Primaris
Healthcare Business Solutions

2020 External Quality Review

Care Management

UnitedHealthcare®

Measurement Period: Calendar Year 2019
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MoHealthNet

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1.0 Purpose and Overview

1.1 Background

The Department of Social Services, Missouri HealthNet Division (MHD), operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care (hereinafter stated "Managed Care"). To ensure all Missourians receive quality care, Managed Care is extended statewide in four regions: Central, Eastern, Western, and Southwestern. The goal is to improve access to needed services and quality of healthcare services in the Managed Care and state aid eligible populations, while controlling the program's cost. Participation in Managed Care is mandatory for certain eligibility groups within the regions in operation. Total number of Managed Care (Medicaid and CHIP combined) enrollees by end of State Fiscal Year 2020 was 657,492 representing an increase of 10.20% as compared to end of SFY 2019.

MHD contracts with Managed Care Organizations (MCOs), also referred to as Managed Care Plans, to provide health care services to its Managed Care enrollees. UnitedHealthcare is one of the three MCOs operating in Missouri (MO). MHD works closely with UnitedHealthcare to monitor services 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 (EQR).

MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an EQR. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish to Medicaid beneficiaries. EQR 2020 evaluates activities of UnitedHealthcare during calendar year (CY) 2019.

1.2 Care Management

Review of UnitedHealthcare's care management (CM) program is one of the activities mandated in MHD-EQRO contract. MHD Managed Care contract, section 2.11, provides guidelines for evaluation of CM Program. The aim of CM review is to identify contributing issues and key drivers. For EQR 2020, MHD requires Primaris to evaluate three focus areas:

- Asthma (members in age group of 5-18 years only).
- Opioid dependence/substance use disorder (SUD).

- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

Care management (CM) is a promising team-based, patient-centered approach "designed to assist patients and their support systems in managing medical conditions more effectively."[1] It also encompasses those care coordination activities needed to help manage chronic illness. Three key strategies to enhance existing or emerging CM programs: (1) identify population(s) with modifiable risks; (2) align CM services to the needs of the population(s); and (3) identify, prepare, and integrate appropriate personnel to deliver the needed services. CM is organized around the precept that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care[2].

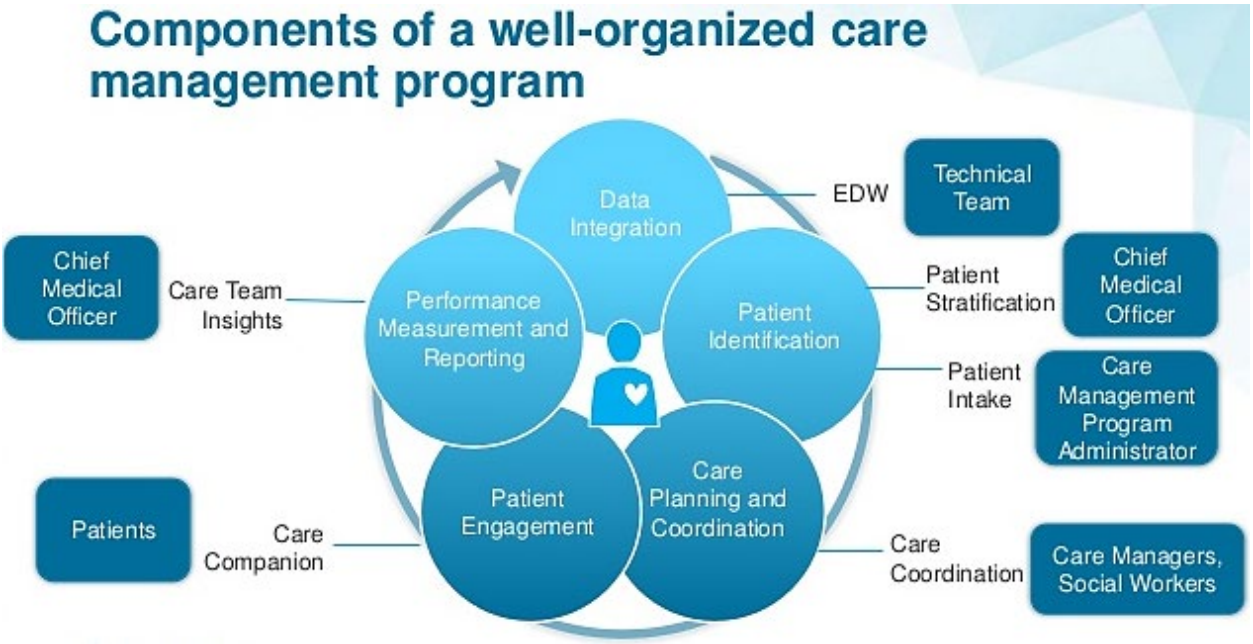


Figure 1. Care Management Components (Source: Healthcatalyst.com, Acronym EDW-Enterprise Data Warehouse)

2.0 Methodology

Evaluation of UnitedHealthcare's CM program was conducted under the following heads (Figure 2):

[1] http://www.chcs.org/resource/care-management-definition-and-framework/
[2] https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html#ref3

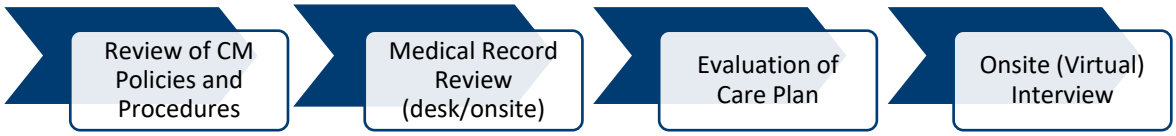


Figure 2. CM Evaluation Process

1. Review of Care Management Policies and Procedures.
In reference to the MHD contract, section 2.11.1c 5, UnitedHealthcare should have policies and procedures in place for CM program. Primaris reviewed all the documents submitted by UnitedHealthcare and reported the results in Table 1 under section 3.1 of this report.

