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframes for implementation and completion, and the person(s) responsible for the project(s).	X					United's QI Work Plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 Work Plans included the planned activity, specific interventions, target dates for completions, responsible parties, and oversight committees.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Management Committee (QMC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The QI Program Description, page 11, clearly outlines the responsibilities of the QMC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Advisory Committee (PAC) and the Healthcare Quality and Utilization Management Committee are responsible for evaluating and monitoring quality activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QMC is chaired by the Chief Medical Officer and membership includes United's senior leaders, department directors, and other health plan staff. A variety of network providers are included on the Provider Advisory Committee.
3. The QI Committee meets at regular intervals.	X					The minutes reviewed for the QMC reflect the committee met quarterly. The Provider Advisory Committee met at least four times per year. Minutes reflected both committees met regularly.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions. The minutes provided with the desk materials indicated the required quorums were met for each meeting. Separate meetings were not held for the CAN and the CHIP programs. However, the minutes clearly indicated which program was being discussed.
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol, "Validation of Performance Measures."	X					The performance measure validation found that United was fully compliant with all information system standards and determined United submitted valid and reportable rates for all HEDIS measures in scope of this audit. There were no concerns with United's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that United followed the measure

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specifications and produced reportable rates for all measures in the scope of the validation. United did not report three non-HEDIS measures for the CAN population. The three measures were Live Births Weighing Less Than 2,500 grams (LBW-CW), Elective Delivery (PC-01) and Cesarean Birth (PC-02 CH). Details of the validation activities and recommendations for the Performance Measures may be found in *Attachment 3, CCME EQR Validation Worksheets*. *Recommendations: United should request clarification from NCQA each year for any medical record abstraction guidance since measure specifications and related guidance can change each year. Also, pay special attention to supplemental data received from aggregated data vendors to confirm that data reflects services provided. Continue to follow NCQA guidelines for chart abstraction and supplemental data. Work proactively with DOM for clarification on core set measures that are required to be reported.*
IV D. 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					The DOM-required topics for PIPs include: Behavioral Health Readmissions, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness Management (Child-Asthma and Adult-COPD). United submitted the Behavioral Health Readmission, Improved Pregnancy Outcomes, Sickle Cell Disease Outcomes, and Respiratory Illness PIPs for validation.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					All PIPs scored in the "High Confidence in Reported Results" range.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Details of the validation activities and recommendations for the PIPs may be found in *Attachment 3, CCME EQR Validation Worksheets.*
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					The 2020 Care Provider Manual provides details of United's QI program and provider participation.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					United's policy QM-01, Monitoring of Clinical and Preventive Health Guidelines provides the process used to monitor provider compliance with United's clinical and preventive practice guidelines. For CAN, United has chosen the Comprehensive Diabetes Care and Weight Assessment and Counseling for Nutrition and Physical Activity measures. The 2019 measurement year results indicated the Weight Assessment and Counseling for Nutrition and Physical Activity measure met the DOM goal; however, the Comprehensive Diabetes Care measure did not. Interventions have been implemented to address diabetes.
4. The CCO tracks provider compliance with EPSDT service provision requirements for:						United's Standard Operating Procedure (SOP) titled, "EPSDT Services – Tracking Process" outlines the process used to track EPSDT Services.
4.1 Initial visits for newborns;	X					
4.2 EPSDT screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					Per the EPSDT Services – Tracking Process SOP, any problems identified during the EPSDT exam that require referrals are tracked on a quarterly basis. United

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provided examples of the tracking report. Like the report provided during the previous EQR, the tracking report failed to link the identified problem with the EPSDT service and did not include or indicate the members who received additional outreach for case management referrals. *Recommendation: The EPSDT tracking report should include the date the EPSDT service was provided, ICD 10 or CPT codes, treatment/referral, if provided, and members who received additional outreach for case management referrals.*
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					Annually, United evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors, the Quality Management Committee, and to the Division of Medicaid. The 2019 Quality Improvement Program Evaluation addressed all aspects of the QI Program.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					United's Utilization Management (UM) Program Description outlines the goals, scope, and staff roles for physical health, behavioral health (BH), and pharmaceutical services for members in Mississippi. Several policies describe UM processes and requirements.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The timeframe for allowing a provider to submit additional information for a service authorization noted in the *CAN Contract, Section 5 (J) (6)* and in Policy UCSMM.06.16, Initial Review Timeframes, page 9, was not included in the 2020 UM Program Description Addendum. The timeframe for notifying a member of the termination, suspension, or reduction of a previously authorized service listed in the *CAN Contract, Section 5 (L) (1)* and on page 14 of the 2020 UM Program Description Addendum was not included in Policy UCSMM.06.16, Initial Review Timeframes. *Corrective Action: Edit the UM Program Description to meet all service authorization timeframe requirements in the CAN Contract, Section 5 (J) (6) and to be*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						consistent with Policy UCSMM.06.16, Initial Review Timeframes. Edit Policy UCSMM.06.16, Initial Review Timeframes, to include all timeframe requirements for denial notices, as noted in CAN Contract, Section 5 (L) (1).
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The role of the Chief Medical Officer (CMO) is described in the 2020 Utilization Management Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, and chairing committees. The BH Regional Medical Director and the Pharmacy Director collaborate with the CMO and have clinical oversight of the respective programs.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the Healthcare Quality and Utilization Committee (HQUM) and the Quality Management Committee (QMC) for approval. The evaluation was approved by the committees on 5/21/2020 and 6/9/2020, respectively.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria are in place for determining medical necessity for all covered benefit situations.	X					Utilization management standards/criteria are documented in the CAN UM Program Description and Policy UCSMM.06.10, Clinical Review Criteria. United

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						uses external and internal clinical review standards that are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines. United's internal review criteria, BH Level of Care Guidelines, is an evidenced-based criterion applied to BH benefits.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of CAN UM approval files reflect consistent decision-making utilizing MS DOM benefit guidelines, evidenced base criteria such as MCG, and relevant clinical information.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy UCSMM.06.10 Clinical Review Criteria Rider 1, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Approval files reflect individual member circumstances are taken into consideration and review staff consult with the Medical Director about the appropriateness of service requests.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					United conducts annual inter-rater reliability (IRR) testing for physicians and non-physician clinical reviewers. Clinical staff, including medical directors, participated in an online MCG Inter-rater Reliability Assessment. The IRR evaluates three MCG products: Inpatient Care, Ambulatory Care, and Recovery Facility Care. Discussions during the onsite teleconference revealed the IRR results reported in the 2019 CAN UM Program Evaluation were incorrect. United confirmed all reviewers, including BH and pharmacy staff, successfully passed the annual IRR testing. Additional documentation was provided.
5. Pharmacy Requirements						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					OptumRx is the pharmacy benefit manager (PBM) and is responsible for implementing all pharmaceutical services for United, including but not limited to, prior authorizations and pharmacy network management. A link to the most current version of Universal Preferred Drug List (PDL) is posted on United's website. The link takes the user directly to DOM's website where the PDL is available in a searchable, electronic format.
5.2 The CCO has established policies and procedures for prior authorization of medications.	X					The CAN UM Program Description Addendum and Policy RX-047, OptumRx Prior Authorization Review Oversight explain that United has policies and procedures which follow DOM's prior authorization criteria for drugs listed on the PDL and for drugs not listed. Optum Rx conducts the PA process according to state, federal and regulatory requirements. PA requests are responded to within 24 hours and a 72-hour (3-day) supply of medication will be approved while a prior authorization request is pending.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Emergency care and post-stabilization requirements are outlined in Policy UCSMM.04.11, Consumer Safety.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					United ensures UM decisions are rendered by appropriate staff as described in Policy UCSMM.06.14, Initial Clinical Review. An initial clinical review is performed by a Mississippi licensed nurse or Referral Specialist, and a Mississippi-licensed physician or other appropriate healthcare practitioner conducts Level II medical necessity review resulting in adverse benefit determinations. Discussions during the onsite teleconference revealed physician reviewers can consult

