Primaris
Healthcare Business Solutions

2020 External Quality Review
Compliance

UnitedHealthcare®

Measurement Period: Calendar Year 2019
Validation Period: May-July 2020
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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).

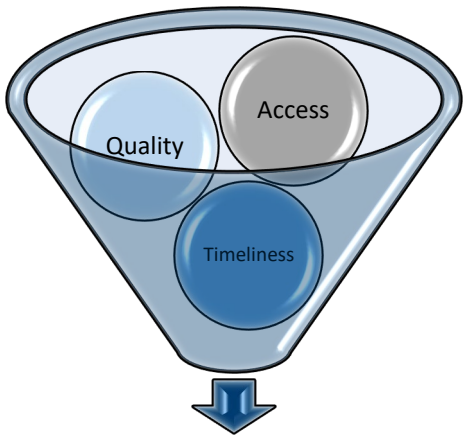
MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an EQR. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish to Medicaid beneficiaries (Figure 1). EQR 2020 evaluates activities of UnitedHealthcare during calendar year (CY) 2019.

1.2 Compliance with Regulations

UnitedHealthcare is audited annually to assess compliance with the Federal Medicaid Managed Care and Children's Health Insurance Program (CHIP) Regulations; State Quality Strategy; MHD Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous year's review. A review is conducted based on Centers for Medicare and Medicaid Services (CMS), Oct 2019 EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, to

meet the requirements of Code of Federal Regulations (CFR) 438.358(b) (iii). This section of the CFR requires a review to be conducted within a previous 3-year period to determine the MCO's compliance with standards set forth in subpart D of 42 CFR 438 and subpart E, 438.330.

Quality (42 CFR 438.320 (2)): as it pertains to external quality review, means the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through:
(1) Its structural and operational characteristics.
(2) The provision of services that are consistent with current professional, evidence-based knowledge.
(3) Interventions for performance



EQR of Managed Care Services

Access (42 CFR 438.320): As it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

Timeliness: Federal Managed Care Regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services.

Figure 1. EQR-A Federal Requirement

2.0 Methodology

Regulation due for review in EQR 2020 (third year of cycle) was 42 CFR 438, Subpart E, 438.330: Quality assessment and performance improvement (QAPI) program (Figure 2). Primaris collaborated with MHD and UnitedHealthcare to:

- Determine the scope of the review, scoring methodology, and data collection methods.
- Finalize the onsite review agenda.
- Collect and review data and documents before, during and after the on-site review.
- Identify key issues through analyzing the data collected.
- Prepare a report related to the findings of current year and a summary of findings from all previous reviews within the current three-year review cycle.
- Review UnitedHealthcare's response to previous EQR recommendations.

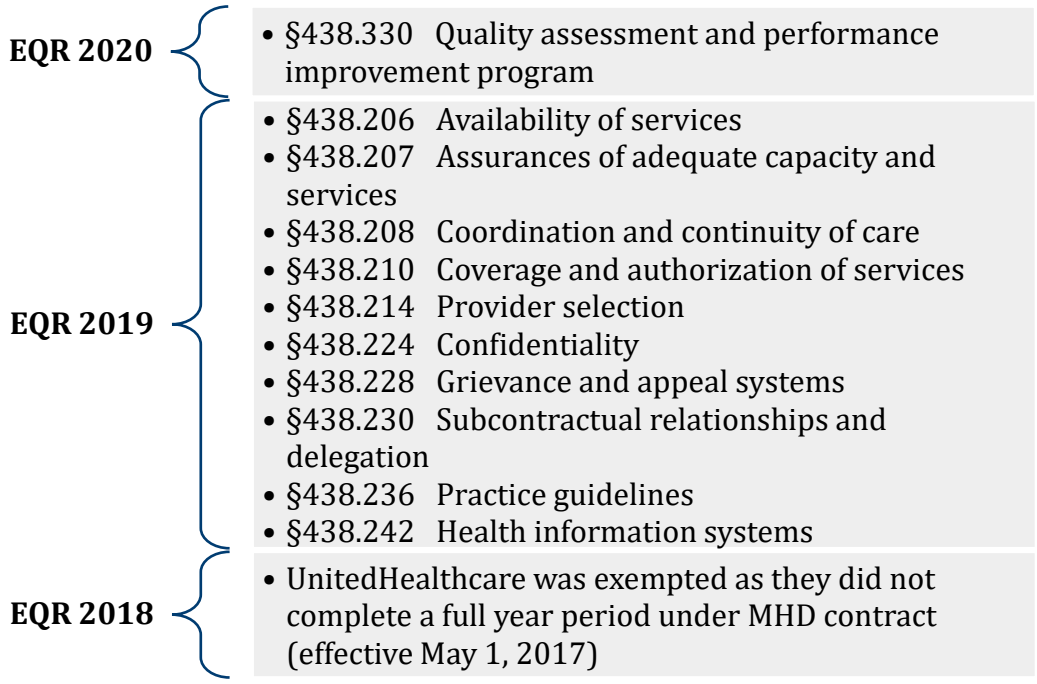


Figure 2. A Three-Year Compliance Review Cycle

Figure 3. Process of Compliance Evaluation

Primaris conducted compliance review in May-July 2020. The evaluation process included requesting and analyzing documentations pre- and post-virtual onsite, and interviews (Figure 3). Primaris provided Technical Assistance (TA) during the review period to steer UnitedHealthcare towards excellence. The details of the technical assistance provided were presented to MHD on Jun 11, 2020. An evaluation tool was created based on MHD instructions and template for QAPI, Managed Care Contract, and 42CFR 438.330 QAPI (appendix A). UnitedHealthcare submitted their documents via Primaris' secure website service to enable a complete and in-depth analysis of their compliance with regulations.