2. Evaluation of Care Plan.
The MHD contract, section 2.11.1e, provides guidelines for the "care plan" as listed below. Primaris followed these guidelines to evaluate the care plan for each of the members included in the samples for medical record review for all three focus areas.
Care plan for ALL eligibles: The MCO shall use the initial assessment to identify the issues necessary to formulate the care plan. All care plans shall include the following components:

- Use of clinical practice guidelines (including the use of CyberAccess to monitor and improve medication adherence and prescribing practices consistent with practice guidelines).
- Use of transportation, community resources, and natural supports.
- Specialized physician and other practitioner care targeted to meet member's needs.
- Member education on accessing services and assistance in making informed decisions about care.
- Prioritized goals based on the assessment of the member's needs that are measurable and achievable.
- Emphasis on prevention, continuity of care, and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings.
- Reviews to promote achievement of CM goals and use of the information for quality management.

3. Onsite Interview.
UnitedHealthcare officials were interviewed to assess:

- The knowledge of MHD contract and requirements for CM. The guiding principle for

CM is that the resources should be focused on people receiving the services they need, not necessarily because the service is available.

- The focus of CM services on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality, health, and cost impact; and creating opportunities and systems to enhance outcomes.

The following UnitedHealthcare officials were interviewed on Oct 29, 2020 via virtual meeting amid Covid-19 Pandemic, to evaluate the CM program

Jamie Bruce, Chief Executive Officer
Katherine Whitaker, Associate Director, Compliance
Aline Hanrahan, Associate Director, Behavioral Health
Colleen Giebe, Director, Medical Clinical Operations
Heidi Strickler, Manager, Medical Clinical Operations
Melanie Rains-Davie, Associate Director, Case Management
Ralph Wuebker, Chief Medical Officer
Michael Leftwich, Care Advocacy Manager
Shannon Zellner, Senior Compliance Analyst
Melissa Howe, Behavioral Care Advocate

4. Medical Record Review (MRR).

Primaris assessed UnitedHealthcare's ability to make available any and all pertinent medical records for the review. A list of members care managed in CY 2019 for the three focus areas was submitted by UnitedHealthcare. Primaris selected a sample of 30 medical records (required sample size of 20, plus 50% oversample for exclusions and exceptions) by using systemic random sampling method based on Appendix B of CMS protocols for EQR, Oct 2019 version). UnitedHealthcare was requested to upload all the 30 medical records electronically at Primaris' secure web-based file upload site.

Desk review of policies, procedures, and medical records was conducted in Feb-Apr 2020. Clarifications were requested during onsite session. (Note: Due to Covid-19 Pandemic, the onsite visit scheduled for Mar 2020 was cancelled per MHD's instructions and rescheduled in Oct 2020 virtually.)

An evaluation tool (Excel sheet) was created to capture information from medical records, which included, at a minimum: referrals; assessment; medical history; psychiatric history;

developmental history; medical conditions; psychosocial issues; legal issues; care planning; lab testing; progress/contact notes; discharge plans; aftercare; transfers; coordination/linking of services; monitoring of services and care; and follow-up. (Note: UnitedHealthcare submits CM Logs to MHD each quarter. Review of these logs is outside the scope of this report.)

Inter Rater Reliability: 10% of the MR from each focus area are reviewed by a different auditor to assess the degree of agreement in assigning a score for compliance in the evaluation tool. Primaris' aim is to achieve 95% score for IRR. We scored 100%.

The following criteria were used for inclusions/exceptions/exclusions of medical records in the study sample:
Inclusion Criteria

- Asthma CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Asthma (ICD-10-CM code J45.xxx)
Anchor date: Members should be enrolled in CM in CY 2019
Age: Members in age group 5-18 years during the measurement year/CY2019.

- Opioid/SUD CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Opioid Dependence (ICD-10-CM code F11.xxx).
Anchor date: Members must be enrolled in CM in CY 2019.
Age: N/A

- BH CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Must not have been in care management in CY 2018 (unless a new diagnosis made in CY 2019). Members should be hospitalized in a psychiatric hospital or be receiving residential treatment for substance use disorder in CY 2019.
Anchor date: Members should be enrolled in CM in CY 2019.
Age: 6 years or older during the measurement year/CY 2019.

Exclusion Criteria: Failure of initial contact with the member in spite of exhausting all means to contact a member-as listed in MHD contract 2.11. There is no exclusion/exception for patient refusal to CM.
Exceptions: The member does not require CM on medical grounds.

3.0 Overall Assessment of Care Management Program

CM Data

Medicaid Managed Care members enrolled in CY 2019 = 156,969
Members enrolled in CM (each focus area) = Asthma: 31, SUD: 7; BH: 68
CM staff available = 47 care managers
Average case load = 250
Maximum members who can receive CM = 11,750 in varying levels of stratification with specialized level of outreach for each level of intensity. The case loads are flexed in order to meet the needs of all members.

