Primaris
Healthcare Business Solutions

2019 External Quality Review
Performance Measures Validation

UnitedHealthcare®

Measurement Period: Calendar Year 2018
Validation Period: June-August 2019
Publish Date: Oct 18, 2019

MoHealthNet

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1.0 Purpose and overview

Validation of Performance Measures

The Department of Social Services, MO HealthNet Division (MHD) operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care (hereinafter stated "Managed Care"). MHD contracts with MO HealthNet Managed Care Organizations (MCOs), also referred to as "Health Plans," to provide health care services to Managed Care enrollees.

Managed Care is operated statewide in Missouri in the Central, Eastern, Western, and Southwestern regions. One of the most important priorities of Managed Care is to provide a quality program that leads the nation and is affordable to members. This program provides Medicaid services to: section 1931 children and related poverty level populations; section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. The total number of Managed Care enrollees by the end of SFY 2019 are 596,646 (1915(b) and CHIP combined). This is a decrease of 16.24 % in comparison to enrollment by end of SFY 2018.

UnitedHealthcare's services are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods including, but not limited to, MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review. MHD requires participating MCOs to be accredited by the National Committee for Quality Assurance (NCQA) at a level of "Accredited" or better. An External Quality Review Organization (EQRO) evaluates the MCOs annually as well. Primaris Holdings, Inc. (Primaris) is MHD's current EQRO and started their five-year contract in January 2018.

Validation of performance measures is one of three mandatory External Quality Review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. Primaris validated a set of performance measures identified by MHD that were calculated and reported by the MCOs for their Medicaid population. MHD identified the measurement period as calendar year (CY) 2018. Primaris conducted the validation in accordance with the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf

2.0 Managed Care Information

Information about UnitedHealthcare appears in Table 1, including the office location(s) involved in the EQR 2019 performance measure validation that occurred on June 26, 2019.

Table 1: MCO Information	
MCO Name:	UnitedHealthcare
MCO Location:	13655 Riverport Dr. Maryland Heights, MO 63043
On-site Location:	13655 Riverport Dr. Maryland Heights, MO 63043
Audit Contact:	Robbyn S Roth, MSN, BSN,RN-BC, NE-BC, CPHQ Senior Director, Clinical Quality Missouri Medicaid
Contact Email:	robbyn.roth@uhc.com

3.0 Performance Measures Validation Process

Primaris validated rates for the following set of performance measures selected by MHD. The performance measures that were validated and the data collection specifications used for each measure are listed in Table 2. Out of the three performance measures selected by MHD, only one measure required medical record validation, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34). The additional two measures: Chlamydia Screening in Women (CHL) and Inpatient Mental Health Readmissions are administrative measures which require primary source verification from each MCO's claim and/or encounter system.

Table 2: Performance Measures			
Performance Measure	**Method**	**Specifications Used**	**Validation Methodology**
Chlamydia Screening in Women (CHL)	Admin	HEDIS	Primary Source Verification
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Hybrid	HEDIS	Medical Record Review Validation
Inpatient Mental Health Readmissions	Admin	MHD	Primary Source Verification

For the hybrid measure, W34, a random selection of 45 medical records was taken from UnitedHealthcare's hybrid sample of 411 records. The 411 medical records were from the samples used by UnitedHealthcare to produce the W34 measure for HEDIS reporting in CY 2018. Primaris conducted over-reads of the 45 medical records to validate compliance with both the specifications and abstraction process.

4.0 Description of Validation Activities

4.1 Pre-Audit Process

Primaris prepared a series of electronic communications that were submitted to UnitedHealthcare outlining the steps in the performance measure validation process based on the CMS Performance Measure Validation Protocol 2. The electronic communications included a request for samples, medical records, numerator and denominator files, source code, if required and a completed Information System Capability Assessment (ISCA). Additionally, Primaris requested any supporting documentation required to complete the audit. Finally, the communications addressed the medical record review methodology of selecting 45 records for over read and the process for sampling and validating the administrative measure during the onsite audit. Primaris provided specific questions to UnitedHealthcare during the audit process to enhance the understanding of the ISCA responses during the on-site visit.