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						internally with other plan physicians for clinical support when reviewing complex cases. Review of denial files reflect decisions are made by appropriate physician specialists such as dentists, pharmacists, or BH specialists.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes reviewed in approval files are consistent with Policy UCSMM.06.16, Initial Review Timeframes, the UM Program Description, and DOM Contract requirements.
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files for CAN members reflect reviewers attempted to obtain additional clinical information when needed, prior to rendering an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Policy UCSMM.06.15 Peer Clinical Review, documents that peer clinical reviewers who are qualified health professionals with a current license to practice render adverse benefit determinations for clinical review outcomes and will be available within one business day to discuss with the provider if needed. Denial files reflect review by a medical director, or appropriate physician, when UM clinical staff cannot approve requests that do not meet medical necessity criteria. Additionally, denials for pharmacy requests are determined by a licensed pharmacist and reviewed by a health plan medical director.
10.3 Denial decisions are promptly communicated to the provider and member	X					Review of denial files confirmed denial decisions are made according to the processes described in Policy UCSMM.06.18 Initial Adverse Determination Notices.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and include the basis for the denial of service and the procedure for appeal.						Determinations were communicated verbally to the requesting provider. An adverse benefit determination letter, mailed to the provider and member, includes the basis for the denial along with appeal procedures.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					The 2020 CAN UM Program Description and POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy outline the appeals processes. Additionally, information is provided in the Care Provider Manual, Member Handbook, and the member section of the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definition of the terms "appeal" and "adverse benefit determination" are correct in POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CAN Member Handbook, CAN Care Provider Manual, and glossary section of the website. However, the UM Program Description does not define the term "adverse benefit determination." The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy correctly defines and describes who can file an appeal. CCME identified the following documentation issues in other areas: •The CAN website does not define or describe who may file an appeal. •Page 64 of the CAN Member Handbook and page 35 of the CAN Care Provider Manual do not specify the requirement that "The legal guardian of the Member for a minor or an incapacitated adult or A representative of the Member as designated in writing to the Contractor" may file an appeal, as noted in the *CAN Contract, Exhibit D.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: To be consistent with the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and other documents, edit the UM Program Description to include the definition of the term "adverse benefit determination." Include the definition or description of who can file an appeal on the CAN website, as required by the CAN Contract, Section 6 (H). Edit the CAN Member Handbook and CAN Care Provider Manual to specify the full requirement that a member's legal guardian can file an appeal.
1.2 The procedure for filing an appeal;		X				The procedure for filing an appeal is correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CAN Member Handbook, and CAN Care Provider Manual. However, CCME did not identify information for the appeal process or procedure on the CAN website. During the onsite teleconference, United staff confirmed that appeals information is located on the Member Portal, not on the public website. However, the *CAN Contract, Section 6 (H)* requires the plan to provide specific, up-to-date appeals information on a non-secure section of the website. The CAN Care Provider Manual, page 35 incorrectly notes an acknowledgment letter is generated in 10 working days for standard appeals instead of 10 calendar days. *Corrective Action Plan: Include information on appeal processes and procedures on the non-secured section of the CAN website, as required by the CAN Contract, Section 6 (H).* *Recommendation: Correct the CAN Care Provider Manual to reflect that an appeal request is acknowledged in 10 calendar days instead of 10 working days.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Requirements for timely resolution of standard and expedited appeals are correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, the CAN Member Handbook, and the CAN Care Provider Manual.
1.6 Written notice of the appeal resolution as required by the contract;		X				The CAN appeal resolution notice template, MS Member Admin or Clinical Uphold, instructs members to file an independent external review instead of a State Fair Hearing as required by the *CAN Contract, Exhibit D*. During the onsite teleconference, United staff reported the template was previously corrected and forwarded the correct version to CCME. Upon review of the resubmitted template CCME identified the language remains uncorrected. *Corrective Action Plan: Correct the appeal resolution notice template, MS Member Admin or Clinical Uphold, to reflect members can request a State fair Hearing instead of an independent external review.*
1.7 Other requirements as specified in the contract.	X					Other appeal requirements are described in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and the CAN Member Handbook.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO applies the appeal policies and procedures as formulated.	X					Review of appeal files reflect timely acknowledgements, resolution, and notification of determinations. Additionally, the 2019 CAN UM Program Evaluation noted 100% compliance in the turn-around time for CAN member appeals.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United tracks, trends, and analyzes appeals for medical and behavioral health services, and reports results to the Service Quality Improvement Subcommittee (SQIS) quarterly, as noted in 2020 CAN Utilization Management Program Description Addendum. The SQIS reviews appeal information to identify and address trends. The SQIS Meeting Minutes on March 18, 2020 confirms Timely Filing & Utilization Review were identified as key appeal drivers with no notable trends. The 2019 CAN Quality Improvement Program Evaluation reports the categorized appeal results in a comparison table from calendar year 2017 to 2019. The report indicates 273 out 556 appeals were upheld.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					United CAN has an established Care Management Program and an established Population Health Management (PHM) Program to ensure and promote access and delivery of physical and behavioral health services. The PHM Program is coordinated in conjunction with the Quality Improvement Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The CM Program Description and Addendum, and Policy NCM 001, Identification of High Risk Members for Case Management, describe methods for how eligible members are identified and referred into case management. In addition to referral guidelines and results from advanced data sources, United uses claims, health risk assessment results, medical records, and utilization management data to identify members who can benefit from case management. The Health Risk Assessment tool is primarily used to screen and identify eligible members into case management. Other methods include, but are not limited to, review of clinical claims, medical records, and utilization management data.
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, Case Management Process, adequately addresses that a health risk assessment will occur within 30 calendar days for members newly assigned to medium and high-risk categories. The treatment plan will be completed within 30 calendar days after the assessment.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					Qualifications for Care Managers include requirements such as holding an unrestricted RN license and CM certification, Behavioral Health Advocate qualifications include holding a Masters degree or Ph.D., and unrestricted license in their state.
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					The Care Management Program Description and Addendum states United will "update the risk level assignment when there has been a change in the health status, needs, or a significant health care event relevant to the Member's risk level assignment."
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					
7.1 Members in the high and medium risk categories are assigned to a specific Care Management team member and provided instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.6 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as Title V Maternal and Child Health Program, and the Department of Human Services, developing, planning and assisting members with information about community-based, free care initiatives and support groups;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract including high risk perinatal and infant services.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					The CAN Care Management Program Description and Addendum state United will transfer the member's care management history, six months of claims history, and other pertinent information to DOM when a member disenrolls. If a member transfers to another health plan, the plan will provide the member's utilization information and care plan data to the new health plan upon request. Policy NCM 002, Case Management Process, indicates cases are evaluated for closure when a member disenrolls from care management or changes health plans.
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					
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					The 2020 CAN Care Management Program Description describes the Transitional Care Management Program as a subgroup of the WPC Management Program for members who are in a low chronic risk category. Policy MS021, Transitional Care Management, outlines processes and requirements for managing transitions of care across healthcare settings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, Policy RX-046, Pharmacy – Automated Transition of Care (ToC), indicates United provides new members with continuation of their current medications until the provider can transition the member to formulary medications.
2. The CCO acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting.	X					Policy MS021, Transitional Care Management, describes United's process for monitoring new members and members transferring from another health plan, discharging from a clinic or inpatient setting, including a psychiatric residential treatment facility (PRTF), and members receiving care from terminated providers.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process.	X					The interdisciplinary transitional care team coordinates and manages required services to ensure continuity of care and prevent duplication of services as members return to their home or other community setting. The team includes, but is not limited to, Care Managers, BH staff, pharmacy staff, and medical directors.
4. The CCO meets other Transition of Care Requirements.	X					Policy MS021, Transitional Care Management and the CAN Care Management Program Description, correctly describes other requirements for Transition of Care. Additionally, members are informed of the requirements in the CAN Member Handbook. CCME identified that page 4 of Policy MS021, Transitional Care Management, inadvertently cut off the complete contract language describing the requirement for members in their second and third trimester. Additionally, Policy HFS 003, Covered Services and Continuity of Benefit Coverage for Pregnant Members, makes references to the *CAN Contract* but does not address the complete contract language to "allow continued access to the Member's prenatal care provider and any provider currently treating the Members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						chronic, acute medical or behavioral health/substance use disorder through the postpartum period." *Recommendation: Edit Policy MS021, Transitional Care Management, and Policy HFS 003, Covered Services and Continuity of Benefit Coverage for Pregnant Members, to include the complete transition of care requirement for members in their second and third trimester, as noted in the CAN Contract, Section 8 (B) (5).*
V F. Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					The UM Program Evaluation is an overview and summary of the initiatives and activities to identify opportunities for improvement. The evaluation report indicates the UM Program was effective in meeting its objectives.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2019 CAN Utilization Management Program Evaluation was reviewed and approved by the Healthcare Quality and Utilization Management (HQUM) on May 21, 2020 and by the Quality Management Committee (QMC) on June 9, 2020.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					United has delegation agreements with: •OptumHealth - Behavioral Health Case Management, Utilization Management, Quality Management, Network Contract Management, and Claims Processing •Dental Benefit Providers - Dental Network Services and 3rd Party Dental Administrator •eviCore National - Radiology and Cardiology Management Services •MARCH Vision Care - Vision and Eye Care Benefit Administration Services, Vision Network Contract Management, Call Center Operations, Claims Processing •Optum Rx - Pharmacy Benefit Administration Services •Medical Transportation Management - Non-Emergency Transportation United delegates credentialing to the following organizations: •Hattiesburg Clinic •River Region Health System •HubHealth •University Physicians, PLLC •HCA Physician Services •Health Choice, LLC •North Mississippi Medical Center •Ochsner •Premier Health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						United provided sample copies of their delegation agreements.
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					Policy UCSMM 03.14, Delegated Credentialing Oversight Policy & Procedure, provides the process the Plan follows to evaluate and monitor the delegated entity's capacity to perform the delegated activities. In addition to delegated credentialing, other health plan functions are delegated. Processes for pre-delegation assessment, ongoing monitoring, and annual oversight are documented in Policy DOV-01, Delegated Vendor Oversight Strategy. Copies of the annual oversight monitoring was provided for all delegated entities. The monitoring tools used for the annual oversight monitoring included all Mississippi credentialing requirements. The query of the social security death master file, the requirement for the Ownership Disclosure form, and the monitoring of practitioner quality concerns (recredentialing) are not delegated functions and scored as N/A on the monitoring tools. Several of the credentialing and recredentialing files reviewed during the monitoring of the credentialing and recredentialing delegates noted the requirement for CLIA certificate was marked as N/A with an explanation noted as "Doesn't have a CLIA." It was unclear from the explanation if the provider did not provide laboratory services or the file did not contain the required CLIA certificate. Also, the monitoring for OptumHealth, Dental Benefit Providers, and MARCH Vision Care did not include a file

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review of the delegates credentialing and recredentialing files. *Recommendation: Include in delegation monitoring oversight a sample of credentialing and recredentialing files and ensure the CLIA certificate is included in the credentialing and recredentialing files for practitioners providing laboratory services.*