3.1 Review of Policies and Procedures

The following policies and procedures were submitted by UnitedHealthcare (Table 1). Upon review, Primaris assigned a score of "Met" with all the requirements mandated by MHD contract. (Note: Definitions of Met/Not Met are adopted from CMS EQRO Protocol 3.)

Table 1: UnitedHealthcare Care Management Policy Review

Policies and Procedures shall include (MHD 2.11.1c5):	Met	Not Met	Document Name(s)
1. A description of the system for identifying, screening, and selecting members for CM services.	●		Community and State WPC Program Description FY 2020, MCM 0012 Risk Stratification Process, MCM 001 Identification of High Risk Members for Case Management
2. Provider and member profiling activities.	●		Community and State WPC Program Description FY 2020, MCM 011 Cultural Proficiency, MCM 001 Identification of High Risk Members for Case Management, NCM 002 Rider-MO_01 Hi Risk Case Management Process
3. Procedures for conducting provider education on CM.	●		MCM 007 Informing and Educating Providers, MCM 11 Cultural Proficiency

	●		MCM 001 Identification of High Risk Members for Case Management
5. A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan.	●		MCM002 CM Process Community and State WPC Program Description FY 2020
6. A process to ensure integration and communication between physical and behavioral health.	●		MCM 006 Integration of Physical and Behavioral Health, MO CM-01 Missouri Case Rounds
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●		MO CM-01 Missouri Case Rounds, NCM 002 Rider-MO_01 Hi Risk Case Management Process
8. A process to ensure that care plans are maintained and updated, as necessary.	●		MCM 002 Care Management Process, NCM 002 Rider-MO_01 Hi Risk Case Management Process
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	●		NCM 002 Rider-MO_01 Hi Risk Case Management Process
10. Timeframes for reevaluation and criteria for CM closure.	●		MCM 002 Care Management Process
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●		Community and State WPC Program Description FY 2020, NCM 030 Clinical Practice Guidelines
12. Additional Information	●		UHC Privacy Policy P15, NCM 010 Case Manager Orientation and Performance Management

3.2 Evaluation of Care Plan

Upon interviewing UnitedHealthcare officials and conducting MRR for all three CM focus areas, Primaris concluded that UnitedHealthcare has policies and procedures based on

contractual guidelines for care plan. However, the care plan per se is member driven and may not include all the components as listed under section 2.0 (2) of this report. The care managers work with the members and create goals based on the care gaps or requirements projected by the members. Interventions are planned to address those requirements before a case is closed. If a member is not willing to address a care gap/issue, it is not included in care plan.

Recommendation

MHD mandate UnitedHealthcare to create a checklist with all the requirements listed under MHD contract section 2.11.1e while developing a care plan for each member.

3.3 Care Management Process

The following information submitted by UnitedHealthcare warrants attention:
1. The Care Managers complete the initial comprehensive assessment as expeditiously as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for high risk CM and is completed within 60 days of identification.

2. Member reassessments will be completed annually, or to document significant change in condition or per contractual requirements.

3. If the member's case is closed due to loss of eligibility, the CM will educate the member regarding the existence of community-based organizations or alternate resources for receiving care.
Figure 3 represents sources of notification/referral to CM program, and Figures 4-5 represent overall CM/SUD/BH process.