Primaris submitted an agenda prior to the onsite visit, describing the onsite visit activities and suggested that subject matter experts attend each session. Primaris exchanged several pre-onsite communications with UnitedHealthcare to discuss expectations, audit session times, specific dates, and to answer any questions that UnitedHealthcare staff may have regarding the overall process.

4.2 Validation Team Members

Table 3: Validation Team Members

Name and Role	Skills and Expertise
Allen Iovannisci, MS, CHCA, CPHQ *Lead Reviewer*	Performance Measure knowledge, Data Integration, Systems Review, and Analysis.
Victoria Alexander Senior Director, Quality Data Services	Managed Care, Project Management, Healthcare Data Auditing and HEDIS Knowledge.
Kaitlyn Cardwell IT Operations Manager	Healthcare Data and Systems Integration for external applications; Analytical and Software Development, Project Management.

Primaris team consisted of a lead auditor and members that possessed the skills and expertise (Table 3) required to complete the validation and requirements review for UnitedHealthcare. Team members participated in an onsite meeting at UnitedHealthcare.

4.3 Methodology, Data Collection and Analysis

The CMS performance measure validation protocol identifies key components that should be reviewed as part of the validation process. The following bullets describe these components and the methodology used by Primaris to conduct its analysis and review:

- CMS's ISCA: UnitedHealthcare completed and submitted the required and relevant portions of its ISCA for Primaris' review. Primaris used responses from the ISCA to complete the onsite and pre-onsite assessment of their information system. A separate report is submitted to MHD on ISCA.
- Medical record verification: To ensure the accuracy of the hybrid data being abstracted by UnitedHealthcare, Primaris requested UnitedHealthcare participate in the review of a sample of 45 medical records for the W34 measure. Primaris used the results of the medical record validation to determine if the findings impacted the audit results for W34.
- Source code verification for performance measures: UnitedHealthcare contracted with a software vendor to generate and calculate rates for the two administrative performance measures, Inpatient Mental Health Readmissions and CHL. The source code review was conducted during the onsite audit sessions where UnitedHealthcare explained its rate generation and data integration processes to the Primaris review team.
- Additional supporting documents: In addition to reviewing the ISCA, Primaris also reviewed UnitedHealthcare's policies and procedures, file layouts, system flow diagrams, system files, and data collection processes. Primaris reviewed all supporting documentation and identified any issues requiring further clarification.
- Administrative rate verification: Upon receiving the numerator and denominator files for each measure from UnitedHealthcare, Primaris conducted a validation review to determine reasonable accuracy and data integrity.
- Primaris took a sample of 45 records from each administrative measure, Chlamydia Screening in Women and Inpatient Mental Health Readmissions in order to conduct primary source verification to validate and assess the MCO's compliance with the numerator objectives.

4.4 Onsite Activities

Primaris conducted UnitedHealthcare's onsite visit for the performance measures on Jun 26, 2019. The information was collected using several methods, including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- Opening Conference: The opening meeting included an introduction of the validation team and key UnitedHealthcare staff members involved in the performance measure validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- Information System Compliance: The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure rates, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
- ISCA Review, Interviews and Documentation: The review included processes used for collecting, storing, validating, and reporting performance measure rates. The review meetings were interactive with key UnitedHealthcare staff members, in order to capture UnitedHealthcare's steps taken to generate the performance measure rates. This session was used by Primaris to assess a confidence level over the reporting process and performance measure reporting as well as the documentation process in the ISCA. Primaris conducted interviews to confirm findings from the documentation review and to ascertain that written policies and procedures were used and followed in daily practice.
- Overview of Data Integration and Control Procedures: The data integration session comprised of system demonstrations of the data integration process and included discussions around data capture and storage. Additionally, Primaris performed primary source verification to further validate the administrative performance measures, reviewed backup documentation on data integration, and addressed data control and security procedures.
- Closing conference: The closing conference included a summation of preliminary findings based on the review of the ISCA and the on-site visit.

5.0 Data Integration, Control and Performance Measure Documentation

MHD provided Primaris with the Healthcare Quality Data Instructions for CY2018 which consisted of instructions and specifications for validation of Inpatient Mental Health Readmissions. HEDIS specifications are used for the CHL and W34 measures.
As part of the performance measure validation process, Primaris reviewed UnitedHealthcare's data integration, data control, and documentation of performance measure rate calculations. The following describes the validation processes used and the validation findings. The scores (Table 4) were assigned per CMS EQRO protocol 2.