CCME CHIP Data Collection Tool

Plan Name:	**UnitedHealthcare Community Plan MS CHIP**
Review Performed:	2020

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy CE-01, Development and Maintenance of Policies and Procedures and Standard Operating Procedures, defines processes for policy review and revision. Policies and SOPs must be current, reviewed annually, and accessible to all employees. Onsite discussion confirmed policies are housed on a SharePoint site for staff access. Newly created and revised policies are reviewed by the policy and review Steering Committee prior to review and approval by other applicable committees, such as the Health Quality Utilization Management (HQUM) Committee, Service Quality Improvement Subcommittee (SQIS), and the Quality Management Committee (QMC).
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to members. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles:						Current staffing is adequate for ensuring health care products and services are provided to members. United reports there are currently fewer than five open positions, and recruiting activities are in progress.
1.1 *Chief Executive Officer;	X					Jeff Wedin is the Chief Executive Officer.
1.2 *Chief Operating Officer;	X					Douglas "Mitch" Morris is the Chief Operating Officer.
1.3 Chief Financial Officer;	X					Heath Seaman is the Chief Financial Officer.
1.4 Chief Information Officer;	X					Mike Rogers is the Chief Information Officer.
1.4.1 *Information Systems personnel;	X					
1.5 Claims Administrator;	X					Shandrika Sutton is the Claims Administrator
1.6 *Provider Services Manager;	X					Nicole Tucker is the Provider Services Manager and Tamara Keane is the Provider Relations Manager.
1.6.1 *Provider credentialing and education;	X					
1.7 *Member Services Manager;	X					Kenisha Potter is Director of Member Services. Marianne Bullian is Member Services Manager and Kobie Wells is Member Outreach Manager.
1.7.1 Member services and education;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Grievance and Appeals Coordinator;	X					Sheree Thompson is the Appeals and Grievances Coordinator.
1.9 Utilization Management Coordinator;	X					Kimberly Bollman is the Health Services / Population Health Director. She is supported by a Prior Authorization Manager, IP Case Manager, and Case Management Managers.
1.9.1 *Medical/Care Management Staff;	X					
1.10 Quality Management Director;	X					Cara Roberson is the Quality Management Director and Lynn Mitchell is Quality Management Manager.
1.11 *Marketing and/or Public Relations;	X					
1.12 *Medical Director;	X					Amit Prasad, MD, is the Chief Medical Officer.
1.13 *Compliance Officer.	X					Juan Rodas is serving as Interim Compliance Officer since the position became vacant in August 2020. United has three current candidates for the position and expects to have the position filled within three to four weeks.
2. Operational relationships of CCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					United's ISCA documentation included a detailed breakdown of the percent of clean claims paid for the last 13 months. United's monthly percent paid average

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for 30 and 90 days surpasses Mississippi's timeliness requirements. Over the 13 months of data provided, United paid 99.89% of clean claims within 30 days, and 99.99% of clean claims within 90 days.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					United collects enrollment and member demographic data in its member/encounter/claims system, CSP-Facets. United uses the member ID provided in the State's 834 file to identify enrollees in its systems. Those systems are capable of tracking members across multiple product lines while retaining the histories associated with each. On a weekly basis, United runs a report to identify members with duplicate records. Duplicate records are voided with a note to the correct subscriber ID. Finally, United provided a short history of updates to its member/encounter/claims system which shows the system yearly upgrades and maintenance occurring on a scheduled basis.
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					United uses NCQA certified software MedMeasures for HEDIS and HEDIS-like reporting. The MedMeasures software is updated by United's vendor annually, and the updates are validated by United to ensure successful operation. HEDIS and HEDIS-like reports are sourced from data that is reviewed by a HEDIS auditor and stored in a dedicated data warehouse.
4. The CCO has a disaster recovery and/or business continuity plan, the plan has been tested, and the testing has been documented.	X					United has a disaster recovery (DR) plan in place for systems which service its Medicaid and Medicare operations. United's documentation indicates there are sound business continuity practices in place to avoid outages, and an impact analysis process to prioritize recovery if there is an outage. Finally, United conducts

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						tabletop DR exercises twice annually to review and revise the DR plan.
I D. Compliance/Program Integrity						
1. The CCO has a Compliance Plan to guard against fraud, waste and abuse.	X					The corporate UnitedHealthcare Anti-Fraud, Waste and Abuse Program 2020 – 2021 (FWA Plan) along with the UnitedHealthcare Community Plan of Mississippi Fraud, Waste, and Abuse Program 2020 – 2021 addendum were submitted for review. The FWA Plan addendum describes United's commitment "to providing Mississippi members with access to high-quality medical care while protecting the ethical and fiscal integrity of the program by operating a Fraud, Waste and Abuse (FWA) program that includes: prevention, detection, reporting, corrective action and best practices." The UnitedHealthcare FWA Plan describes the comprehensive FWA program and the addendum includes expectations specific to the state of Mississippi.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					Any issues identified are described in the standards that follow.
2.1 Standards of conduct;						The UnitedHealth Group Code of Conduct: Our Principles of Ethics & Integrity (Code of Conduct) provides guidelines for helping staff "sustain the highest possible standards of ethical behavior." The Code of Conduct addresses expectations for ethical work behavior, as well as information about violations of the Code of Conduct and policies and who to contact with questions and concerns.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Identification of the Fraud and Abuse Compliance Officer;						The corporate FWA Plan provides information about the overarching Compliance Program that applies to all businesses within the UnitedHealth Group, including UnitedHealthcare Community & State plans. The FWA Plan briefly describes the role of the UnitedHealthcare Program Integrity Chief Compliance Officer and Vice President, Payment Integrity. The Mississippi addendum to the FWA Plan references the Compliance Officer and briefly describes the role of the Compliance Officer. CCME noted the Mississippi addendum references the compliance officer by name and the information is outdated. *Recommendation: Update the reference to the Compliance Officer in the Mississippi addendum to the FWA Plan.*
2.3 Information about the Compliance Committee;						The corporate FWA Plan discusses the UnitedHealthcare Compliance Program Integrity Oversight Committee. CCME received minutes for the UnitedHealthcare Community Plan of Mississippi Compliance Oversight Committee. The 2020 Quality Improvement Program Description, page 15, includes detailed information about the health plan's Compliance Committee.
2.4 Compliance training and education;						The corporate FWA Plan provides an overview of Compliance training for employees, internal and external vendors/contractors, and network providers. The CHIP 2020 Care Provider Manual (Provider Manual) provides thorough information about FWA (including definitions, examples, reporting methods), ethics and integrity, and the Compliance Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						United distributes educational materials to its members regarding FWA detection through written communications designed to raise awareness of how to identify potential FWA and how to report suspected FWA. The CHIP Member Handbook includes a brief explanation of FWA, provides examples of FWA, and information about reporting FWA.
2.5 Lines of communication;						As stated in the FWA Plan, employees are expected to report and/or provide information about compliance violations and suspected FWA. United takes precautions to maintain the confidentiality of those who report and prohibits retaliatory actions against anyone who, in good faith, reports or provides information about suspected violations. Reporting methods include designated web portals, call centers, databases, and anonymous hotlines. The CHIP Provider Manual and Member Handbook include the telephone number for reporting to the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum (1-866-242-7727) but do not include the phone number for reporting to DOM's Office of Program Integrity (1-800-880-5920). The Health Talk member newsletters contain telephone numbers to report suspected fraud and abuse by providers or members to DOM's Office of Program Integrity but not to Optum's AFRS unit. *Recommendation: Ensure all options for reporting suspected FWA are included in the CHIP Provider Manual and Member Handbook as well as in the Health Talk newsletters.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Enforcement and accessibility;						The Code of Conduct informs staff that all violations will be taken seriously and may result in discipline, up to and including termination of employment and possible legal action, including referral to law enforcement. The CHIP Member Handbook informs members that "Committing fraud or abuse is against the law." The handbooks further state that making an intentional false statement or claim to receive or increase benefits can result in criminal charges, prosecution, and loss of benefits. The CAN and CHIP 2020 Care Provider Manuals include information about the expectation that provides give assistance in notifying United about any suspicions of or actual FWA, cooperate with initiatives to detect, prevent and combat FWA, and cooperate with any review of such a situation.
2.7 Internal monitoring and auditing;						The FWA Plan addresses monitoring and auditing activities, including: •Prospective detection (pre-payment data analysis, data mining, and analysis of abnormal billing patterns) •Retrospective detection (post-payment data and payment error analytics) •Industry trend analysis •Exclusion and sanction monitoring •Monitoring and oversight of delegated entities, providers, and related entities •Provider audits •FWA Program compliance and performance audits

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Response to offenses and corrective action;						The FWA Plan and its related Mississippi Addendum state investigations of FWA are conducted by the Special Investigations Unit (SIU). The SIU staffing includes investigators with experience in health care and prescription drug FWA, industry business practices and systems, and infrastructure. The Payment Integrity Department reviews and incorporates the latest research on detecting new and emerging FWA schemes and practices. Actions taken in response to detected offenses include, but are not limited to: •Provider notification and education •Recovery efforts •Termination of network participation •Referral to law enforcement, regulatory, and administrative agencies
2.9 Exclusion status monitoring.						Policy ID-5881, New Hire and Periodic Employee Sanction Review states, "UnitedHealth Group will not knowingly hire, continue to employ, or contract with someone of law or contract prohibits the person from providing services for our customers." The policy defines the monitoring conducted and the frequency of the monitoring. Policy ID-5787, Practitioner Sanctions Monitoring, describes sanctions monitoring of network providers.
3. The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The 2020 Quality Improvement Program Description, page 15, includes detailed information about the health plan's Compliance Committee. The committee meets at least quarterly and as needed, and its quorum is defined as 51% of membership. Members may designate surrogate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						attendees with voting privileges. Responsibilities of the local Compliance Committee include: •Supporting the prevention, detection, and correction of legal and regulatory risks and promoting compliance •Ensuring accountability throughout the organization for compliance with legal and business requirements •Identifying and promoting best practices, resources, and operational efficiencies. •Reviewing regulatory concerns and status of corrective action plan(s) •Reviewing and suggesting changes to key policies and procedures as indicated •Reviewing results of internal and external audits, reports, and compliance indicators •Providing CCO leadership and appropriate internal and corporate departments with key information and updates about CCO compliance activities The Compliance Committee Charter states the Compliance Committee co-chaired by the Compliance Officer and Plan CEO. However, the QI Program Description, pages 15 and 16, states the Compliance Committee is chaired only by the Compliance Officer. Onsite discussion confirmed the documentation in the Compliance Committee Charter is correct. *Recommendation: Revise the QI Program Description to include correct information about who chairs the Compliance Committee.*
4. The CCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The CCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Optum's Prospective Investigation and Clinical Review Policy and Procedure provides the activities conducted throughout the pre-payment investigation of detected claims. Additional information about conducting investigations of reported incidents is found in the FWA Plan and its associated Mississippi Addendum.
6. The CCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The CCO implements and maintains a Pharmacy Lock-In Program.	X					
I E. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