These included policies, procedures, logs, PowerPoint presentations, reports, and print-screens as follows:

- ✓ Quality improvement program description
- ✓ 2019 Annual state quality improvement program evaluation
- ✓ Quality improvement work plan 2020
- ✓ 2019 Annual population health management assessment and evaluation
- ✓ Population health management strategy
- ✓ Inventory by Language of Member Materials Translated
- ✓ Whole Person Care Program Description
- ✓ Special Healthcare Needs (SHCN) narrative
- ✓ UnitedHealthcare–Missouri Architecture
- ✓ 2019 Patient Care Opportunity Report (PCOR)
- ✓ Systemic data correction narrative
- ✓ Hybrid resample
- ✓ All access metrics
- ✓ LAMP metrics (languages)
- ✓ QA003-POL.2413020-Provider profiling and monitoring of over and under utilization
- ✓ PowerPoint presentation: QAPI
- ✓ 2019 Annual collaborative analysis continuity and coordination between behavioral health and medical care
- ✓ Compliance committee report
- ✓ Annual fraud, waste, and abuse (FWA) training
- ✓ 2019 Interpreter reports
- ✓ Care Provider Demographic Information Update
- ✓ Minutes of meetings: Compliance Oversight Committee (COC), Healthcare Quality & Utilization Management (HQUM), Physician Advisory Committee (PAC), Quality Improvement Committee (QIC).

Onsite Interviews

A virtual meeting with UnitedHealthcare was conducted on May 27, 2020, as travel to onsite office location in St. Louis, Missouri was restricted due to the Covid-19 Pandemic. The following personnel from UnitedHealthcare were available for an interactive session:

- Jamie Bruce, Chief Executive Officer
- Ralph Wuebker, MD, Chief Medical Officer
- Lisa Overturf, CPHQ, Associate Director, Clinical Quality
- Katherine Whitaker, Associate Director, Compliance
- Kayla Townley, Consultant, Clinical Quality

- Angela Edmondson, Consultant, Clinical Quality
- Shannon Zellner, Senior Analyst, Compliance
- Jenene Dean, Coordinator, EPSDT

Compliance Ratings

The information provided by UnitedHealthcare was analyzed and an overall compliance score in percentage was given. Each section of an evaluation tool was assigned 2 points (denominator) and was scored as: Fully Met (2 points), Partially Met (1 point), or Not Met (0 point). Primaris will utilize a compliance rating system as defined in Table 1 (Source: EQR Protocol 3).

Table 1. Compliance Scoring System

●	**Fully Met** (2 points): All documentation listed under a regulatory provision, or component thereof, is present. MCO staff provide responses to reviewers that are consistent with each other and with the documentation. A State-defined percentage of all data sources–either documents or MCO staff–provide evidence of compliance with regulatory provisions.
●	**Partially Met** (1 point): All documentation listed under a regulatory provision, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a regulatory provision would result in a "Partially Met" designation for the provision as a whole.
●	**Not Met** (0 point): No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions; or No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the State) of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

3.0 Performance Strengths and Areas Requiring Corrective Action

3.1 Overall Summary of Findings

An assessment was done for one federal regulation in EQR 2020, with UnitedHealthcare achieving a compliance score of 96.9%. Table 2 summarizes findings from EQR 2020 as well as previous reviews within the current three-year review cycle.

$$\text{Compliance Score \%} = \frac{\text{Total Score X100}}{\text{Total Sections X 2 points}} = 100\%$$

Table 2. Summary of Compliance-3 Year Cycle

		Number of Sections						
42 CFR Code	**Regulation**	**Total**	**Met**	**Partially Met**	**Not Met**	**Score**	**Score %**	**Aggregate Score% (3 Years)**
§438.330	Quality assessment and performance improvement program	33	31	2	0	64	**96.9**	Year 3 **96.9** EQR 2020
§438.206	Availability of services	11	11	0	0	22	**100**	Year 2 **99.4** EQR 2019
§438.207	Assurances of adequate capacity and services	10	10	0	0	20	**100**	
§438.208	Coordination and continuity of care	17	17	0	0	34	**100**	
§438.210	Coverage and authorization of services	22	20	2	0	42	**95.5**	
§438.214	Provider selection	12	12	0	0	24	**100**	
§438.224	Confidentiality	19	19	0	0	38	**100**	
§438.228	Grievance and appeal systems	44	44	0	0	88	**100**	
§438.230	Sub Contractual Relationships and Delegation	7	7	0	0	14	**100**	
§438.236	Practice Guidelines	6	6	0	0	12	**100**	
§438.242	Health Information Systems	7	7	0	0	14	**100**	
	Exempted. UnitedHealthcare was not operational for one full year (new contract)							Year 1 **N/A** EQR 2018

3.2 Regulation I-Quality Assessment and Performance Improvement Program

UnitedHealthcare was evaluated for 33 criteria under this standard and received "Met" for 31 and "Partially Met" for two of them, scoring 96.9% for compliance (Appendix A).

3.2.1 Quality, Timeliness, and Access to Healthcare Services

Strengths

1. QAPI Program: The National Quality Oversight Committee (NQOC) directs quality programs for UnitedHealthcare at the national level. The Governing Board of Directors (BOD) delegates oversight of the QAPI program to the State level Quality Management Committee (QMC). QMC is the decision-making body that is ultimately responsible for the implementation, coordination, and integration of all QAPI activities for UnitedHealthcare in MO. QMC meets at least quarterly and reports to the BOD at least annually. The Chief

Executive Officer (CEO) is responsible for oversight of the QAPI Program and chairs or designates the chair for the QMC.

UnitedHealthcare's QAPI program procedures are developed and implemented by experienced professionals in quality assessment, utilization management, and continuous improvement processes. The Chief Medical Officer is a Missouri licensed physician who is responsible for implementation of the QAPI Program. The Associate Director, Clinical Quality, is responsible for coordination of all QAPI activities. The coordinator is a Certified Professional in Healthcare Quality (CPHQ) designated by the National Association of Healthcare Quality (NAHQ).

An annual review of the overall effectiveness of the QAPI Program is conducted to assess the utilization of resources to improve the quality and safety of clinical care and services provided to members. The results of the annual QAPI Evaluation are used to develop and prioritize activities for the next year's QAPI Work Plan. An analysis and evaluation of action items are documented in the meeting minutes of UnitedHealthcare's quality and compliance committee(s).