Table 4: Scoring Criteria for Performance Measures	
Met ●	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met ●	The MCO's measurement and reporting process was not compliant with State specifications. This designation should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include explanation of the deviation in the comments section.
N/A	The audit element was not applicable to the MCO's measurement and reporting process.

5.1 Data Integration

Met ●	Not Met ☐	N/A ☐

Data integration is an essential part of the overall performance measurement creation/reporting process. Data integration relies upon various internal systems to capture all data elements required for reporting. Accurate data integration is essential for calculating valid performance measure rates. Primaris reviewed UnitedHealthcare's actual results of file consolidations and extracts to determine if they were consistent with those which should have resulted according to documented specifications. The steps used to integrate data sources such as claims and encounter data, eligibility and provider data require a highly skilled staff and carefully controlled processes. Primaris validated the data integration process used by UnitedHealthcare, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

5.2 Data Control

Met ●	Not Met ☐	N/A ☐

Data control procedures ensure the accurate, timely, and complete integration of data into the performance measure database by comparing samples of data in the repository to transaction files. Good control procedures determine if any members, providers, or services are lost in the process and if the organization has methods to correct lost/missing data. The organization's infrastructure must support all necessary information systems and its backup procedures. Primaris validated the data control processes UnitedHealthcare used which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, Primaris determined that the data control processes in place at UnitedHealthcare were acceptable and received a "Met" designation.

5.3 Performance Measure Documentation

Met ●	Not Met ☐	N/A ☐

Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided necessary information to complete the audit, the majority of the validation review findings were based on documentation provided by UnitedHealthcare in the ISCA. Primaris' Information Technology Operations Manager and Lead Auditor reviewed the computer programming codes, output files, work flow diagrams, primary source verification and other related documentations.

6.0 Validation Analysis

Primaris evaluated UnitedHealthcare's data systems for the processing of each data type used for reporting MHD performance measure rates. General findings are indicated below.

6.1 Medical Service Data (Claims and Encounters)

UnitedHealthcare's FACETs system captured primary, secondary, and modifier codes appropriately. Coding updates to the FACETs system were made annually to ensure UnitedHealthcare used standard claims and/or encounter forms when receiving administrative data from their hospital, physician, home health, mental health, and dental sources. UnitedHealthcare was able to distinguish between the primary and secondary coding schemes. Incomplete claims submitted from providers were promptly rejected back

for additional information. The incomplete claims were not allowed in the claims system until all required fields were present and valid. UnitedHealthcare's pre-processing edits verified the accuracy of submitted information on all claims and encounters. Claims that contain errors such as invalid Current Procedural Terminology (CPT) or diagnosis codes are rejected and sent back to the provider of service for correction. There were no circumstances where a processor was able to update or change the values on a submitted claim.

All medical and behavioral claims were processed using an industry standard paper and electronic means.

Medicaid claims were audited regularly for financial and procedural accuracy. Thirty-two (32) claims are randomly sampled on a weekly basis to validate accuracy and data quality. Quality errors are rectified, and additional training is provided to the claims examiners when issues arise.

FACETS provided the claims examiner error messages when a potential authorization match or if a service requires an authorization and no authorization is on file. If the claim requires medical review it will be pended internally and routed to Utilization Management for review.

The current timeliness standard is meeting a 30-day turnaround time and current production standard is achieving a 14.2 claim per hour individual standard. Claim payment accuracy is 98.75%.

Primaris had no concerns with UnitedHealthcare's claims/encounter processing.

6.2 Enrollment Data

UnitedHealthcare uniquely identified enrollees using the daily enrollment files provided by the state against the information found in FACETS. Daily files are submitted to UnitedHealthcare from the State indicating changes, additions and deletions of member from the Medicaid plan. UnitedHealthcare processes the files within 24 hours and sends the roster information on to delegated vendors so they too will have the most updated member data.

Medicaid disenrollment and re-enrollment information is entered in the CSP FACETS eligibility module. Once UnitedHealthcare receives notification of a member's disenrollment, a termination date is entered. If that same member is re-enrolled, the member is reinstated, and a new effective date is created. The member's enrollment spans were captured for reporting and combined to assess continuous enrollment.