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 a	X					United policies and procedures define processes for credentialing and recredentialing of health care providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
manner consistent with contractual requirements.						
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 National Credentialing Committee (NCC) makes credentialing decisions and communicates the decisions to the health plan. The NCC includes participating providers from the health plan networks, Medical Directors, and a designated Medical Director Chairperson. The health plan's Provider Advisory Committee (PAC) is chaired by United's Chief Medical Officer and is responsible for reviewing credentialing and recredentialing decisions of the NCC. Membership of the PAC includes providers with specialties of pediatrics, obstetrics and gynecology, internal medicine, psychiatry, dentistry, and family medicine. The PAC reports to the Quality Management Committee
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						Identified issues are discussed in standards 3.1.1 through 3.1.16.
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					One initial credentialing file did not contain a copy of the query of the System for Award Management (SAM). *Recommendation: Ensure all initial credentialing files contain a screenshot showing the date the SAM was queried and the query results.*
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					

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					
3.1.12 Query of the National Plan and Provider Enumeration System (NPPES)	X					One initial credentialing file did not contain a copy of the query of the National Plan and Provider Enumeration System (NPPES). *Recommendation: Ensure all initial credentialing files contain a screenshot showing the date the NPPES was queried and results of the query.*
3.1.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.14 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number or providers billing laboratory services;	X					
3.1.15 Ownership Disclosure form.	X					For one initial credentialing file, the Ownership Disclosure Form was signed and dated in 2015, more than four years prior to credentialing approval date. Note: This is a repeat finding from the 2019 EQR. During the 2019 EQR, CCME noted some files contained outdated Ownership Disclosure Forms. United presented a response in the corrective action documentation for the 2019 EQR that "UnitedHealthcare Community Plan

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						will continue to collect at the time of contracting and maintaining to the 3 year signature date policy." *Recommendation: Ensure Ownership Disclosure Forms are current at the time of initial credentialing.*
3.1.16 Fingerprints, when applicable.	X					
3.2 Site assessment.	X					
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						Issues are addressed in standards 4.2.1 through 4.2.14.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.5 Practitioner attestation statement;	X					
4.2.6 Re-query the National Practitioner Data Bank (NPDB);	X					
4.2.7 Re-query the System for Award Management (SAM);	X					
4.2.8 Re-query for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline) and the MS DOM Sanctioned Provider List;	X					
4.2.9 Re-query for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 Re-query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.11 Re-query of the National Plan and Provider Enumeration (NPPES);	X					
4.2.12 CLIA certificate or waiver of a certificate of registration along with a CLIA identification number for providers billing laboratory services;	X					
4.2.13 In good standing at the hospital designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.14 Ownership Disclosure form.	X					
4.3 Provider office site reassessment, when applicable.	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					The Credentialing Plan defines the process for evaluating potential quality of care concerns which may result in a network provider's suspension, restriction, or termination. This process includes review by the Medical Director, and if the Medical Director determines that action is necessary, and in collaboration with the Regional Peer Review Committee chairperson and the regional chief medical officer, a network provider's network participation may be restricted or suspended. If immediate action is not warranted, the information is referred to the Peer Review Committee, and possibly to the National Peer Review and Credentialing Policy Committee. Providers are notified in writing of any suspension, restriction, or termination for cause.
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.		X				File review findings for organizational providers include: •All initial credentialing files for organizational providers contained evidence that the MS DOM Sanctioned Provider List was checked, but for three of the files, the date the MS DOM Sanctioned Provider List was updated was not captured on the document included in the file. During onsite discussion, United staff stated they would follow-up with CCME, but no additional information was provided. •All recredentialing files for organizational providers contained screenshots of the SAM query; however, four of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the screenshots did not display the date the query was conducted. •Three recredentialing files for organizational providers included screenshots of the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE) query; however, the screenshots did not display the date the query was conducted. •One recredentialing file for an organizational provider did not contain evidence of the query of the OIG LEIE. *Corrective Action: Ensure the date the MS DOM Sanctioned Provider List was updated is included on screenshots captured as evidence of query. Ensure primary source verification of the SAM includes the date the query was conducted. Ensure primary source verification of the OIG LEIE is included in all files and that it includes the date the query was conducted.*
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.						Policy PS3, Geographic Access Standards, defines the PCP geographic access standards for United's provider network. Standards listed in the policy comply with contract requirements; however, the table on page two of the policy does not include urban and rural geographic access standards for OB/GYN and DME Providers, as defined in the *CHIP Contract, Section 7 (B) (1)*, Table 4. Onsite discussion revealed this was on oversight when the policy was last revised. Geo access reports confirm these provider types are included in the assessment of network adequacy. *Recommendation: Revise Policy PS3 to include urban and rural geographic access standards for OB/GYN and DME*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Providers, as defined in the CHIP Contract, Section 7 (B) (1), Table 4.
1.1 The CCO has policies and procedures for notifying primary care providers of the members assigned.	X					As stated in Policy PS10, PCP Panel Notification, United makes member panel information available to all participating PCPs via the secure provider portal. United identifies PCPs with changes in member panels and mails post card notification about these changes within five days of receiving the Member Listing Report from DOM.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy PS4, Member Enrollment Verification, describes processes to verify member enrollment status. Network providers can access enrollment information via the secure provider portal. Out of network providers can verify enrollment by calling the telephone number on the member ID card.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					During initial credentialing and contracting, PCPs inform the health plan of any member panel restrictions, as defined in Policy PS10, PCP Panel Notification. If no panel restrictions are communicated, it is understood that the PCP agrees to accept all members as assigned. The Provider Directory explains indicates if providers are not accepting new patients. Onsite discussion confirmed United runs quarterly reports of providers who are not accepting new patients and have a standing monthly meeting to review and ensure there are enough providers in the network who are accepting new patients to meet member needs.
1.4 Members have two PCPs located within a 15-mile radius for urban counties or two PCPs within 30 miles for rural counties.	X					Quarterly geographic access reports are developed to assess compliance with the contractual standards for PCP access.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 displays standards for some rural family medicine, internal medicine, pediatricians, and nurse practitioners as 1 provider within 60 miles. The standard noted in the report for some urban family medicine, internal medicine, pediatrics, and nurse practitioners as 1 within 30 miles. Onsite discussion revealed the providers assessed under these standards may not act as PCPs, e.g. those working in urgent care centers, etc.
1.5 Members have access to specialty consultation from network providers located within the contract specified geographic access standards.		X				Policy PS3, Geographic Access Standards, defines the specialist geographic access standards for United's provider network. The most recent Managed Care Accessibility Analysis (Geo access report) dated July 23, 2020 lists the standard for rural emergency medicine as one provider within 60 miles. However, the standard stated in the *CHIP Contract, Section 7 (B)* is 1 within 30 miles for both urban and rural. CCME noted the goal of 90% of members with access to various specialties is not met for some specialty types. During onsite discussion, United acknowledged this finding and confirmed they continue to target and work toward securing contracts with the needed specialty types. *Corrective Action: Ensure Geo access reports are run using the contractually-required standard for Emergency Care Providers.*
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					The Annual Assessment of Network Adequacy Report dated March 2020 states: "The goal is for 90 percent of members to have access to the specific practitioner types

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						within the miles designated based on the population of the geographic area." During onsite discussion, United confirmed the established goal is that 90% of members have access to PCPs. Geo access reports are run quarterly and evaluated to determine the adequacy of the provider network. The Geo access report dated July 23, 2020 confirms adequate access for PCPs for members across the state.
1.7 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, complex medical needs, and accessibility considerations.	X					United's Multicultural Health Care Program activities include: •Assessing race/ethnicity and languages of members and providers and focusing on initiatives to reduce health care disparities, improve cultural competency in member materials and communication, and to advance network adequacy to address the needs of a diverse membership. United conducts a population language profile assessment at least every three years, and an assessment of the practitioner network to identify language or cultural gaps is conducted at least every three years. •Measuring activities to reduce disparities. •Evaluating the effectiveness of interventions on the reduction of disparities and prioritizing opportunities to reduce health care disparities and improve CLAS. •Embracing diversity by creating a continuum of culturally sensitive initiatives that promote health and prevent avoidable health care cost.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Practitioner Accessibility						
2.1 The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy PS2, Access Standards – Appointment Availability Requirements, defines appointment availability requirements for providers who provide services to CAN and CHIP members. The appointment availability standards listed in the policy are compliant with contractual requirements. Provider education includes information about appointment availability standards. The policy states, "Quarterly assessments are performed to gauge 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, as well as to support identification of improvement opportunities and development of corrective action initiatives." The Annual Assessment of Network Adequacy Report dated March 2020 documents results for 2019 assessments of practitioner accessibility. The document states, "Assessment of the 2019 PCP practitioner survey for after-hours care for primary care physicians demonstrate the goal was not met. The 2019 after-hours care (60.94) decreased by 35.28 percentage points over the 2018 year (96.22). The barriers found include inappropriate PCP responses for after-hours needs: 1) the clinic does not have an answering service 2) clinic has answering machine with message stating a) go to the nearest ER or b) leave message after the tone 3) generic answering machine message with no after-hours information. The plan will continue to monitor after-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						hours care to identify any future opportunities for improvement." *Recommendation: When goals are not met for provider after-hours access, develop and implement interventions to address any identified deficiencies.*
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy PS14, Provider Orientation Plan, and its associated Standard Operating Procedure (SOP-PS14) describe the orientation process for newly contracted providers. New providers are contacted within 30 days of their contract effective date to schedule orientation. An on-site orientation meeting is scheduled at when convenient for the provider.
2. Initial provider education includes:						Identified issues are addressed in standards 2.1 through 2.18.
2.1 A description of the Care Management system and protocols, including transitional care management;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums;			X			During the 2019 EQR, CCME noted numerous discrepancies in the benefits information presented in the CHIP Care Provider Manual and Member Handbook. When comparing the CHIP Care Provider Manual and Member Handbook information for the current EQR, CCME again noted numerous discrepancies, including: •The CHIP Care Provider Manual does not include Parenting Education as a benefit, but the CHIP Member Handbook does.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•For Prosthetic/Orthotic Devices, the CHIP Care Provider Manual does not include the coverage restrictions for orthotic shoes that are included in the CHIP Member Handbook. •For Speech Therapy, the CHIP Care Provider Manual does not include the restrictions on maintenance speech therapy that are found in the CHIP Member Handbook. *Corrective Action: Update the CHIP Care Provider Manual and/or the CHIP Member Handbook to ensure correct and consistent information about member benefits is included in both.*
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					Appointment scheduling timeframes are defined in the *CHIP Contract, Section 7 (b) (2).* The CHIP Care Provider Manual section titled "Timeliness Standards for Appointment Scheduling" does not include the requirement for: •Dental Providers—Routine and Urgent visits •Urgent Care Providers •Behavioral Health/Substance Use Disorder providers (post-discharge from an acute psychiatric hospital when the CCO is aware of the member's discharge) *Recommendation: Revise the "Timeliness Standards for Appointment Scheduling" section of the CHIP Care Provider Manual to include the missing information.*
2.6 Recommended standards of care including Well-Baby and Well-Child screenings and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Responsibility to follow-up with members who are non-compliant with Well-Baby and Well-Child screenings and services;		X				The PCP Responsibilities section of the CHIP Care Provider Manual does not clearly state the responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule. Refer to *CHIP Contract Section 7 (H) 2 (m)*. *Corrective Action: Revise the CHIP Care Provider Manual to include the PCP's responsibility to follow up with members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule.*
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and member grievance and appeal procedures, including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					The CHIP Care Provider Manual details information about pharmacy services, including prior authorizations, prescription limitations, the Preferred Drug List (PDL), and the availability of a 72-hour emergency supply of medication.
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a member to another PCP;	X					
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.	X					United maintains a Provider Directory that is available in a printable format as well as an online searchable directory that is available on the health plan's website. Onsite discussion confirmed Provider Directories are available in State Medicaid Regional Offices, United's office, Women Infant and Children offices, libraries, etc. The Provider Directory is available upon member request. Policy NQM-052 MS Rider 1, Web-Based Directory Usability Testing, confirms the web-based Provider Directory must be updated within five business days upon changes to the provider network.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					United ensures ongoing education for network providers continues, despite the restrictions resulting from the COVID-19 pandemic. The health plan has adjusted to those restrictions and now conducts ongoing provider education through alternative formats including telephonic outreach, virtual town hall sessions, the "Ask the Advocate" Program, WebEx presentations, through