2. Population Analysis: UnitedHealthcare has a Population Health Management Strategy that analyzes and evaluates information population characteristics: race, ethnicity, languages, and special needs to segment members into categories (e.g., selected age or gender bands, common diagnoses, identified social determinants, disability categories, and utilization patterns). Within these segments, members may be determined to be at low or high risk and interventions are directed accordingly. Low risk members are primarily focused on prevention. High-risk, medically fragile members are targeted for the Intensive Opportunity Complex Case Management Program. UnitedHealthcare analyzes, evaluates, and provides Culturally and Linguistically Appropriate Services (CLAS) to its members.

3. Accessibility of Services: Access to urgent care services (within 24 hours) was 98.01% in CY 2019 (CAHPS survey) as compared to 91.98% in CY 2018 (member survey by UnitedHealthcare). The goal of 80% was met. Non-symptomatic routine appointments (within 30 days) availability with PCPs was 95.54% in CY 2019 (CAHPS survey) as compared to 88.73% in CY 2018 (member survey). The appointment availability for specialty care was at 89.02% in CY 2019 (CAHPS survey) as compared to 78.87% in CY 2018 (member survey conducted by the UnitedHealthcare). The goal of 80% was met in CY 2019.

4. Network Adequacy: The number of PCPs-to-enrollees ratio in CY 2019 was 1:6 (goal

1:1000, ratio targets are set based on analysis of published literature and trend performance for the UnitedHealthcare network). Ratio of Pediatricians to enrollees was 1:15 (goal 1:1000). Ratio of High Impact providers (Cardiologists and Oncologists) to enrollees was 1:10 (goal 1:2000) and 1:22 (goal 1:4000) respectively. Analysis of the network indicates the plan has a robust network of practitioners to meet members' needs.

5. Performance Measures: UnitedHealthcare reported 14 HEDIS measures. Of these, 10 measures showed improvement from previous year. Performance Improvement Projects are done around two HEDIS measures: Childhood Immunization Status (CIS combo 10) rate in CY 2019 (25.06%) showed an increase by 3.41% points from CY 2018 and Annual Dental Visit (ADV) measure (53.70%) increased by 5.46% points from CY 2018 (interim rates as on 5.4.20). UnitedHealthcare monitors concurrent (prospective) HEDIS® reports to identify any areas of concern or opportunities for improvement. The Patient Care Opportunity Report (PCOR) is a preventive health care information report run by the provider's Tax ID Number (TIN) that includes a list of attributed members based on claims data and their compliancy with certain HEDIS® measures. The PCOR is updated on a monthly basis and is available on UnitedHealthcare's provider portal. In addition, UnitedHealthcare's Clinical Practice Consultants (CPCs) deliver the PCOR monthly to providers who participate in the Community Plan–Primary Care Practitioner Incentive (CP-PCPi) program and discuss the open care opportunities and quality improvement practices related to incentive/Pay for Performance (P4P) HEDIS® measures.

6. Fraud, waste, and abuse (FWA) program: UnitedHealthcare has a prospective claim review process. Claims are identified by pre-pay flags as being potential FWA. During CY 2019, UnitedHealthcare reviewed approximately 4,036 MO Medicaid claims. Following medical record review by certified coders, about 53% claims were paid, 25% were denied. About 2.8% (117 out of 4036) were hard denials for reasons such as previous investigations or sanctions. As a part of these campaigns a potential billing issue is chosen and then analytics are run to identify providers requiring education on a large scale across all identified states.

7. Information Management (claims processing-timeliness, membership, providers): UnitedHealthcare processed 99.98% to 100% clean claims within the turnaround time of 30 days each month (1.59 million clean claims for Medicaid in CY 2019). Primaris commends these strict internal goals established by UnitedHealthcare. These are higher than those in MHD contract section 2.26 which requires the MCO to follow timeframes listed under RSMo 376.383 and 376.384 (2014) and permits a processing time of up to 45 days from the date of receipt of the claim.

Compliance: UnitedHealthcare

8. Credentialing/Recredentialing: UnitedHealthcare met 99% of the goal of 60 days set by State for credentialing practitioners and facilities. Recredentialing was completed within 3 years for 99.6% of providers.

9. Medical Record Review: UnitedHealthcare carried out a medical record review to determine whether a provider is following the policies and procedures related to advance directives (required per MHD contract as a part of recredentialing). PCPs (33) were randomly selected from claims data from 9.1.18 to 9.30.19. All providers were compliant in CY 2019.

10. Clinical Practice Guidelines (CPGs): UnitedHealthcare utilizes evidence-based CPGs that are formally adopted by UnitedHealthcare's National Quality Oversight Committee (NQOC), which oversees the implementation and compliance of the clinical program/care management content with the guidelines.

11. The grievance and appeal department did not receive any provider complaints in CY 2019. Providers have many options for resolving issues before filing a provider complaint, such as working with the provider advocates.

12. Utilization Management: UnitedHealthcare has systems and processes in place to monitor under and overuse of services and to communicate information on member utilization using provider profiles to PCPs. Provider profiles were generated and shared with PCPs having 200 or more members bi-annually. UnitedHealthcare's Chief Medical Officer (CMO) and quality staff utilize the data to build relationships with network providers and educate them about expectations relative to utilization and the quality of care. The report includes provider- or group-specific data for key utilization measures with a peer comparison percentile ranking.

13. Quality Evaluation: The evaluation process of quality issues and actions identified through the quality strategy includes a review of all aspects of the QI Program, emphasizing demonstrated improvements in the quality and safety of care and quality of service provided to members as well as opportunities for improvement. For all goals that are not met, a root cause or barrier analysis is conducted to identify the underlying reason. This information is utilized to determine changes or restructuring of the QI Program as necessary.

14. Subcontractors: Vendors for Dental, Vision, Transportation, and Call Center services are evaluated for Fraud, Waste, and Abuse (FWA); Encounter data; Prior Authorization Denials;

Timely payment; PIPs and HEDIS® measures (Dental Vendor); and Customer Satisfaction and Member Experience (Transportation Vendor). Transportation vendor reported 19 cases of FWA in CY 2019 which have decreased from 25 cases in CY 2018 and 36 cases in CY 2017. UnitedHealthcare stated that all vendors have a good relationship with UnitedHealthcare and met established performance requirements related to quality in CY 2019.