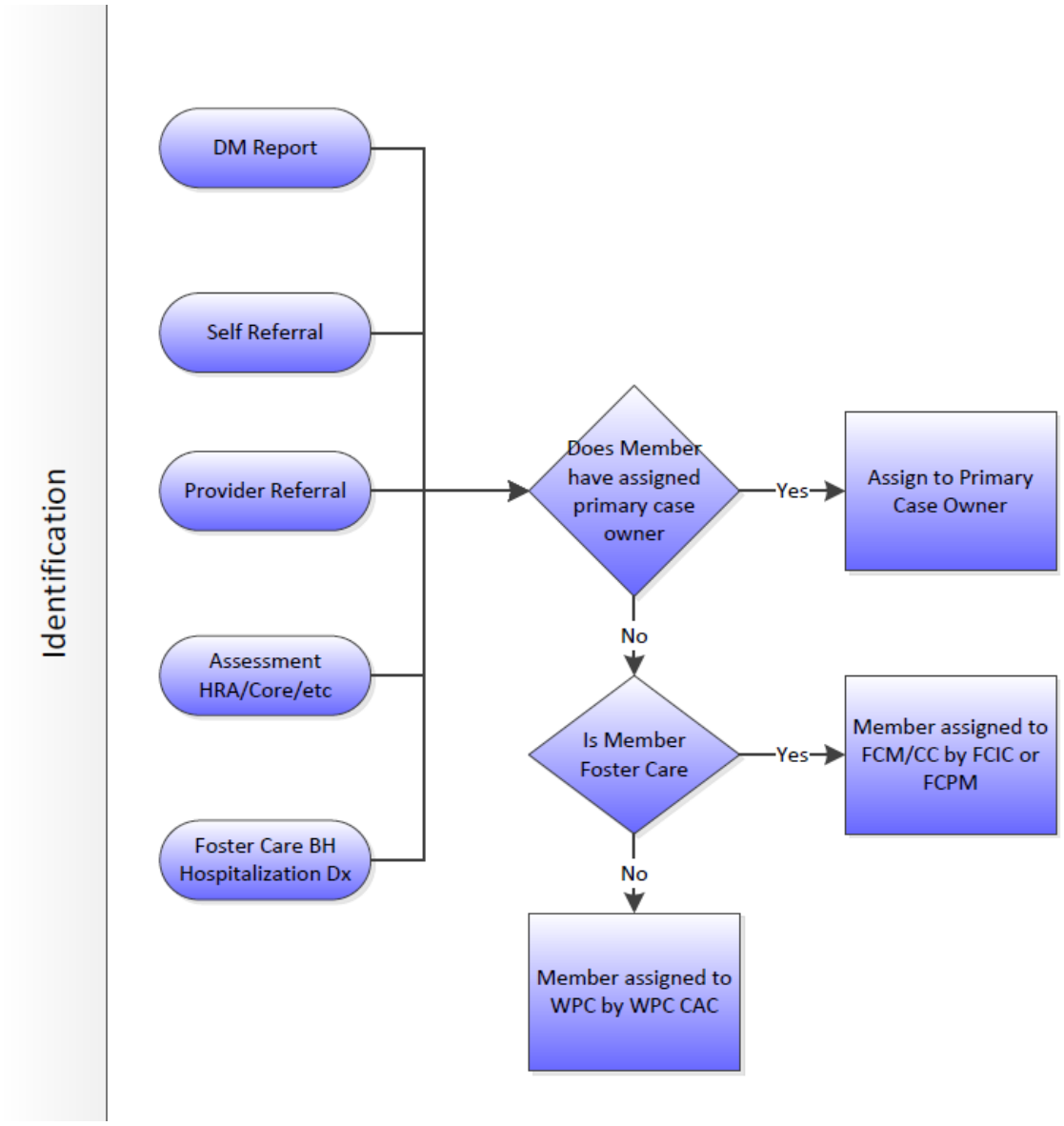


Figure 3. Population Identification for CM (Source: UnitedHealthcare)
(Acronyms used: CC-care coordinator; FC/JJ-foster care/juvenile justice; FCIC-foster care intake coordinator; FCPM-foster care program manager; CANS-assessment for foster kids, WPC-whole person care management program; CAC-clinical administrative coordinator; HRA-high risk assessment)

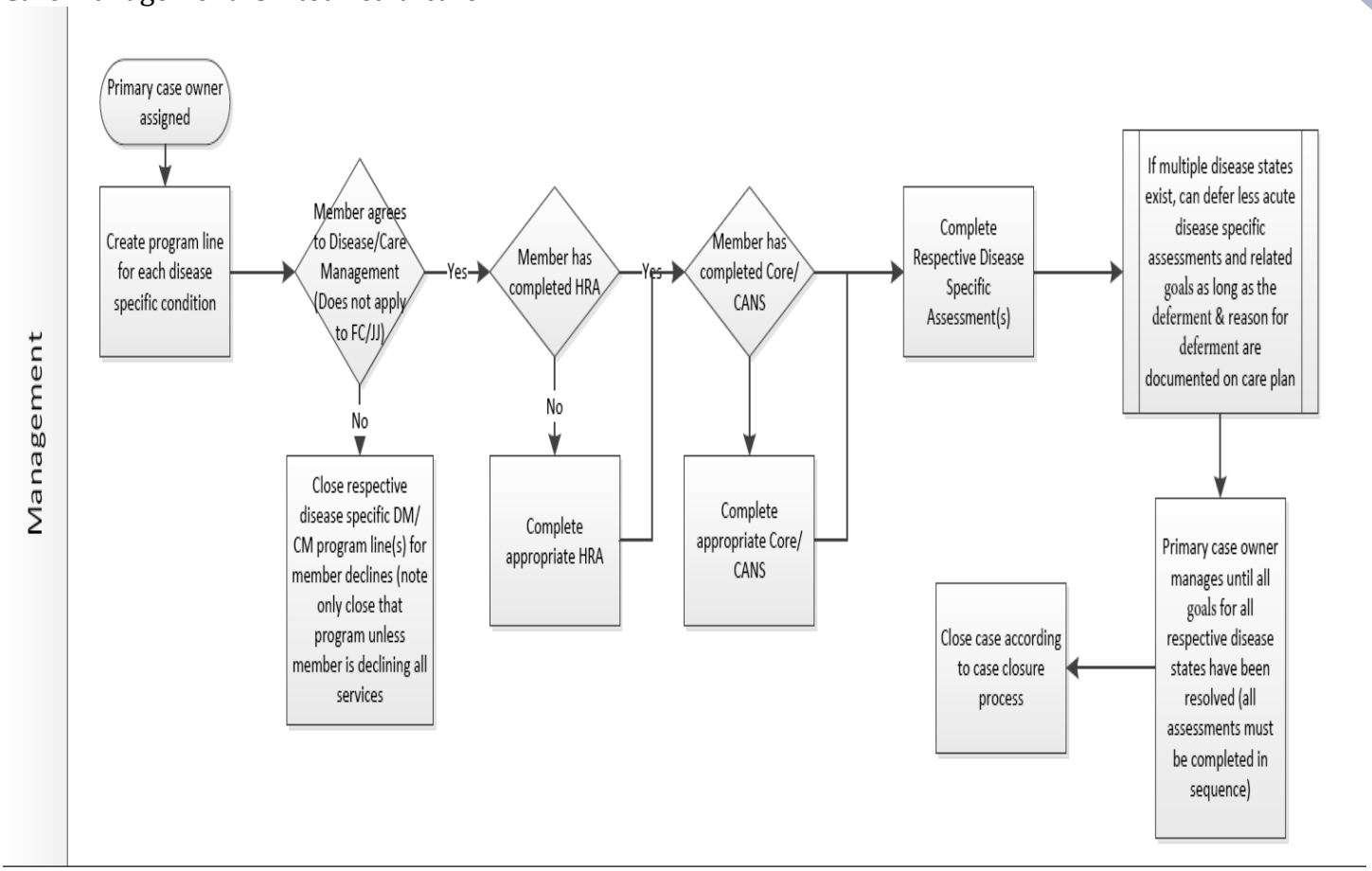


Figure 4. Overall CM Process (Source: UnitedHealthcare)