There is only one circumstance where a Medicaid member can have multiple identifiers. If MHD sends a subscriber under different identification elements, the system may create a duplicate entry. A weekly report is run to identify members with more than one Subscriber

ID record. If a member is found having more than one Subscriber ID record, the additional record is voided, and a note added with the correct CSP Subscriber ID.
Additional enrollment system criteria was evaluated under the ISCA report.
There were no issues identified with UnitedHealthcare's enrollment data processes as it pertains to performance measurement.

6.3 Provider Data

UnitedHealthcare updates their provider paper directories on a weekly basis. A weekly provider feed is sent to their vendor to update the most current provider data. This allows a member to get a current directory any time they request one via Customer Service. The data is a direct reflection of what is in the system with no manual manipulation to the data. Members can call Customer Service and request a weekly updated directory via mail. Rally is also available as a provider search tool online via UnitedHealthcare's website. Rally is updated daily except on Saturdays. Changes in directory information are driven by system updates to provider demographic information and newly loaded or terminated providers. Provider directories are refreshed with the most current provider data available at the time of the directory data inquiry. UnitedHealthcare's plan directory manager has change authority with approval from the health plan leadership.
UnitedHealthcare does maintain provider profiles in their information system. The Network Database (NDB) is used as their validity source for their provider directories and data entered there flows through UnitedHealthcare's other systems in a standard data flow process. There are 41 data elements maintained and displayed for both paper and online applications. The data elements include standard demographics/contact information, languages spoken and office accessibilities. UnitedHealthcare maintains provider specialties in accordance with professional licensing board and national taxonomy standards. Provider data are frequently compared to determine if providers are sanctioned and if providers specialties are not in sync.
Primaris reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. Primaris found UnitedHealthcare to be compliant with the credentialing and assignment of individual providers at the Federally Qualified Health Centers (FQHCs).
There were no concerns with UnitedHealthcare's provider processing.

6.4 Medical Record Review Validation (MRRV)

UnitedHealthcare was fully compliant with the MRR reporting requirements.
UnitedHealthcare abstracted records in accordance with the standard specifications for each measure. UnitedHealthcare conducted initial and ongoing training for each abstractor

and regularly monitored the accuracy through inter-rate reliability checks. UnitedHealthcare provided adequate oversight of its vendor and Primaris had no concerns. The validation team randomly selected 45 numerator positive records from the total numerator positive records abstracted during the HEDIS medical record validation process. The records selected were numerator positive hits. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the W34 measure. The MRR findings and final result are presented in the Table 5.

Table 5: MRRV Results

Performance Measure	Sample Size	Findings	Results
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	45	45/45 Compliant	Pass

6.5 Supplemental Data

Primaris conducted a review of the supplemental process offsite and did not have any concerns with their process.

6.6 Data Integration

UnitedHealthcare utilized the CSP FACETS system as well as its relational database/data warehouse to collect and integrate data for reporting.
The CSP FACETS production database contained claims, provider and member data. These data streams were extracted weekly and loaded into the data warehouse and consumed with vendor data (e.g. laboratory and vision providers). FACETS and encounter data were linked using unique identifiers in FACETS linking all other identifiers from external sources such as state Medicaid identifiers and social security numbers. All identifiers were tracked and captured in a central data warehouse where they linked members with their encounter and claims transactions.
UnitedHealthcare utilized senior analysts or managers to examine and approve code for quality and validation. Results were compared to prior year's metrics when available or Medicaid benchmarks to determine reasonableness of results. Per UnitedHealthcare's maintenance cycle, data was reviewed and validated by the assigned analyst and the business owner after requirements were verified and approved. Although UnitedHealthcare utilized a source code quality validation process, it did not prevent a critical error from occurring. During Primaris' onsite validation process, a critical error

was found in the Inpatient Mental Health Readmission measure. The numerator contained members that were not in the Medicaid population. The critical error also impacted several measures that needed correction, however, the additional measures were outside Primaris' scope of the audit.
Ultimately the error was corrected for the Inpatient Mental Health Readmission measure prior to the submission date and the rates were finalized and approved.
There were no other concerns with UnitedHealthcare's ability to consolidate and report data.