Weaknesses

1. Provider Satisfaction: Response to a provider satisfaction survey conducted by UnitedHealthcare (Sept 9-Oct 31, 2019 with sample size 2,027) was very low (3%). The satisfaction result for claims processing was approximately 38%, care coordination was < 38%, and communications < 36%.

2. UnitedHealthcare formed a collaborative work group in June 2018 and continued to meet throughout CY 2019 on a Bi-monthly/frequent basis. Data and work group activities reviewed were related to exchange information between medical and behavioral health practitioners. The results of clinical satisfaction survey showed UnitedHealthcare has met their goal of 5% increase in usefulness of information provided by PCPs to Behavioral Health providers in CY 2019 in comparison to CY 2018, but the rate is still very low (45% for usefulness of information). The goal for timeliness of information exchange was not met (36%).

3. Grievances and Appeals: The number of member grievances increased from 2.39 (SFY 2018) to 3.09 (SFY 2019) per 1000 members which is an increase of 29.28%. The number of member appeals increased from 1.2 (SFY 2018) to 1.7 (SFY 2019) per 1000 members which is an increase of 41.66%. The increase in grievances and appeals were in the areas of Access, Attitude/Service, and Billing/Financial.

4. Confidentiality: In CY 2019, there were two instances of a breach of confidentiality (misdirected mail and misdirected manual fax) affecting two members though they were of a low impact.

5. Access: After-hours care access decreased to 78.66% in CY 2019 as compared to 93.10% in CY 2018. This was a decrease of 14.44 percentage points from the previous year's member survey (goal 80%).

3.2.2 Areas Requiring Corrective Action

A Corrective Action Plan (CAP) is not recommended. However, UnitedHealthcare is required to resolve issues associated with two criteria that are assigned a score of "Partially Met" (details in appendix A):

1. UnitedHealthcare should report data and analysis on availability of appointments for routine symptomatic patients per MHD contractual requirements (section A 5 iv)-Partially Met.

2. An analysis and evaluation of disease management program: The active participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility). UnitedHealthcare has not reported on NCQA participation rate (section A 10 ii)-Partially Met.

4.0 Corrective Action Plan Process

Table 3. Audit Results for UnitedHealthcare (EQR 2018 2020)

42 CFR Regulation	Key Findings	Sections Met/Total	Audit Results
§438.330 Quality assessment and performance improvement program	Concerns identified	31/33	Partially Met
438.206 Availability of services	No concerns identified	11/11	Met
438.207 Assurances of adequate capacity and services	No concerns identified	10/10	Met
438.208 Coordination and continuity of care	No concerns identified	17/17	Met
438.210 Coverage and authorization of services	Concerns identified	20/22	Partially Met
438.214 Provider selection	No concerns identified	12/12	Met
438.224 Confidentiality	No concerns identified	19/19	Met
438.228 Grievance and appeal systems	No concerns identified	44/44	Met
§438.230 Sub Contractual Relationships and Delegation	No concerns identified	7/7	Met
§438.236 Practice Guidelines	No concerns identified	6/6	Met
§438.242 Health Information Systems	No concerns identified	7/7	Met

UnitedHealthcare must identify for each "Not Met" criteria that requires a corrective action the interventions it plans to implement to achieve compliance with the requirement, including how the UnitedHealthcare will measure the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. MHD, in consultation with Primaris, will review, and when deemed sufficient, approve UnitedHealthcare's CAP to ensure the CAP adequately addresses the interventions needed to bring performance into compliance with the requirements. Primaris does not initiate a CAP for "Partially Met" sections. However, UnitedHealthcare is required to resolve these issues that would be evaluated during next year's review. Table 3 is inclusive of all deficiencies noted during a three-year review cycle (EQR 2018-2020).

5.0 Conclusion

5.1 Improvement by UnitedHealthcare

Figure 4 depicts the performance of UnitedHealthcare over a three-year review cycle. In EQR 2018, UnitedHealthcare was exempted from EQR as it did not complete a full one-year contract under MHD. However, a technical assistance session was provided by Primaris. All the regulatory standards due in EQR 2018 were covered in EQR 2019. In EQR 2020 (CY 2019-96.9%), there is a decline of 2.5% points in compliance score from EQR 2019 (CY 2018-99.4%). None of the regulatory standards scored "Not Met" in two EQRs.

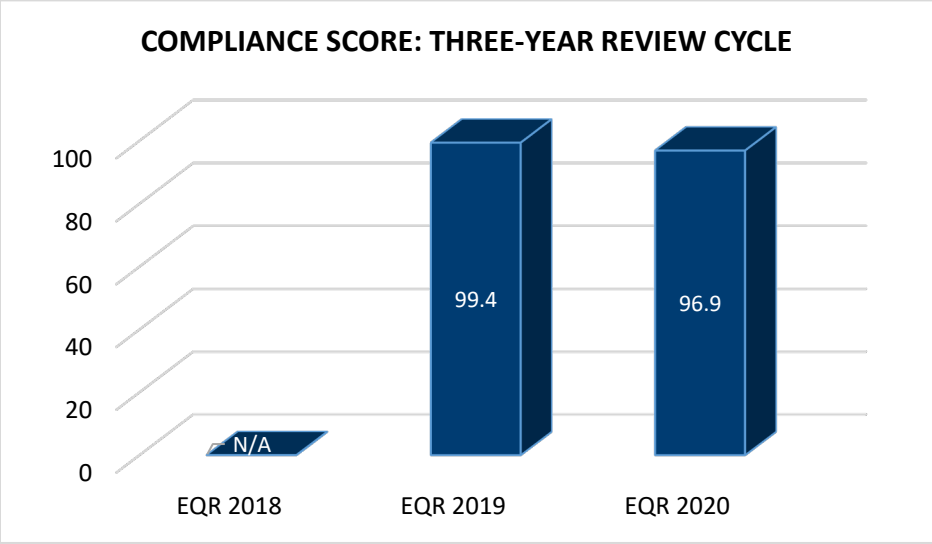


Figure 4. Compliance Score (EQR 2018-EQR 2020)

5.2 Response to Previous Year's Recommendations

UnitedHealthcare is required to submit documentation to support all "Partially Met" criteria from last year's review including response to recommendations (Table 4).