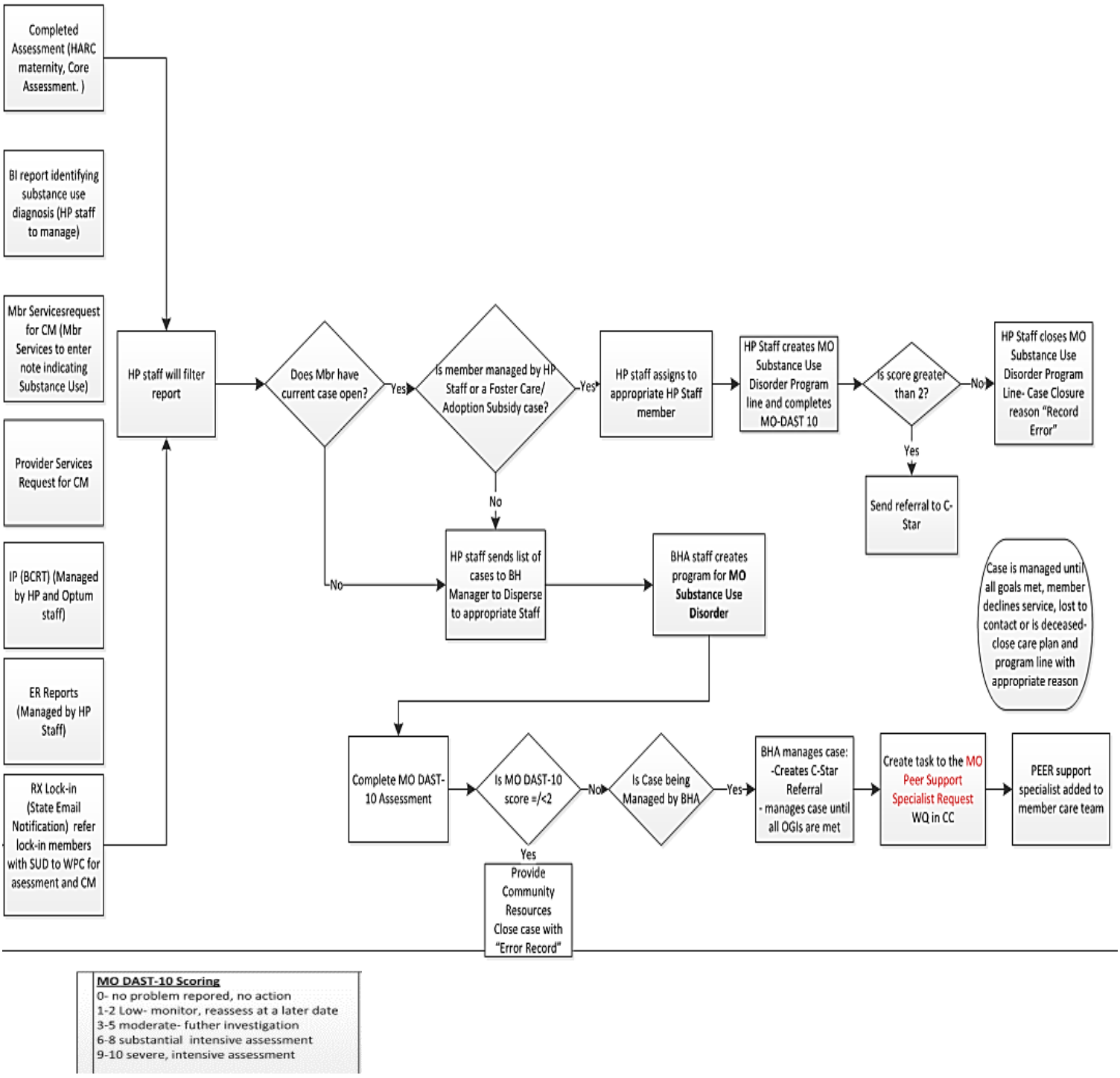
Whole Person Care (WPC) Program

Behavioral health care management is provided by UnitedHealthcare's WPC program. This program provides care coordination within an integrated, multi-disciplinary and geographically local team. The Whole Person Care (WPC) Management program is designed to address both the management of acute events as well as the reduction of future risk for a member through integrated medical and behavioral care management/care coordination to Medicaid members. The WPC program focuses on the clinical and psychosocial needs to optimize the health status of individuals with complex and/or chronic health conditions. The program is accredited by National Committee for Quality Assurance (NCQA) case management.

Interventions:

- The BH CM team collaborates with UM partners via daily rounds and multiple internal teams via interdisciplinary rounds to foster integrative and efficient member support.
- The BH CM team maintains relationships with facilities, outreaching upon member admission, either telephonically or in the field.
- The BH CM team identifies admissions proactively, via census reporting, to

promptly assess for member needs, facilitate FUH appointments and assist with discharge-planning.



(Acronym: DAST-drug abuse screening test)

Figure 5. Substance Use CM Process (Source: UnitedHealthcare)

3.4. Findings of Medical Record Review

Table 2 shows number of medical records included in the study for each CM focus area.