7.0 Performance Measure Specific Findings

Table 6 shows the key review findings and final audit results for UnitedHealthcare for each performance measure.

Table 6: Key Review Findings and Audit Results for UnitedHealthcare

Performance Measures	Key Review Findings	Audit Results
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Report
Chlamydia Screening in Women (CHL)	No concerns identified	Report
Inpatient Mental Health Readmissions	The numerator contained members outside of the Medicaid population. The issue was brought to the attention of the MCO during onsite which was rectified and the resubmitted post-onsite. The measure was approved and reportable.	Report

Primaris determined validation results for each performance measure rate based on the definitions listed below. The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "NOT MET." Consequently, it is possible that an error for a single audit element may result in a designation of "Not Reported (NR)" because the impact of the error biased the reported performance measure by more than "x" percentage points. Conversely, it is also possible that several audit element errors may have little impact on

the reported rate and, thus the measure could be given a designation of "Report (R)." The following is a list of the validation findings and their corresponding definitions:
R = Report: Measure was compliant with State specifications.
NR = Not Reported: This designation is assigned to measures for which: 1) MCO rate was materially biased or 2) the MCO was not required to report.
NB = No Benefit: Measure was not reported because the MCO did not offer the benefit required by the measure.

8.0 Documentation Worksheets

Worksheet 1: Data Integration and Control Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
Accuracy of data transfers to assigned performance measure data repository.				
UnitedHealthcare accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the calculations of the performance measure rates have been completed and validated.	●	☐	☐	
Samples of data from the performance measure data repository are complete and accurate.	●	☐	☐	
Accuracy of file consolidations, extracts, and derivations.				
UnitedHealthcare's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	●	☐	☐	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	●	☐	☐	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	●	☐	☐	

Worksheet 1: Data Integration and Control Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance measure reporting are lost or inappropriately modified during transfer.	●	☐	☐	
If UnitedHealthcare uses a performance measure data repository, its structure and format facilitates any required programming necessary to calculate and report required performance measure rates.				
The performance measure data repository's design, program flow charts, and source codes enable analyses and reports.	●	☐	☐	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	●	☐	☐	
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including UnitedHealthcare production activity logs and UnitedHealthcare staff review of report runs, is adequate.	●	☐	☐	
Prescribed data cutoff dates are followed.	●	☐	☐	
UnitedHealthcare retains copies of files or databases used for performance measure reporting in case results need to be reproduced.	●	☐	☐	
The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	●	☐	☐	
UnitedHealthcare's processes and documentation comply with	●	☐	☐	

Worksheet 1: Data Integration and Control Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
UnitedHealthcare standards associated with reporting program specifications, code review, and testing.				

Worksheet 2: Denominator Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	●	☐	☐	
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	●	☐	☐	UHC included members that were in the Medicare population in the Inpatient Mental Health Readmissions measure. UHC ultimately corrected this information prior to the final submission and the final rate was approved.
UnitedHealthcare correctly calculates member months and member years if applicable to the performance measure.	●	☐	☐	
UnitedHealthcare properly evaluates the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes are appropriately identified and	●	☐	☐	

Worksheet 2: Denominator Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
applied as specified in each performance measure.				
If any time parameters are required by the specifications of the performance measure, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital).	●	☐	☐	
Exclusion criteria included in the performance measure specifications are followed.	●	☐	☐	
Systems or methods used by UnitedHealthcare to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	●	☐	☐	

Worksheet 3: Numerator Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Partially Met**	**Not Met**	**Comments**
UnitedHealthcare uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	●	☐	☐	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	●	☐	☐	
UnitedHealthcare avoids or eliminates all double-counted members or numerator events.	●	☐	☐	
Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of	●	☐	☐	Nonstandard coding was not used

Worksheet 3: Numerator Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Partially Met**	**Not Met**	**Comments**
the programming logic or a demonstration of the program.				
If any time parameters are required by the specifications of the performance measure, they are followed (i.e., the measured event occurred during the time period specified or defined in the performance measure).	●	☐	☐	