Table 4. UnitedHealthcare's Response to Previous Recommendations

Recommendations	Action by UnitedHealthcare	Comment by EQRO
1. Member handbook/policies did not state that "family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20"-Partially Met	UnitedHealthcare has updated the required language in Member handbook (page 59).	Fully Met
2. MCO is responsible for payment of custom items (e.g. custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) that are delivered or placed within six (6) months of approval, even if the member's enrollment in the health plan ends (MHD contract 2.5.5h): UnitedHealthcare stated that they have not had any occurrences of this issue since May 01, 2017 (effective date of contract with MHD), and were unaware of a need for this policy. However, UnitedHealthcare has a new setup which pays for these custom items-Partially Met	UnitedHealthcare has a policy in place: CL-001 Payment of Custom Items	Fully Met
3. UnitedHealthcare should update all of their subcontractors' agreements with the "right to audit for 10 years…" as per 42 CFR 438.230(c) (3) (iii), consistently. (Date of applicability: July 1, 2017).	UnitedHealthcare has submitted in writing that they have updated all subcontractors' agreements per their Master Agreement: Missouri State Program(S) Regulatory Requirements Appendix.	No further action required. Item closed.
4. Revisions to policies/documents as a result of technical assistance should be submitted to the MHD for approval.	UnitedHealthcare updated the following policies and received an approval from MHD.	No further action required. Item closed.

	• Payment of Custom Items PP20 UHC024 (MHD approval 8.2.19) • UHC State notification of provider termination policy PP19 UHC033 (MHD approval 5.21.19) • MO Privacy and Confidentiality PP19-UHC032 (MHD approval 5.29.19) • MO Medicaid Member Appeal and Grievance Policy PP19-UHC031 (MHD approval 6.12.19) • Subcontractor Oversight PP21 UHC005 (MHD approval 7.15.20) • UCSMM.06.10 Clinical review criteria PP21-UHC024 (MHD approval 7.15.20)	

6.0 Recommendations

6.1 UnitedHealthcare

1. UnitedHealthcare is required to address two "Partially Met" criteria as detailed in section 3.2.2 of this report.
Disease Management-Active Participation Rate (as defined by NCQA): UnitedHealthcare stated that they did not report these rates due to technology upgradation requirement for such reporting. Primaris recommends UnitedHealthcare to provide these rates in QAPI. Any difficulties in the process should be communicated to MHD.

2. Grievances and Appeals: UnitedHealthcare has reported Member Appeals under categories adopted from NCQA accreditation standards such as: Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not in alignment with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends UnitedHealthcare to seek written clarification on expectations from MHD. UnitedHealthcare should update data in 2019 QAPI report as well as comply with MHD's instructions for future reporting.

(Suggestion: UnitedHealthcare may report criteria from all authorities such as NCQA, MHD contract, and incorporate adjacent columns to indicate applicable/not applicable, goals met/not met, in the data tables presented in QAPI report.)

Additional Resources

1. UnitedHealthcare should continue to improve the scores obtained in Provider Satisfaction Survey per their plan in QAPI. UnitedHealthcare may explore the following ways to improve low response to satisfaction surveys:

- https://www.ajmc.com/journals/issue/2019/2019-vol25-n7/physician-satisfaction-with-health-plans-results-from-a-national-survey
- https://www.nap.edu/read/18293/chapter/6
- https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-015-0016-z

2. Improving Access to Care, After-hour appointments.

- Appointments scheduled at these times (5 p.m.-8 a.m., Monday-Friday, any time on weekends, holidays) may be billed using the appropriate after-hours CPT code for an additional reimbursement.
- PCPs may provide coverage via telemedicine, video conferencing, phone, in person, by email or combination of these means of communication.[1]
- After-hours care may be coordinated with a patient's usual primary care provider and facilitated by consideration of patient demand, provider capacity, a shared electronic health record, systematic notification procedures and a broader practice approach to improving primary care access and continuity. Also, payer support is important to increasing patients' access to after-hours care.[2]

3. Care Management-Collaboration between PCPs and Behavioral Health Providers. UnitedHealthcare has analyzed the barriers, opportunities, and interventions to improve this collaboration. They should continue to work on them for improved outcomes. Information from the following sources may be helpful.

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/ (Figure 5)
- https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf

[1] https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0494
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3475839/