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						print publications such as newsletters, and by posting information to its website.
II D. Primary and Secondary Preventive Health Guidelines						
1. The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					United's Preventive Health Guidelines (PHGs) include the American Academy of Pediatrics/Bright Futures guidelines as well as multiple recommendations from the US Preventive Services Task Force. The Provider Advisory Committee (PAC) reviews and approves the PHGs annually. They were most recently approved during the May 2020 PAC meeting.
2. The CCO communicates to providers the preventive health guidelines and the expectation that they will be followed for CCO members.	X					Preventive health guidelines are available on United's website. The CHIP Care Provider Manual includes a link for providers to access the guidelines. The CHIP Member Handbook includes preventive health guidelines for children. Members and providers can request a printed copy of the guidelines, and information about the guidelines is included as needed in newsletters.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Pediatric and adolescent preventive care with a focus on Well- Baby and Well-Child services;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Recommendations specific to member high-risk groups;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 Behavioral health.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated, and are developed in conjunction with pertinent network specialists.	X					United uses evidenced-based Clinical Practice Guidelines (CPGs) to monitor and improve the quality of care provided by participating providers. The Provider Advisory Committee (PAC) reviews and approves nationally endorsed Clinical Practice Guidelines (CPGs), providing input as appropriate. PAC decisions are reviewed by the Quality Management Committee (QMC).
2. The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO members.	X					Clinical practice guidelines (CPGs) are available on United's website. The CHIP Care Provider Manual includes a link for providers to access the guidelines. Members and providers can request a printed copy of the guidelines and information about the guidelines is included as needed in newsletters.
II F. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy NQM-025, Ambulatory Medical Record Review Process, states documentation standards and record review tools are developed to comply with state and federal regulations and accreditation standards. Practitioners are informed of medical record standards in the Provider Administrative Manual and via other communication documents. The National Quality Oversight Committee (NQOC) reviews and approves documentation standards and Medical Record Documentation Standards/Tools annually. United may include additional medical record requirements that are state-specific to the state and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PAC approves the documentation standards and review tools. The CHIP Care Provider Manual provides information about the Medical Record Review process and includes specific requirements for member medical record confidentiality, organization, and documentation standards. A copy of the Medical Record Documentation Standards Audit Tool is also included.
2. The CCO monitors compliance with medical record documentation standards through periodic medical record audits and addresses any deficiencies with the providers.	X					Policy NQM-025, Ambulatory Medical Record Review Process, states United requires member medical records to be maintained in a current, detailed, and organized manner that permits effective and confidential patient care and quality review. Medical record reviews (MRR) are completed annually. Improvement action plans are implemented if standards are not met. For scores below the established threshold of 85%, the provider is notified of the failing score and documentation deficiencies and informed that a follow-up review will be conducted in six months. If the score falls below the threshold on follow-up review, action may be taken by the Medical Director, PAC, or QMC. Actions may include education and counseling, additional reviews, and/or recommendation for termination of contract due to non-compliance with Medical Record Documentation Standards. Aggregate results are presented annually to the PAC and QMC and included in the Quality Improvement Annual Evaluation. The 2019 Medical Record Review results indicated many providers did not pass because the requested records

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						were not submitted, even after multiple follow-up requests. A small percentage of providers did not pass due to actual documentation issues. For all providers falling under the threshold, notification was sent, and the provider was informed a follow-up review would be conducted within 6 months. However, due to COVID-19, the follow-up review has been delayed and is expected to begin soon.
II G. Provider Satisfaction Survey						
1. A provider satisfaction survey was conducted and meets all requirements of the CMS Survey Validation Protocol.	X					A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems. Evidence of this was noted in the UnitedHealthcare Provider Satisfaction Survey Results report for 2019.
3. The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified.	X					The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems identified. Results were presented to the QMC in the March 2020 meeting.

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					United ensures member rights and responsibilities as described in Policy MBR4a, Notification of Rights and Policy NQM-051, Members Rights and Responsibilities. Members are informed of their rights in the CHIP Member Handbook and providers are notified of member rights and responsibilities in the CHIP Care Provider Manual. Information is also posted on the website under Member Resources.
2. Member rights include, but are not limited to, the right:	X					Member rights are listed in Policy MBR4a, Notification of Rights, CHIP Member Handbook, CHIP Care Provider Manual, and the CHIP member website. Policy MBR15a, Advanced Directives, describes members are advised on wo types of Advanced Directives, a Living Will and a Medical Power of Attorney.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.6 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.7 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.8 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the member;						
2.9 To be furnished with health care services in accordance with 42 CFR §438.206 – 438.210.						
3. Member responsibilities include the responsibility:	X					Member responsibilities are correctly listed in Policy MBR4a, Notification of Rights and communicated in the CHIP Member Handbook, CHIP Care Provider Manual, and the member website.
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff;						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						
III B. Member Program Education						
1. Members are informed in writing, within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled, including:	X					Policy MBR 2a, Information Packets to Members (Prior to the first day of the month of their enrollment), indicates members are provided, via priority or first class mail, a New Member Packet within 14 days after United receives the member's enrollment data from DOM. Discussions during the onsite teleconference confirmed the packet includes all required information, such as an introduction letter, CHIP ID card, CHIP Member Handbook, and instructions to access a Provider Directory.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include family planning and direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 Limits of coverage and maximum allowable benefits; information regarding co-payments and out-of-pocket maximums;						The CHIP Member Handbook provides instructions for accessing care from an out-of-network provider. CHIP Members are informed that they may have to cover the costs for unauthorized services from out-of-network providers.
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Processes and requirements for prior approval of medical, behavioral health (BH), and pharmaceutical services are described in the CHIP Member Handbook. Services that require prior approval are indicated in the benefits grid. Prior approval is not required for family planning services, emergency visits, or BH. Additionally, services requiring prior authorization are clearly listed in the CHIP Care Provider Manual.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The CHIP Member Handbook and United's website provide clear and specific information instructing members about appropriate level of care for routine, urgent, or emergent healthcare needs for medical, dental, and behavioral health services.
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The CHIP Member Handbook includes information about obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and find participating