Table 2. Number of Medical Records

	Asthma CM	Opioid/SUD CM	BH CM
Sample size/oversample			20
Number of medical records excluded from review	None	None	None
Number of medical records included in study	20	6	20
Cases closed goals met	4	1	8
Cases open in progress	9	2	1

Table 3 identifies compliance (%) of medical records with various criteria per MHD contract, applicable to all three CM focus areas.

Table 3. Compliance (%) with CM Criteria

Evaluation Criteria	Asthma CM	Opioid/SUD CM	BH CM
Diagnosis			90
Risk stratification	90	Not applicable (N/A)	N/A
Enrollment date CM	100	100	100
Case closure date	100	100	100
Referral date	100	100	100
Offer CM (Assessment) within 30 days (new patient or new diagnosis).	70	100	N/A
Offer CM (Assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program	N/A	N/A	60
Assessment	100	100	70
Medical history	100	50	65
Psychiatric history	95	100	70
Developmental history	95	100	75
Psychosocial issues	100	100	75
Legal issues	85	83	55
Care plan	100	100	95

Participation by member in care plan/reasons for non participation			N/A
Care plan updated	100	100	95
Progress notes	100	100	100
Lab tests	100	100	95
Transfer	100		100
Monitoring medication adherence	95	N/A	N/A
Monitoring services and care	95	100	90
Coordination and linking of services	100	100	95
Discharge plan	27	25	47
Follow up	27	25	47
PCP notification of case closure*	100	100	94
Aggregate Score	**91**	**90**	**81**

*Applicable for children only (age through 18 years).

Red highlighted figures indicate areas for improvement.

Note: Criterion-Provider Treatment Plan-is not evaluated in EQR 2020 per MHD's instructions.

4.0 Conclusions

4.1 Issues and Key Drivers

Issues:

1. CM Need Assessment: UnitedHealthcare did not include medical, psychiatric, developmental, psychosocial, and legal history in a single questionnaire. They elicited members' history in their notes which they refer to as "Functional Domain." Several questions pertaining to these areas/histories were missed by care managers. In BH CM, these areas scored between 55-75%, and in Opioid/SUD CM, score was between 50-100% (Table 3).

2. The questionnaire used for assessment included a few issues. For example: i. advance directives (addressed in care plan) should not be included for all children. They should be based on State guidelines; ii. a question on military service should not be included in assessment for children; iii. a question on breast feeding should not be included in assessment for older children.

3. Repeat CM Assessment: A need assessment for CM is not conducted each time a member

is enrolled in BH CM.
Members may be hospitalized several times while remaining enrolled in CM or a member may be reenrolled in CM after a previous case closure. UnitedHealthcare stated they reassess a case on a six month/annual basis or in case of three or more ER visits, inpatient admissions (Transition of Care assessment).
Primaris noticed ambiguity in this regard during MRR. There are no guidelines in MHD contract on this issue.

4. CM Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for a new member with a diagnosis/new diagnosis of an existing member (for Asthma CM and Opioid/SUD CM).
UnitedHealthcare lacks clarity on what constitutes a "new diagnosis" or a "new member." A member may have multiple enrollment dates in a given year. However, they use the "special healthcare needs" file sent to them from MHD on a monthly basis and begin to outreach members for CM need assessment.
Since these terms are not specifically defined in the MHD contract, Primaris evaluated this criterion as: Offer CM (date of need assessment) within 30 calendar days of notification/referral (by any source: member services/case managers/utilization management alerts/internal reports generated by using claims data and authorizations).

5. Policy: One of the policies submitted by UnitedHealthcare: Case Management Process number NCM 002, states, "the care managers complete the initial comprehensive assessment as expeditiously as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for high risk CM and is completed within 60 days of identification."
Per MHD contract the requirement is to screen new enrollees within 30 days and not within 60 days.

5. CM Criterion: Offer CM (need assessment) within 5 business days of admission to psychiatric hospital or a substance use treatment program.
UnitedHealthcare scored 60% for this criterion in EQR 2020. Even though this is a noteworthy improvement from EQR 2019 (20%); low score remains an issue.

6. Care Plan: As stated earlier in section 3.2 of this report, the care plan addresses areas based on members' projected needs and does not include all points listed in MHD contract. A case in BH CM was closed as "goals met" even though a CM assessment was not conducted. #One of the six cases that was UTC in Asthma CM was closed as "goals met" even

though there was no discharge plan/follow up.
During interview, UnitedHealthcare informed Primaris that short-term goals are created as members allow and case is closed once those goals are achieved.

7. Discharge plan and follow up: Low compliance scores for these criteria are noted across all CM focus areas.
Asthma CM: Cases were lost due to unable to contact (UTC-6 cases#); loss of eligibility (2 case); reason not specified (1 case).
Opioid/SUD CM: UTC (2 cases); loss of eligibility (1 cases).
BH CM: UTC (7cases); loss of eligibility (4 cases).

8. Pharmacy: UnitedHealthcare reported difficulties they had faced on some occasions in gathering member information from MHD's Pharmacy unit. On further enquiry by Primaris, UnitedHealthcare agreed that they do not maintain a log or a tracking mechanism related to issues faced and actions taken to resolve those issues.

Key Drivers:
The following information was obtained from medical records and UnitedHealthcare CM staff during interview (Table 4).