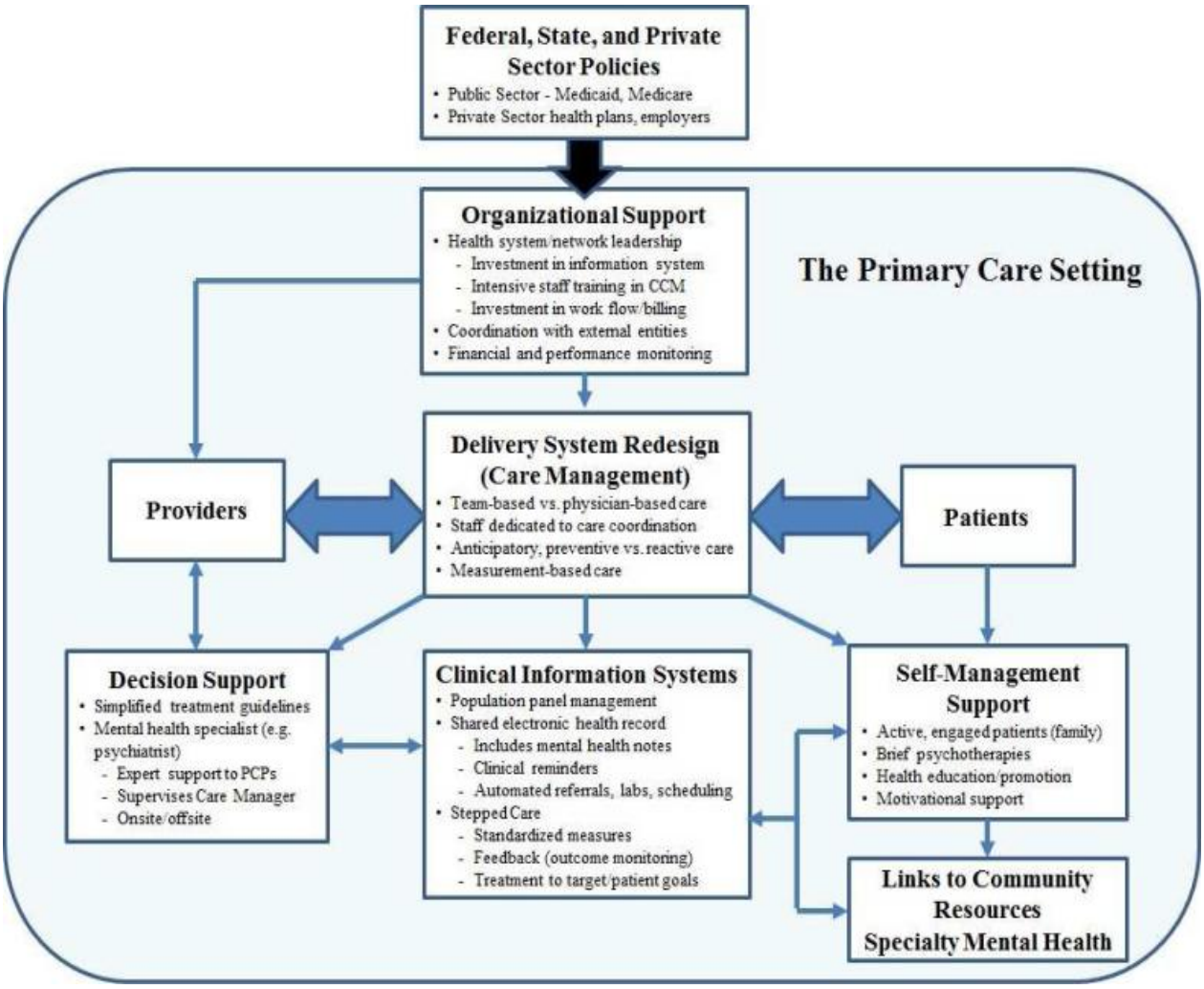


Figure 5. Evidence-based Components of Collaborative Care for Mental Health in Primary Care. Based on the original model articulated in Wagner et al. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/)

6.2 MHD

During EQR 2020, Primaris noted a few criteria under the QAPI Program evaluation for which there were either no instructions provided to the MCOs or there was ambiguity regarding expectations from MCOs. For this reason, two sections out of 35 were marked as "Not Applicable" (N/A) in the evaluation tool (ref. to appendix A). Table 5 lists criteria for which MHD is required to set expectations for MCOs.

Table 5. Recommendations for MHD

Requirements and References	Recommendation for MHD
3. Population Characteristics: An analysis and evaluation of how MCO incorporates its population characteristics into its quality strategy: race, ethnicity, languages, special needs, and opt outs.	MHD should clarify what information is expected from MCOs to present in QAPI regarding "opt outs." **Suggestion:** opt out of CM program opt out of MCO opt out of Managed Care to Fee-for-Service
4. Quality Indicators	
i. Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services (DHSS).	MHD should consult DHSS and provide indicators to MCOs. These should be clarified in QAPI instructions.
iii. MO HealthNet Managed Care HEDIS Measures.	In addition to HEDIS measures, MHD to consider if MCOs should include custom measures from Quality Data Instructions in QAPI.
9. iv. Quality Management: Medical Record Review.	MHD should specify the provider groups (PCP/Specialty) and criteria for auditing medical records. **Suggestion:** MHD contract 2.28.5; 2.18.8c2; EPSDT; Use of CPGs by providers for Asthma, Hypertension.
12. The MCO must include the following in their QAPI program: xi. Timeliness of Care Delivery	MHD should clarify indicator expected from MCO. **Suggestion:** Timeliness of Prenatal care/postpartum care; EPSDT screening in foster care; and care management in foster care. Additionally, Agency for Healthcare Research and Quality (AHRQ) is a great resource. The access standards already established by state can also be used to guide MCO on this criterion.
17. Trends identified for focused study; results of focused studies; corrective action taken; evaluation of the effectiveness of the actions and outcomes; description of how the results of the focused studies will impact the health plan's Quality Improvement Program during the upcoming year.	MHD should provide guidance on topic(s) around which the MCO should conduct focus studies. This should be incorporated in the contract as well as instruction guidelines regarding QAPI. MCO may be allowed to identify trends for their focus studies even if a topic or statewide trend is not identified by

	MHD. Sometimes these trends are within the MCO's population, based on how they conduct business or is a physician/provider specific.

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Appendix A. QAPI Evaluation Tool

Subpart E, 42 CFR 438.330 Quality Assessment and Performance Improvement (QAPI) Program		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees that includes the elements identified in this section (MHD QA & I instructions).		
1. Development, approval, and monitoring of QAPI: i. Quality and Compliance Committee. An analysis and evaluation of action items documented in the meeting minutes of MCO's quality and compliance committee(s).	2019 Annual State Quality Improvement Program Evaluation: Pages-5 to 8 2019 Quality Improvement Program Description: Pages: 9 to 24 Supporting Documents: • Compliance Oversight Committee (COC) Minutes • Healthcare Quality & Utilization Management Committee (HQUM) Minutes • Quality Management Committee (QMC/QIC) Minutes • Physician Advisory Committee (PAC) Minutes	Fully Met
Findings: The National Quality Oversight Committee (NQOC) directs the quality programs for UnitedHealthcare Community and State Health Plans at the national level and interfaces with other national and regional committees, as applicable. The committee provides oversight of the quality improvement program including handling of quality of care and service complaints. The Board of Directors (BOD) or its Executive Committee is responsible for oversight of the QI Program. The Governing Board of Directors delegates oversight of the quality program to the State level Quality Management Committees (QMC). The Quality Management Committee (QMC) is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for UnitedHealthcare. The QMC is the highest multi-departmental quality committee in the health plan composed of senior level representatives from each department in the health plan. It receives reports from Network Management, Operations, Quality, Health Services,		