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pharmacies or contact Member Services to obtain this information.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						United notifies members of changes to the CHIP program no later than 30 calendar days prior to implementation and within 15 days of written notice of termination of a provider, as described in Policy MBR8a, Proper Notice to Members on Written Notices in Material Changes, Policy MBR8b, 15 Day Written Notices of Termed Provider, and in the CHIP Member Handbook. Updates to the Preferred Drug List (PDL) are maintain by DOM, appropriately dated to indicate the effective date, and is accessible on United's website.
1.9 A description of the member's identification card and how to use the card;						
1.10 Primary care provider's roles and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, and the member portal;						The CHIP Member Handbook provides telephone numbers and descriptions for Member Services, the 24-Hour NurseLine, and information to access the secure Member Portal on the website. As discussed during the onsite teleconference, members can communicate with Members Services staff, view their benefit summary, and change their PCP when logged into the secure member portal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 A description of the Well-Baby and Well-Child services which include:						The CHIP Member Handbook lists a complete description of Well-Baby and Well-Child services, indicating the guidelines are from the American Academy of Pediatrics. Detailed EPSDT information and a current Bright Futures immunization schedule are available on the website.
1.13.1 Comprehensive health and development history (including assessment of both physical and mental development);						
1.13.2 Measurements (e.g., head circumference for infants, height, weight, BMI);						
1.13.3 Comprehensive unclothed physical exam;						
1.13.4 Immunizations appropriate to age and health history;						
1.13.5 Assessment of nutritional status;						
1.13.6 Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);						
1.13.7 Vision screening;						The CHIP Member Handbook provides information on the requirements for disenrollment and instructs members to make requests directly to DOM either in writing or by phone.
1.13.8 Hearing screening;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13.9 Dental and oral health assessment;						
1.13.10 Developmental and behavioral assessment;						
1.13.11 Health education and anticipatory guidance; and						
1.13.12 Counseling/education and referral for identified problems.						
1.14 Procedures for disenrolling from the CCO;						
1.15 Procedures for filing complaints/grievances and appeals;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						
1.17 Instructions on reporting suspected cases of fraud and abuse;						Fraud and abuse are defined and appropriately described in the CHIP Member Handbook and the website. Instructions are provided for members to anonymously report fraud and abuse to United and DOM.
1.18 Information regarding the Care Management Program and how to contact the Care Management team;						
1.19 Information about advance directives;						A Living Will and Medical Power of Attorney are two types of Advanced Directives described in the CHIP Member Handbook, CHIP Care Provider Manual, and on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the website. CCME identified the Member Handbook directs members to the website to obtain the necessary forms, however the CHIP Care Provider Manual does not provide those instructions. *Recommendation: Edit the CHIP Care Provider Manual to include information on how members can obtain Advance Directive forms.*
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					United notifies members by mail of significant changes in benefits 30 days prior to the effective date as described in Policy MBR8a, Proper Notice to Members on Written Notices in Material changes, and in the CHIP Member Handbook. The Enrollment Department sends written notice of any provider terminations within fifteen (15) days after the notification of termination, as indicated in Policy MBR8b, 15 day Written Notices of Terminated Provider. During the onsite teleconference, United provided a copy of the Provider Termination Letter – MEMBER template, which addresses the requirements.
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages.		X				Policy MBR7, Member Materials/Sixth (6th) Grade Level of Reading Comprehension and Policy MBR1b2, Notification of Oral Interpretation Services, describes and outlines the processes United uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME could not identify documentation of the requirement for member materials to have a minimum 12-point font for regular print items and 18-point font for large print items. During the onsite teleconference, United staff explained this requirement is documented in Policy MBR11a, Marketing Material. Upon review CCME still could not identify documentation of this requirement. This requirement was discussed during the 2019 EQR and a recommendation was made to address it. *Corrective Action Plan: Ensure the requirement to print written material using a minimum 12-point font for regular print and 18-point font for large print are documented.*
4. The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages.	X					Interpreter and translation services are provided to non-English speaking members, members who have limited English proficiency, and for members who are deaf or hearing impaired free of charge, as described in the CHIP Member Handbook, Policy MBR1b2, Notification of Oral Interpretation Services. Additionally, contact information for Member Services, the NurseLine and Relay 711 for members with hearing and speech limitations are noted on the website, in member materials, and on the member's ID card.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
III C. Call Center						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.		X				United maintains a Member Services Call Center, Provider Services Call Center, and 24-Hour NurseLine. In addition, members can access a 24-hour behavioral health hotline staffed with mental health professionals and TTY 711 relay is communicated in several areas. During the onsite teleconference, CCME discussed the following documentation issues with toll-free telephone numbers and hours of operation for Member Services and Provider Services: •The CHIP website, under the "See more benefits and features" section, informs members they can call Member Services and the NurseLine, however it does not provide the telephone number to call. • The Member Services hours of operation listed in the CHIP Member Handbook are not consistent with the hours listed on the CHIP website. •The tollfree number for Provider Services is correctly listed on page 6 in the CHIP Care Provider Manual, but incorrectly on page 20 as 888-980-8728. •The CHIP Care Provider Manual does not have hours of operation for Provider Services Call Center listed. *Corrective Action Plan: Edit the CAN Member Handbook, CAN Care Provider Manual, and website to include the correct toll-free telephone numbers and hours of operations for Member Services and Provider Services call centers as required in CAN Contract, Section 6 (A) and Section 7 (H) (1) and ensure consistent documentation of such across the respective areas.*
2. Call Center scripts are in-place and staff receive training as required by the contract.	X					United has Call Center scripts in place. During the onsite teleconference United staff confirmed the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						training logs submitted for review include the CHIP Call Center staff and reflects training conducted as required.
3. Performance monitoring of Call Center activity occurs as required and results are reported to the appropriate committee.	X					United monitors and evaluates member and provider Call Center Agents for the quality of incoming and outgoing calls. The 2019 Quality Improvement Program Evaluation indicates Call Center metrics are monitored monthly by the Performance Improvement Team and reported to the Quality Improvement Committee. Results indicate that all 2019 CHIP Call Center goals were met. The Abandonment Rate was less than 5% and the Average Speed of Answer was below the 30 second goal.
III D. Member Enrollment and Disenrollment						
1. The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III E. Preventive Health and Chronic Disease Management Education						
1. The CCO informs members about available preventive health and chronic disease management services and encourages members to utilize these benefits.	X					The CHIP Member Handbook has information on scheduled preventive health services, available case management programs, and instructions to obtain educational support for medical, BH, and pharmaceutical services. United's website includes information on a variety of health topics. Additionally, the plan sends targeted mailers, such as an EPSDT brochure and member newsletters, and makes calls to eligible members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reminding them of screenings and well visits. The mascot, Dr. Health E. Hound, travels around Mississippi to teach kids about fun ways to stay fit and healthy.
2. The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					Policy MBR9, Open Enrollment Period, describes how United uses claims data and submits a weekly CHIP Maternal Report to DOM for members identified as pregnant. Once identified, Care Management from the Healthy First Steps program evaluates the CHIP member's eligibility for coverage under Medicaid and enrollment into the program. The Healthy First Steps™ (HFS) program can identify pregnant members, stratifying them by risk level and, providing care management, and health education provides participants with the education and tools to reduce their risk of adverse pregnancy outcomes. Member engagement in the HFS program is tracked and monitored by various methods, such as communication with the OB provider. Additionally, United tracks timeliness of prenatal care by Healthcare Effectiveness Data Information Set (HEDIS) monitoring of pregnant members and participation in HFS program. The 2019 CAN Quality Improvement Program Evaluation reports a 43% decline in pregnant members since October 2018.
3. The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages members to utilize these benefits.	X					United has processes in place to ensure Early Periodic Screening and Diagnostic Treatment (EPSDT) and immunization services are provided to members through the month of their 21st birthday and addresses barriers

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by creating interventions to encourage members to use the services.
4. The CCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III F. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.	X					The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS Survey Validation Protocol. United contracts with DSS Research, a certified CAHPS Survey vendor, to conduct the Child Surveys. The actual sample size was below the NCQA suggested minimum sample size for valid surveys (at least 411) for the Adult CAHPS. For United CHIP, the generalizability of the Child CCC survey results is difficult to discern due to low response rate for total sample 21.11% and 20.45% for general population. This is a decrease from last year's response rates although it was higher than the average United CHIP general population response rate of 17.62%. *Recommendation: In addition to other ongoing interventions, continue working with DSS Research to increase response rates for Adult and Child surveys.*
2. The CCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					The CCO analyzes data obtained from the Member satisfaction survey to identify quality problems. Data for CHIP CAHPS survey was analyzed and compared to internal goals and last year's results, aa noted in the CHIP 2019 Quality Improvement limits.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO reports the results of the member satisfaction survey to providers.	X					The CCO reports the results of the Member satisfaction survey to providers. The results were reported to the providers for 2019 in comparison to the 2017 and 2018 results for the CHIP population.
4. The CCO reports the results of the member satisfaction survey and the impact of measures taken to address quality problems that were identified to the appropriate committee.	X					Discussion of CAHPS results relative to last year's results were discussed in QMC.
III G. Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, describes United's processes for receiving, processing, and responding to member requests for informal and formal complaints and grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance is correctly defined in the POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, the CHIP Member Handbook, CHIP Care Provider Manual, and on the website glossary.
1.2 The procedure for filing and handling a grievance;		X				The procedure for filing a grievance is correctly described in Policy POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance, the CHIP Member Handbook, and CHIP Care Provider Manual. CCME did not identify grievance procedures or instructions on the CHIP website. During the onsite teleconference, United staff confirmed that grievance information is located on the Member Portal and not on the public website. However, the *CHIP Contract*,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Section 6 (H) requires the plan to provide specific up-to-date grievance information on a non-secure section of the website. The CHIP Member Handbook and CHIP Care Provider Manual correctly state grievances will be acknowledged in writing within 5 calendar days, however the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy (POL2015-01) indicates 10 calendar days. Members must give written permission for someone else to file a grievance on their behalf and are instructed to contact Member Services or access the Grievance and Appeal Form in the CHIP Member Handbook. Additionally, the CHIP Member Handbook informs members of the process and timelines for filing a complaint. *Corrective Action Plan: Include information on grievance procedures on the non-secured section of the CHIP website, as required in the CHIP Contract, Section 6 (H). Correct the Member Appeal, State Fair Hearing, External Appeal, and Grievance Policy (POL2015-01) to indicate that grievances will be acknowledged in 10 calendar days.*
1.3 Timeliness guidelines for resolution of the grievance;	X					
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract;		X				The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy indicates grievance records are retained for a minimum of 10 years, however it does not specify that grievance records will be retained "during the entire term of this Contract and for a period of 10 years thereafter," as required by the *CHIP Contract, Section 11 (A)*. *Corrective Action Plan: Edit the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy to include the complete grievance requirement in the CHIP Contract, Section 11 (A).*
2. The CCO applies the grievance policy and procedure as formulated.	X					CCME's review of grievance files reflected timely acknowledgements, resolution, and notification of determinations.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United tracks, trends, and analyzes grievances for medical and behavioral health services, and reports results to the Quality Improvement Committee (QIC) quarterly, as noted in Policy MS.MBRS.07, Member Grievance and Complaints Process. The QIC reviews the grievance information to identify and address trends. QIC Meeting Minutes from April 30, 2020 confirm presentation and discussion of grievance reports. The goal for grievances is 3 or less complaints per 1,000 members. In 2019 grievance goals for BH were met and goals for medical services were not.
4. Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					Policy MBR3a, Assignment of Primary Care Provider, describes Member Services staff assist members with PCP change requests for any reason including dissatisfaction.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III H. Practitioner Changes						
1. The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					
2. Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV A. Quality Improvement (QI) Program						
1. The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					United has developed a QI program description for the CHIP program. The 2020 Quality Improvement Program Description for the CHIP program was provided for review. The program description clearly outlines the programs objectives, structure, QI activities, and methodologies.
2. The scope of the QI program includes monitoring of services furnished to members with special health care needs and health care disparities.	X					A description of United's Multicultural Health Program designed to address special health care needs and health disparities is included in the program description.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Utilization data used for identifying trends is described in Policy NQM-005, Provider Profiling and Monitoring Over and Under-Utilization.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					United maintains a separate work plan for the CHIP Program. The work plan includes the programs specific objectives and goals, QI activities, responsible persons for each activity, quarterly updates, and status.
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Oversight of the QI activities for the CHIP population has been delegated to the Quality Management Committee (QMC). The Provider Advisory Committee and the Healthcare Quality and Utilization Management Committee are also responsible for monitoring QI activities and providing recommendations as appropriate.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QMC is chaired by the Chief Medical Officer and membership includes United's senior leaders, department directors, and other health plan staff. A variety of network providers are included on the Provider Advisory Committee.
3. The QI Committee meets at regular intervals.	X					
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of	X					The performance measure validation found that United was fully compliant with all information system