9.0 UnitedHealthcare Measure Specific Rates

Table 7: Health Care Quality Data Report for Inpatient Mental Health Readmissions*			
Region	**Measure**	**Age**	**Count****
Central	Inpatient Mental Health Readmissions (4.13)	Age 0-12	10
Central	Inpatient Mental Health Readmissions (4.14)	Age 13-17	26
Central	Inpatient Mental Health Readmissions (4.15)	Age 18-64	11
Central	Inpatient Mental Health Readmissions (4.16)	Age 65+	0
East	Inpatient Mental Health Readmissions (4.13)	Age 0-12	13
East	Inpatient Mental Health Readmissions (4.14)	Age 13-17	23
East	Inpatient Mental Health Readmissions (4.15)	Age 18-64	24
East	Inpatient Mental Health Readmissions (4.16)	Age 65+	0
Southwest	Inpatient Mental Health Readmissions (4.13)	Age 0-12	14
Southwest	Inpatient Mental Health Readmissions (4.14)	Age 13-17	11
Southwest	Inpatient Mental Health Readmissions (4.15)	Age 18-64	13
Southwest	Inpatient Mental Health Readmissions (4.16)	Age 65+	0
West	Inpatient Mental Health Readmissions (4.13)	Age 0-12	9
West	Inpatient Mental Health Readmissions (4.14)	Age 13-17	23
West	Inpatient Mental Health Readmissions (4.15)	Age 18-64	5
West	Inpatient Mental Health Readmissions (4.16)	Age 65+	0

* Lower readmissions indicate better performance. **UnitedHealthcare was not operational until May 2017 and therefore did not have any results to compare prior years.

Table 8: HEDIS Performance Measures*				
Measures	**Central**	**East**	**Southwest**	**West**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	50.03%	60.10%	46.71%	61.56%
Chlamydia Screening in Women All Ages (CHL)	39.51%	56.77%	33.30%	44.54%

*UnitedHealthcare was not operational until May 2017 and therefore did not have any results to compare prior years.

10.0 Conclusions

10.1 Strengths and Weaknesses

Strengths

- UnitedHealthcare staff was well prepared for an onsite and had all claims and preparation completed ahead of schedule.
- UnitedHealthcare was able to demonstrate and articulate their knowledge and experience of the measures under review.
- UnitedHealthcare continues to update their systems with most current diagnoses and procedures as they become available during the year.

Weakness

During the onsite primary source verification process, Primaris uncovered a numerator accuracy issue involving a member from another product line being counted in the Inpatient Mental Health Readmission measure. This discovery lead to UnitedHealthcare having to adjust their measure coding language to include only Medicaid members.

10.2 Quality, Timeliness and Access to Healthcare Services

- UnitedHealthcare did not appear to have any barriers to care services.
- UnitedHealthcare's policies and procedures address quality of care for its members.
- Appropriate services such as laboratory, primary care and hospital access, are readily available in all regions. Admission to hospitalization would require proper authorization. However, participating hospitals are well informed on the process for obtaining authorizations from UnitedHealthcare.
- UnitedHealthcare was able to demonstrate its ability to capture the specific diagnosis codes for each Inpatient Mental Health Readmissions, CHL and W34.

10.3 Improvement by UnitedHealthcare

This was UnitedHealthcare's first review under MHD and therefore there was no baseline to assess improvements.

11.0 Recommendations

MCO

- UnitedHealthcare should examine the measure specifications and programming language in more detail to avoid any inclusion or exclusion of members in the measures. It is recommended that UnitedHealthcare include a data quality review prior to final submission and onsite review.
- UnitedHealthcare continues to engage members through outreach programs to ensure they are informed of upcoming service requirements. However, there are still concerns with reaching all members. UnitedHealthcare's chlamydia screening rates are significantly lower in the Central and Southwest Regions. It seems that these two regions would be good candidates for deeper dives into why compliance is lower than other regions.
- UnitedHealthcare should investigate the root cause of low performance in Central (39.51%) and Southwest (33.30%) regions as compared to East (56.77%) and West (44.54%) regions and mitigate the access issues or quality of care issues within the provider network.
- Members should be encouraged to seek outpatient mental health services and follow up once a member is discharged from the hospital following an admission for mental health reasons.

MHD

- MHD is advised to consider including more of State custom measures, CMS coreset measures apart from HEDIS measures for validation purpose, so as to diagnose inaccuracies in the results that are reported and submitted by UnitedHealthcare to MHD/CMS.