Finance and Delegated Entities. It provides program direction and continuous oversight of QI activities as related to the unique needs of the members and providers in the areas of clinical care, service, patient safety, administrative processes, compliance and network credentialing and recredentialing. Also, recommends policies or revisions to policies brought forth for approval from associated committees and subcommittees for the effective operation of the QI program and the achievement of the program objectives. **Required Actions:** None.		
ii. Analysis of quality improvement process.	2019 Annual State Quality Improvement Program Evaluation: Page-9	Fully Met
Findings: A comprehensive evaluation was completed to assess effectiveness and adequacy of UnitedHealthcare's QI committee structure in support of the QI process. Each committee held their scheduled meetings and completed responsibilities. Barriers to goals or opportunities identified by a committee were addressed through modifications to the QI Work Plan. The QI Program Description and QI Work Plan (QIWP) describe the coordination of QI activities and collaboration between the health plan and United Clinical Services (UCS) Regulatory Adherence & Accreditation. Throughout CY 2019, performance data were systematically collected and analyzed as defined in the UnitedHealthcare QI Program Description (QIPD). This measurement and analysis contributed information used to guide decision-making related to improving the overall safety, quality of clinical care, and quality of service provided to members. Multiple resources, both inter-departmental and cross-functional, along with corporate resources, were effectively leveraged to guide the structure and processes implemented to improve outcomes for members. **Required Actions:** None.		
iii. MCO should have a designated staff (coordinator) with expertise in quality assessment, utilization management, and continuous quality improvement.	2019 Annual State Quality Improvement Program Evaluation (revised): Page 6	Fully Met
Findings: The Associate Director, Clinical Quality is responsible for coordination of all QI activities, including timelines for correction and deliverables which meet the contractual requirements, and meets the contractual requirements of quality certification as a Certified Professional in Healthcare Quality (CPHQ) designated by the National Association of Healthcare Quality (NAHQ). **Required Actions:** None.		
2. Evaluation of impact and effectiveness of QAPI: i. Strengths and accomplishments.	2019 Annual State Quality Improvement Program Evaluation: Pages-13, 14	Fully Met

ii. Opportunities for improvement.		

Findings: A comprehensive evaluation was completed to assess effectiveness and adequacy of the national and health plan QI committee structure. Each committee held their scheduled meetings and completed responsibilities as defined in the annual QI Program Description. Barriers to goals or opportunities identified by a committee were addressed through modifications to the QI Work Plan.
Required Actions: i. UnitedHealthcare reported the following Strengths and Accomplishments in CY 2019.

- Completion of regulatory audits (MHD and EQRO) with no Corrective Action Plans or liquidated damages.
- Achieved NCQA accreditation in May 2019.
- Implementation of the 2019 provider incentive program.
- National staffing resources were aligned to include subject matter experts in accreditation, HEDIS®, CAHPS®, and Quality Data Analysis and Reporting (QDAR) and adequate resources were available to implement the UnitedHealthcare's QI Program.
- Member Engagement programs to support pregnant women and children such as Baby Blocks and Health First Steps (HFS).
- Implementation of Member Rewards programs to support gap closure for HEDIS Measures: ADV, AWC, CDC, LSC, PPC, and W34.
- Practitioner participation in clinical QI activities such as medical policy review, technology assessments, credentialing, and peer review.
- Approval of Clinical Practice Guidelines (CPGs) by the National Quality Oversight Committee (NQOC) and adopted by PAC.
- Implementation of the Provider Profiling process October 2019 to identify over-and-under-utilization, as well as performance related to selected HEDIS measures
- Completion of Population Health Management (PHM) Assessment and Annual Evaluation and Member Experience reports used to validate diverse populations are being served in a manner that is culturally and linguistically appropriate and addresses social determinants of health (SDOH)
- Completion of Continuity and Coordination of Care reports for Medical, and between Medical and Behavioral Health.
- Completion of Provider Satisfaction (Network) and Clinical Practice Consultant (CPC) Provider Engagement Satisfaction surveys
- Provider engagement with CPCs focused on HEDIS education and gap closure.
- High-touch member engagement (live calls with dedicated health plan staff) focused on EPSDT compliance which met the state target of 65% for all regions.
- Language services were provided to members through customer service and as needed at the practitioner office, including both oral interpretation and written translation of information
- Availability of Complex Case Management
- Collaboration with Optum BH, state partners (FUH Work Group)

ii. Opportunities for improvement identified in CY 2019:

• BH targeted HEDIS® measures. • Physician satisfaction with Continuity and Coordination of Care (Medical). • Clinician and physician satisfaction with Continuity and Coordination of Care (between Medical and BH). • NICU post-hospitalization care coordination. • Improving access to after-hours care (Child CAHPS® Survey). • Member response rate to Health First Step (program) Satisfaction Survey **Required Actions:** None.		
3. Population Characteristics: An analysis and evaluation of how MCO incorporates its population characteristics into its quality strategy: race, ethnicity, languages, special needs, and opt outs.	2019 Annual State Quality Improvement Program Evaluation: Pages-14 to 18 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-17 to 19 Supporting Documents: • Population Health Management Annual Report Apr 2019 • Population Health Management Strategy 2018-2019	Fully Met
Findings: UnitedHealthcare reported their predominant age/gender groups are members aged 0-20 at over 84% of the membership. The predominant gender group overall is Female (55%). Members who are eligible for are the ones who are at or near the poverty level. Overall, 94.8% plan members are Temporary Assistance for Needy Families (TANF) eligible. These members have unique socioeconomic stressors related to issues with housing, food, transportation, employment and health literacy. The other group is the CHIP population, which accounts for only 5.2% of the UnitedHealthcare's membership. The predominant racial group among the membership is White (65.05%) with a slight decline in membership in 2019 (-0.52%). Among the membership, it was identified that there were large communities of Black or African Americans (22.48%). Members with primary language as English are 99.78%, other most spoken language is Spanish (19%). UnitedHealthcare conducts outreach to any member identified by the state as having a Special Health Care Need. Of those members who were identified for Care Management in 2019, 1570 declined or opted out of care management. Out of the 1570 who declined, 283 initially enrolled in CM services, then opted-out after initiation of services and the remaining 1287 declined prior to service enrollment. One primary resource, the Healthify application, a mobile application with a link to over 210,000 social service resources across multiple geographic regions is used by		

UnitedHealthcare staff, to identify and link members to community supports such as educational trainings, daycare centers, food and housing assistance.