Table 4. Key Drivers

Asthma CM
• Education to providers on using asthma action plan. • Education to members on cessation of smoking, identification, and avoidance of environmental triggers-Asthma Education Program. • Checking for immunization status for influenza vaccine. • Monitoring for medication adherence (CyberAccess℠)*. • Providing nutritional and physical activity counselling resources. • Nurse line (nursing advice services round the clock, 24 x 7). • Transportation services (for all CM focus areas) • Providing information about PCPs/Urgent Care/ED utilization.
Opioid/SUD CM
• Skilled clinical staff (licensed social workers, counsellors) are assigned to all aspects of the screening and assessment process, including initial telephone contacts. • Providing information about psychiatrists and counsellors, behavioral therapy (ReDiscover/ PEEPS recovery program). • Provider portal-providers have access to care plan and information about written patient consent for sharing care plan with PCPs. • Educating members on medication adherence, self-management, post hospitalization appointments.

• Nurse line services
BH CM
• Skilled clinical staff (licensed social workers, counsellors) are assigned to all aspects of the screening and assessment process, including initial telephone contacts. • Engagement of care managers with the members during hospitalization. • Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital. • Linking to community resources/BH support services/therapists. • Medication adherence monitoring. • Monitoring compliance with doctors' appointments. • Crisis line services

* CyberAccess℠ is a web-based, HIPAA-compliant tool that allows the MCO to view drug utilization information in near real time.

4.2 Quality, Timeliness, and Access to Care

UnitedHealthcare scored 80% to 100% in: 21 of 24 criteria evaluated for Asthma CM; 18 of 21 criteria for Opioid/SUD CM; and 12 of 21 criteria for BH CM (Table 4). Table 5 reports some of the HEDIS® measures related to the three focus areas. Improvement in some of the rates can be attributed to UnitedHealthcare's CM Program.

Table 5. HEDIS® Measures Related to CM Focus Areas

CM	HEDIS® Measures	CY 2018	CY 2019	National Average (Medicaid)
Asthma	Medication Management for People with Asthma (age 5-64 years)-50% covered	70.95%	65.81%*	61.52%
	Medication Management for People with Asthma (age 5-64 years)-75% covered	46.62%	41.99%*	37.76%
	Asthma Medication Ratio (age 5-64 years)	71.60%	61.94%	62.99%
Opioid	Use of Opioids from Multiple Providers (Prescribers)	21.87%	BR**	23.20%
	Use of Opioids from Multiple Providers (Pharmacies)	12.40%	BR**	8.29%
	Use of Opioids from Multiple Providers (Prescribers and Pharmacies)	7.20%	BR**	4.83%

BH	Follow Up After Hospitalization for Mental Illness-within 7 days	17.88%	26.15%	35.80%
	Follow Up After Hospitalization for Mental Illness-within 30 days	37.41%	47.81%	56.78%

*Exceeds the national average for Medicaid-HMO

**UnitedHealthcare reported as biased rate

The following data is provided by UnitedHealthcare in support of timeliness of care for BH CM (Table 6).

Table 6. BH CM- Transition of Care (TOC)

Criteria	Score (%)
Discharge Outreach	
• Within 1 Day of Discharge Alert	99.5%
• Beyond 1 Day of Discharge Alert	0.5%
Post-Hospitalization Assessment (PHA)	
• PHA Within 3 Days	73.8 %
• PHA Beyond 3 Days	26.2%

4.3 Improvement by UnitedHealthcare

Table 7 shows results of medical records' compliance with CM criteria listed under MHD contract, for two years (EQR 2019-EQR 2020). (Note: The overall score for these years is not comparable due to exclusion of one of the low scoring areas from previous year, "Provider Treatment Plan" in EQR 2020.)

Table 7. MRR-Compliance with CM Criteria (EQR 2019-EQR 2020)

UnitedHealthcare	OB*	EBLLs*	BH	Asthma	Opioid/SUD	Average Score*
EQR 2020	N/A	N/A	81%	91%	90%	87%
EQR 2019	71%	62%	66%	N/A	N/A	66%

*Acronyms: OB-Obstetric, EBLLs-Elevated blood lead levels / **Not comparable

Response to Previous Year's Recommendations

Table 8 shows previous year's recommendations applicable to overall CM program and UnitedHealthcare's response to them. (Note: The Table does not address previous

recommendations specific to focus areas which were not reviewed in EQR 2020).

Table 8. Response to Previous EQR's Recommendations

Recommendation	Action by UnitedHealthcare	Comment by EQRO
1. UnitedHealthcare should include all the information pertaining to medical, psychiatric, developmental, psychosocial, and legal history in a single questionnaire which should be used for assessing a member's needs.	They have not created a comprehensive assessment to include several areas in history. However, UnitedHealthcare elicits history in their notes which they refer to as Functional Domain.	Partially Met
2. Before closing a case for UTC, at least three (3) different types of attempts should be made prior to closure for this reason. Where appropriate, these should include attempts to contact the member's family. Examples of contact attempts include (MHD Managed Care Contract 2.11f (1)): • Making phone call attempts before, during, and after regular working hours. • Visiting the family's home. • Checking with the primary care provider, Women, Infants, and Children (WIC), and other providers and programs. • Sending letters with an address correction request. (Post Offices can be contacted for information on change of address).	UnitedHealthcare does make calls/sends letters before closing a case in most instances.	Partially Met UnitedHealthcare should also consider visiting a family's home and checking with the PCP, other providers and programs before closing a case as UTC.
3. CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program:	UnitedHealthcare has improved their score from 20% (EQR 2019) to 60% (EQR 2020).	Partially Met Most of the referrals for BH CM occur during concurrent review. UnitedHealthcare should continue to