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the CMS protocol, "Validation of Performance Measures."						standards and determined that United submitted valid and reportable rates for all HEDIS measures in scope of this audit. There were no concerns with United's data processing, integration, and measure production for the CMS Adult and Child Core Set measures that were reported. Aqurate determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation. United did not report two non-HEDIS measures. The two measures were Live Births Weighing Less Than 2,500 grams (LBW-CW) and Cesarean Birth (PC-02 CH). Details of the validation activities and recommendations for the Performance Measures may be found in Attachment 3, *EQR Validation Worksheets*. *Recommendations: United should request clarification from NCQA each year for any medical record abstraction guidance since measure specifications and related guidance can change each year. Pay special attention to supplemental data received from aggregated data vendors to confirm that data reflects services provided. Also, continue to follow NCQA guidelines for chart abstraction and supplemental data. Work proactively with DOM for clarification on core set measures required to be reported.*
IV D. 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					For the CHIP population, United submitted four projects for validation. Topics included Adolescent Well Child Visits (AWC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Reducing Adolescent and Childhood Obesity), Getting

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Needed Care CAHPS, and Follow Up After Hospitalization for Mental Illness.
2. The study design for QI projects meets the requirements of the CMS protocol, "Validating Performance Improvement Projects."	X					For the 2019 review, all four PIPs scored in the "High Confidence in Reported Results" range. The same PIPs were submitted and validated for the current review, with all four PIPs scoring in the "High Confidence in Reported Results" range. Details of the validation activities for the PIPs, along with specific outcomes related to each activity, may be found in *Attachment 3, CCME EQR Validation Worksheets*.
IV E. Provider Participation in Quality Improvement Activities						
1. The CCO requires its providers to actively participate in QI activities.	X					The 2020 CHIP Care Provider Manual provides details of United's QI program and provider participation.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
3. The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines.	X					Policy QM-01, Monitoring of Clinical and Preventive Health Guidelines, provides the process used to monitor provider compliance with United's clinical and preventive practice guidelines. For CHIP, United has chosen the Antidepressant Medication Management (AMM) and Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measures. The 2019 measurement year results indicated both measures showed an increase and met the established goal.
4. The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for:						United's Standard Operating Procedure (SOP) titled "Well Child Services – Tracking Process" was provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Initial visits for newborns;	X					
4.2 Well-Baby and Well-Child screenings and results;	X					
4.3 Diagnosis and/or treatment for children.	X					The Well-Child Services – Tracking Process SOP indicates any problems identified during Well-Baby or Well-Child exams requiring referrals are tracked on a quarterly basis. United provided examples of the tracking report. Similar to the report provided during the previous EQR, the tracking report failed to link the identified problem with the Well-Baby or Well-Child exam and did not include or indicate the members who received additional outreach for case management referrals. *Recommendation: The Well-Baby or Well-Child exam tracking report should include the date the Well-Baby or Well-Care exam was provided, ICD 10 or CPT codes, treatment/referral, if provided, and members who received additional outreach for case management referrals.*
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.	X					United evaluated the QI Program for CHIP and summarized the results of this evaluation in the 2019 Quality Improvement Program Evaluation. Most of the program's objectives were met. Areas not meeting the goals are being analyzed, along with any interventions needed to improve performance identified.
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V A. Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, that includes, but is not limited to:	X					United's Utilization Management (UM) Program Description outlines the goals, scope, and staff roles for physical health, behavioral health (BH), and pharmaceutical services for members in Mississippi. Several policies describe UM processes and requirements.
1.1 Structure of the program;	X					
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The following service authorization timeframe requirement is found in Policy UCSMM.06.16, Initial Review Timeframes, but is omitted from the 2020 CHIP UM Program Description Addendum: "Contractor will notify the requesting provider of additional medical information needed and Contractor must allow three (3) calendar days and/or two (2) business days for the requesting provider to submit the medical information. If Contractor does not receive the additional medical information, Contractor shall make a second attempt to notify the requestor of the additional medical information needed and Contractor must allow one (1) business day or three (3) calendar days for the requestor to submit medical information to Contractor." Refer to the *CHIP Contract, Section 5 (I) (4)*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The following timeframe requirement for denial notices is found in the 2020 CHIP UM Program Description Addendum, but is omitted from Policy UCSMM.06.16, Initial Review Timeframes: "For termination, suspension or reduction of previously authorized Medicaid-covered services, within 10 calendar days of the date of the Action for previously authorized services as permitted under 42 C.F.R. § 431, Subpart E." Refer to the *CHIP Contract, Section 5 (K).* *Corrective Action Plan: Edit the UM Program Description to meet all service authorization timeframe requirements in the CHIP Contract, Section 5 (I) (4), and to be consistent with Policy UCSMM.06.16, Initial Review Timeframes. Edit Policy UCSMM.06.16, Initial Review Timeframes, to include all timeframe requirements for denial notices, as noted in the CHIP Contract, Section 5 (K).*
1.5 Consideration of new technology;	X					
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives and/or quotas to provider or UM staff for denials of coverage or services.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The role of the Chief Medical Officer (CMO) is described in the 2020 Utilization Management Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, and chairing committees. The Behavioral Health (BH) Regional Medical Director and the Pharmacy Director

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						collaborate with the CMO and have clinical oversight of the respective programs.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually to assess its strengths and effectiveness. The evaluation and recommendations are presented to the Healthcare Quality and Utilization Committee (HQUM) and the Quality Management Committee (QMC) for approval and were approved on 5/21/2020 and 6/9/2020 respectively.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Utilization management standards/criteria are documented in the CHIP UM Program Description and Policy UCSMM.06.10, Clinical Review Criteria. United applies a hierarchal approach while using external and internal clinical review standards that are based upon applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines. United's internal review criteria, BH Level of Care Guidelines (LOCGs), is an evidenced-based criterion applied to BH benefits. Policy UCSMM 06.10 Rider 1, Clinical Review Criteria, lists the hierarchy for evaluating service authorization requests.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of CHIP UM approval files reflected consistent decision-making, using DOM benefit guidelines, evidenced base criteria such as MCG, and relevant clinical information.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy UCSMM.06.10, Clinical Review Criteria Rider 1, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to established criteria. Approval files

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reflected individual member circumstances are taken into consideration and review staff consulted with the Medical Director about the appropriateness of service requests.
4. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					United conducts annual inter-rater reliability (IRR) testing for physicians and non-physician clinical reviewers. Clinical staff, including medical directors, participated in an online MCG Inter-rater Reliability Assessment. The IRR evaluates three MCG products: Inpatient Care, Ambulatory Care, and Recovery Facility Care. Discussions during the onsite teleconference confirmed the IRR results reported in the 2019 CHIP UM Program Evaluation were incorrect. United confirmed all reviewers, including that BH and pharmacy staff, successfully passed the annual IRR testing, and additional documentation was provided.
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					OptumRx is the pharmacy benefit manager (PBM) and is responsible for implementing all pharmaceutical services for United, including but not limited to, prior authorizations and pharmacy network management. A link to access the most current version of Universal Preferred Drug List (PDL) is posted on United's website. The user is taken to DOM's website, where the PDL is available in a searchable, electronic format.
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					The CHIP UM Program Description Addendum and Policy RX-047, OptumRx Prior Authorization Review Oversight, state United has policies and procedures that follow DOM's prior authorization criteria for drugs listed on the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PDL and for drugs not listed. Optum Rx conducts the prior authorization process according to state, federal and regulatory requirements. Prior authorization requests are responded to within 24 hours and a 72-hour (3-day) supply of medication will be approved while a prior authorization request is pending.
6. Emergency and post-stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Emergency care and post-stabilization requirements are outlined in Policy UCSMM.04.11, Consumer Safety.
7. Utilization management standards/criteria are available to providers.	X					
8. Utilization management decisions are made by appropriately trained reviewers.	X					United ensures UM decisions are conducted by appropriate staff as described in Policy UCSMM.06.14, Initial Clinical Review. An initial clinical review is conducted by Mississippi licensed nurses or Referral Specialists, and a Mississippi-licensed physician or other appropriate healthcare practitioner conducts a Level II medical necessity reviews resulting in an adverse benefit determination. Discussions during the onsite teleconference revealed physician reviewers can consult internally with other plan physicians for clinical support when reviewing complex cases. Review of files with adverse benefit determinations reflected decisions were made by appropriate physician specialists such as dentists, pharmacists, or BH specialists.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes reviewed in approval files were consistent with Policy UCSMM.06.16, Initial Review Timeframes, the UM Program Description, and CHIP Contract requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Denials						
10.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files for CHIP members reflected reviewers attempted to obtain additional clinical information when needed prior to rendering an adverse benefit determination.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Policy UCSMM.06.15, Peer Clinical Review, states peer clinical reviewers who are qualified health professionals with a current license to practice render adverse benefit determinations and will be available within one business day to discuss with the provider if needed. Denial files reflected review by a medical director, or appropriate physician, when UM clinical staff cannot approve requests that do not meet medical necessity criteria. Additionally, denials for pharmacy requests were determined by a licensed pharmacist and reviewed by a health plan medical director.
10.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files reveal denial decisions are made according to the processes described in Policy UCSMM.06.18 Initial Adverse Determination Notices. Determinations were communicated verbally to the requesting provider. Adverse benefit determination letters were mailed to the provider and member and included the basis for the denial and procedures for appeal.
V C. Appeals						
1. The CCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the CCO in a manner consistent with contract requirements, including:	X					The 2020 CHIP UM Program Description Addendum and POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, outline appeals processes. Additionally, information is provided in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CHIP Care Provider Manual, CHIP Member Handbook, and the member tab of the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The terms "appeal" and "adverse benefit determination" are correctly defined in POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, the CHIP Member Handbook, CHIP Care Provider Manual, and the glossary section of the website. However, the CHIP UM Program Description does not define the term "adverse benefit determination." The Member Appeal, State Fair Hearing, External Appeal and Grievance Policy correctly defines and describes who can file an appeal. CCME identified the following documentation issues in other areas: •The CHIP website does not define or describe who may file an appeal. •Page 51 in the CHIP Member Handbook does not specify the requirement that "The legal guardian of the Member for a minor or an incapacitated adult or A representative of the Member as designated in writing to the Contractor" may file an appeal, as noted in the *CHIP Contract, Exhibit D.* *Recommendation: Revise the CHIP UM program Description to include the definition of the term adverse benefit determination, to be consistent with the POL2015-01, Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, and other CHIP UM documents. Include the definition or description of who can file an appeal, on the CHIP website, as required in the CHIP Contract, Section 6 (H).Edit the CHIP Member Handbook and CHIP Care Provider Manual*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to describe the full requirement that a member's legal guardian can file an appeal.
1.2 The procedure for filing an appeal;		X				The procedure for filing an appeal is correctly documented in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy, CHIP Member Handbook, and CHIP Care Provider Manual. However, CCME did not identify information for appeals processes and procedures on the CHIP website. During the onsite teleconference, United staff confirmed that appeals information is located on the Member Portal, not on the public website. However, the *CHIP Contract, Section 6 (H)* requires the plan to provide specific, up-to-date appeals information on a non-secure section of the website. CCME identified the CHIP Provider Manual omits the requirement that states "A verbal appeal shall be followed by a written appeal signed by the member within 30 calendar days of the oral filing date," as required by the *CHIP Contract, Exhibit E (D).* *Corrective Action Plan: Include information on appeals processes and procedures on the non-secured section of the CHIP website, as required in the CHIP Contract, Section 6 (H).* *Recommendation: Edit the CHIP Care Provider Manual to include the requirement that a verbal appeal shall be followed by a written appeal signed by the member within 30 calendar days of the oral filing date.*
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,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
by a practitioner with the appropriate medical expertise who has not previously reviewed the case;						
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal;	X					
1.6 Written notice of the appeal resolution;	X					
1.7 Other requirements as specified in the contract.	X					Other appeal requirements are described in the Member Appeal, State Fair Hearing, External Appeal and Grievance Policy and the Member Handbook.
2. The CCO applies the appeal policies and procedures as formulated.	X					Review of appeal files reflected timely acknowledgement, resolution, and notification of determinations. Additionally, the 2019 CHIP UM Program Evaluation noted 100% compliance in the turnaround time for CHIP member appeals in 2019.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					United tracks, trends, and analyzes appeals for medical and behavioral health services, and reports results to the Service Quality Improvement Subcommittee (SQIS) quarterly, as noted in 2020 CHIP Utilization Management Program Description Addendum. The SQIS reviews appeal information to identify and address trends. As evidenced by the SQIS Meeting Minutes on March 18, 2020, Timely Filing & Utilization Review were identified as key appeal drivers with no notable trends. The 2019 CHIP Quality Improvement Program Evaluation reports the categorized appeal results in a comparison

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						table from calendar year 2017 to 2019. The report indicates 33 out 91 appeals were upheld.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V D. Care Management						
1. The CCO has developed and implemented a Care Management and a Population Health Program.	X					United CHIP has an established Care Management Program and an established Population Health Management Program to ensure and promote access and delivery of physical and behavioral health services. The Population Health Management Program is coordinated in conjunction with the Quality Improvement Program.
2. The CCO uses varying sources to identify members who may benefit from Care Management.	X					The CHIP CM Program Description and Addendum, and Policy NCM 001, Identification of High Risk Members for Case Management, describe methods for how eligible members are identified and referred into case management. In addition to referral guidelines and results from advanced data sources, United uses claims, health risk assessment results, medical records, and utilization management data to identify members who can benefit from case management. The Health Risk Assessment tool is primarily used to screen and identify eligible members into case management. Other methods include but are not limited to review of clinical claims, medical records, and utilization management data.
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 Rider1, Case Management Process, states a health risk assessment will occur within 30 calendar days for members newly assigned to medium and high-risk categories and the treatment plan will be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						completed within 30 calendar days after the assessment.
4. The detailed health risk assessment includes all required elements:						
4.1 Identification of the severity of the member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan, if available.	X					
5. The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessment.	X					
6. The risk level assignment is periodically updated as the member's health status or needs change.	X					The Care Management Program Description and Addendum states United will “update the risk level assignment when there has been a change in the health status, needs, or a significant health care event relevant to the Member’s risk level assignment.”
7. The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members through the following minimum functions:	X					United uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels according to standard outreach processes.
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management team member and provided						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
instructions on how to contact their assigned team;						
7.2 Appropriate referral and scheduling assistance for members needing specialty health care services, including behavioral health;						
7.3 Documentation of referral services and medically indicated follow-up care in each member's medical record;						
7.4 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.5 Coordination of discharge planning;						
7.6 Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.7 Ensuring that when a provider is no longer available through the Plan, the Contractor allows members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.8 Procedure for maintaining treatment plans and referral services when the member changes PCPs;						
7.9 Monitoring and follow-up with members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. The CCO provides members assigned to the medium risk level all services included in the low risk level and the specific services required by the contract.	X					
9. The CCO provides members assigned to the high risk level all the services included in the low and medium risk levels and the specific services required by the contract.	X					
10. The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan.	X					The CHIP Care Management Program Description and Addendum state United will transfer the member's care management history, six months of claims history, and other pertinent information to DOM when a member disenrolls. If a member transfers to another health plan, the plan will provide the member's utilization information and care plan data to the new health plan upon request. Policy NCM 002, Case Management Process, states cases are evaluated for closure when a member disenrolls from care management or changes health plans.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Transitional Care Management						
1. The CCO monitors continuity and coordination of care between PCPs and other service providers.	X					The 2020 CHIP Care Management Program Description describes the Transitional Care Management Program as a subgroup of the WPC Management Program for members who are in a low-chronic-risk category. Policy MS021, Transitional Care Management, outlines processes and requirements for managing transitions of care across healthcare settings. Additionally, Policy RX-046, Pharmacy – Automated Transition of Care (ToC), describes how United provides new members with continuity of their current medications until the provider can transition the member to formulary medications.
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					Policy MS021, Transitional Care Management, describes United's process for monitoring new members, members transferring from another health plan, when discharged from a clinic or inpatient setting, including a psychiatric residential treatment facility (PRTF), and terminated providers.
3. The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements the transition of care plan, and provides oversight to the transition process.	X					The interdisciplinary transitional care team coordinates and manages required services to ensure continuity of care and prevent duplication of services as members return home or other community setting. The team includes nurses and the necessary staff required to implement the transition of care plan.
4. The CCO meets other Transition of Care Requirements.	X					Policy MS021, Transitional Care Management, and the CHIP Care Management Program Description correctly describe other requirements for Transition of Care.
V F. Annual Evaluation of the Utilization Management Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					United describes the 2019 CHIP UM Program Evaluation as an overview and summary of the initiatives and activities to identify opportunities for improvement. The evaluation notes the UM Program was effective in meeting its objectives.
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					The 2019 CHIP Utilization Management Program Evaluation was reviewed and approved by the Healthcare Quality and Utilization Management (HQUM) on May 21, 2020 and by Quality Management Committee (QMC) on June 9, 2020.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION						
1. The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					United has delegation agreements with: •OptumHealth - Behavioral Health Case Management, Utilization Management, Quality Management, Network Contract Management, and Claims Processing •Dental Benefit Providers - Dental Network Services and 3rd Party Dental Administrator •eviCore National - Radiology and Cardiology Management Services •MARCH Vision Care - Vision and Eye Care Benefit Administration Services, Vision Network Contract Management, Call Center Operations, Claims Processing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Optum Rx - Pharmacy Benefit Administration Services •Medical Transportation Management - Non-Emergency Transportation United delegates credentialing to the following organizations: •Hattiesburg Clinic •River Region Health System •HubHealth University Physicians, PLLC •HCA Physician Services •Health Choice, LLC •North Mississippi Medical Center •Ochsner •Premier Health United provided sample copies of their delegation agreements.
2. The CCO conducts oversight of all delegated functions to ensure that such functions are performed using standards that would apply to the CCO if the CCO were directly performing the delegated functions.	X					Policy UCSMM 03.14, Delegated Credentialing Oversight Policy & Procedure, provides the process the Plan follows to evaluate and monitor the delegated entity's capacity to perform the delegated activities. In addition to delegated credentialing, other health plan functions are delegated. Processes for pre-delegation assessment, ongoing monitoring, and annual oversight are documented in Policy DOV-01, Delegated Vendor Oversight Strategy. Copies of the annual oversight monitoring was provided for all delegated entities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The monitoring tools used for the annual oversight included all Mississippi credentialing requirements. The query of the social security death master file, the requirement for the Ownership Disclosure form, and the monitoring of practitioner quality concerns (recredentialing) are not delegated functions and scored as N/A on the monitoring tools. Several of the credentialing and recredentialing files reviewed during the monitoring of the credentialing/recredentialing delegates noted the requirement for CLIA certificate was marked as N/A with an explanation noted as "Doesn't have a CLIA." It was unclear from the explanation if the provider did not provide laboratory services or the file did not contain the required CLIA certificate. Also, the monitoring for OptumHealth, Dental Benefit Providers, and MARCH Vision Care did not include a file review of the delegates' credentialing and recredentialing files. *Recommendation: Include in delegation monitoring oversight a sample of credentialing and recredentialing files and ensure the CLIA certificate is included in the credentialing and recredentialing files for practitioners providing laboratory services.*