		work with the hospital authorities to secure permission for the care managers to visit patients during hospital stay so that they can engage with the member for a CM assessment during hospitalization.
4. UnitedHealthcare should consider enrolling a member in CM program and completing "Access to Care-assessment" when they have an opportunity to interact with a member post-discharge for completing their "TOC-assessment."	Same comment as above.	Partially Met
5. Care managers should obtain written consent from the members in BH CM so that their care plan can be shared with PCPs. This is important for integration of BH and physical health. (Care managers must also recognize some patients with severe mental illness may not have the capacity to make decisions regarding the sharing of their information, as in the case of intoxication or temporary psychosis.)	Some of the medical records show that a consent was taken from patients and care plan was shared with the PCPs.	Partially Met BH care plan should be shared with PCPs after obtaining written consent from members according to instructions in 42 CFR Part 2,* as applicable.
6. The care plan submitted to the providers should receive an acknowledgement/approval from providers.	This criterion was not evaluated in EQR 2020 per MHD's instructions.	Partially Met MHD and UnitedHealthcare are working on a process to address this issue.
7. Engaging members in CM program. Deploying the right team member at the right time has a significant impact on a patient's interest in participation.	UnitedHealthcare has made progress in this regard. The number of BH cases closed due to "goals	Partially Met

Tailor messaging to different patient populations to address any unique barriers to enrollment for each.	met" have increased from 5 to 8 in comparison to previous EQR; cases closed due to "UTC" have decreased from 10 to 7. None of the members declined CM once they were enrolled in CM.	
8. MHD contract section 2.11.1 e 5 requires a documentation of member/family notification of discharge from CM. Primaris recommends UnitedHealthcare notify members by sending a member closure letter as opposed to a verbal notification.	UnitedHealthcare has complied with the requirement. They scored 100% in Asthma and Opioid/SUD CM; and 94% in BH CM.	Met

*42 Code of Federal Regulations Part 2: Confidentiality of SUD Patient Records

5.0 Recommendations

UnitedHealthcare

1. UnitedHealthcare should continue to work on the recommendations scored as "Partially Met" in Table 8 .

2. Members in BH CM are neither assessed each time a case is reopened nor when a member is discharged from hospital multiple times, while being enrolled in CM.
Primaris recommends UnitedHealthcare refer to MHD contact, section 2.11.1d5 as applicable for BH CM and contact MHD for additional clarifications on the frequency of CM assessment for existing patients who have recurring episodes of behavioral issues.

3. UnitedHealthcare informed Primaris about educating their providers regarding use of asthma action plan [3] for their members in asthma CM.
Primaris recommends UnitedHealthcare audit providers' medical records at planned intervals to determine whether providers are using asthma action plan (recommended by Centers of Disease Control and Prevention (CDC)/or tailored) in managing asthma. Also, to

[3] https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/asthma-action-plan

check whether providers have adopted prescribing practices consistent with clinical practice guidelines.

4. Assessment should include population specific questions (adults/children of different age groups).

5. Policy on Case Management Process number: NCM 002, requires a revision to reflect the correct time requirement of screening of new enrollees for health needs.

6. UnitedHealthcare should address all points listed under MHD contract, section 2.11.1.e while developing a care plan for each member.

7. Primaris recommends UnitedHealthcare initiate a process that tracks all the issues related to MHD's Pharmacy unit, from start to finish, including but not limited to: date/time of encounter; who spoke to whom (with titles/roles); name and Medicaid ID of the member for whom the communication/contact was made; issue discussed; and the specific outcome. UnitedHealthcare must use supporting documentation (e.g., fax, letters); collaborate with provider services to support improving communication with the MHD Pharmacy unit; and utilize the demographic reports sent by the MHD, the providers (of record) to locate the member for CM services.

MHD

1. Care Plan: Intervention by MHD is needed to improve care plan per section 3.2 of this report.

2. Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for new member with diagnosis/new diagnosis of existing member.
Criterion needs to be modified so that the requirement of contract wherein, "an MCO is required to conduct a risk assessment/need assessment within 30 days of notification of enrollment by the MHD" can be assessed accurately. Clear definitions of "new member" "new diagnosis" should be provided.

3. Criterion: CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program.
Primaris recommends a change in the criteria by replacing "admission" with "discharge" and "business days" with "calendar days." Many members may not be in a proper mental

state to engage with care managers within five days of admission. UnitedHealthcare may have several holidays/non-business days which may delay members' care.

4. Case Closure Notification: MHD contract section 2.11.1f states that a PCP must be notified in writing of all instances of children discharged from CM and the reason for discharge. MHD should provide clarification as to whether PCP notification requirement is limited to children (age limit) only and not applicable for adults.

5. The MHD should provide a minimum duration for which a CM outreach should be tried by UnitedHealthcare before case closure for "UTC" occurs.

6. The MHD should consider setting benchmarks and incentives for critical criteria in the CM program which can serve as a driving force for the MCOs to improve their efforts towards member outcomes.

Suggested Resources

1. Engaging Stakeholders in a Care Management Program. https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm2.html

2. Patient Engagement. https://www.healthcatalyst.com/three-must-haves-of-an-effective-care-management-system

3. A guide for an overview of case management for substance use disorder treatment providers. https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215. It discusses models, program evaluation, managed care issues, referral and service coordination requirements, and clients with special needs.