UnitedHealthcare uses information from the population assessment and data integration findings to segment members into categories, which align to the Population Health Management (PHM) Program Strategy (e.g., selected age or gender bands, common diagnoses, identified social determinants, disability categories, utilization patterns). Within these segments, members may be determined to be at low or high risk and actions taken accordingly. Interventions directed at low risk members are primarily focused on prevention. High-risk, medically fragile members are targeted for the Intensive Opportunity Complex Case Management Program. Each year the PHM strategy is evaluated through the review of clinical, utilization, and member experience performance measures. HEDIS® effectiveness measures are selected that reflect the goal of keeping members healthy and managing those with emerging risk.

The overall impact of the PHM Strategy indicated partial improvement with Keeping Members Healthy and Managing Emerging Risk, and demonstrated the need for additional, restructured programs/services, and/or interventions for members in the Patient Safety and Transitioning targeted and possibly the Managing Multiple Chronic Illnesses (depending on ER Rate/1000) populations.

UnitedHealthcare received a total of 4,665 Special Health Care Need referrals in CY 2018, which increased to a total of 5,227 member Special Health Care Need referrals in CY 2019. These members are subsequently engaged in outreach by a variety of different teams comprised of care managers, care coordinators, community health workers, and behavioral health advocates. If a member is in state custody, is a former foster care youth, or receives adoption subsidy, the member is reached out to by the foster/adopt team. All other members are outreached by a member of the medical or behavioral care management team.

Based on the CY 2019 year, the foster/adopt program implemented a member/caregiver mailing to outreach members identified for Special Healthcare Needs as most of these members are either new to foster care or new to the health plan, explaining the foster/adopt care management program and how it differs from the state Children's Division and contracted case workers. The foster/adopt team is developing additional training platforms in conjunction with recently approved trainings for trauma and foster caregivers through the National Child Traumatic Stress Network to better assist foster caregivers and adoptive parents with understanding the special needs of these members. Similarly, the health plan will implement verbiage with the call center for members not in the care and custody of the state to inquire if they have additional care management needs and ensure that such information is passed on to the care management teams. The health plan is developing a brochure for members identified for Special Healthcare Needs that are not in the care and custody of the state.

Required Actions: None.

4. Quality Indicators: An analysis and evaluation of all MHD Managed Care quality indicators including the following and how MCO will incorporate the results from this analysis and evaluation into MCO's QAPI and implementation of PIPs, MCO initiatives, member/provider incentives, additional benefits, etc. during the upcoming year.		
i. Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services.	2019 Annual State Quality Improvement Program Evaluation: Pages-18 to 20 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-22 to 27	Not Applicable (N/A)
Findings: UnitedHealthcare informed Primaris they had contacted Department of Health and Senior Services (DHSS) to clarify reporting requirements and requested data from DHSS on 9/20/2019. DHSS explained this data is provided to the UnitedHealthcare by MHD. The data was received from MHD on 4/21/2020 at UnitedHealthcare's request (QAPI submission was due on 4/30/2020). Since MHD did not provide this information to all MCOs on a timely basis, this criterion is marked N/A for EQR 2020. Even though this section is N/A, Primaris acknowledges the information submitted by UnitedHealthcare on the indicators provided for CY 2018: Asthma Inpatient Admissions under age 4-17, 18, 18-64, Asthma ER Visits under age 4, Asthma ER Visits age 4-17, ER Visits under age 18, ER Visits age 18-64, Preventable Hospitalizations under age 18, Hysterectomies per female age 18-64. As UnitedHealthcare did not operate in MO for entire CY 2017, data for CY 2018 cannot be compared with CY 2017 and thus no trends are available to report. However, UnitedHealthcare will continue its Asthma Disease Management program, Care Management activities, Emergency Room Diversion program and monitor Year Over Year (YOY) trends to identify opportunities for improvement. **Required Actions:** None.		
ii. HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births provided by the Department of Health and Senior Services.	2019 Annual State Quality Improvement Program Evaluation: Pages-21 to 24 2019 Annual State Quality Improvement Program	Fully Met

	Evaluation (revised): Pages-27 to 34	
Findings: UnitedHealthcare has reported CY 2018 rates for Cesarean Sections, Vaginal Birth after Cesarean, Adequacy of Prenatal Care, Early (1st Trimester) Prenatal Care, Low Birth Weight (LBW Less than 2500G), LBW (<2500G) Delivered in Level II/III Hospital, VLBW (<1500G) Delivered in Level III Hospital, Smoking During Pregnancy, Spacing Less Than 18 Months, Birth Mothers Less than 18 Years, Repeat Births to Teen Mothers (<20 Years), Prenatal WIC Participants. No significant changes in rates were noted over two years (CY 2018 over CY 2017) for most of these indicators (7 of 12). UnitedHealthcare plans to continue its Maternal/Child Case Management activities and monitor year-over-year trends to identify opportunities for improvement, although receiving data from MHD in 2019 for 2018 without a benchmark creates a barrier for timely and effective intervention. In CY 2019, UnitedHealthcare implemented Makena (i.e., 17-P), a Maternity Care program through Optum to engage members identified as a risk for pre-term births. Also implemented in CY 2019, was a diagnosis-specific intervention via home visits to administer antiemetic and/or IV fluids for members experiencing symptoms of hyperemesis to prevent unnecessary hospitalization. CY 2019 results will be provided by DHSS/MHD later in the year 2020 for analysis. **Required Actions:** None.		
iii. MO HealthNet Managed Care HEDIS Measures.	2019 Annual State Quality Improvement Program Evaluation: Page-26 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-35, 36	Fully Met
Findings: UnitedHealthcare reported 14 HEDIS measures (unaudited). Of these, 10 measures showed improvement from previous year. AWC-Adolescent Well Care Visit, MMA-Medication Management for People with Asthma (5-11 years, 12-18 years), FUH-Follow Up After Hospitalization for Mental Illness-30 days, showed decrease from previous year. However, MMA (5-11 years, 75% compliant) met the 75th percentile, and MMA (12-18, 75% compliant) met the 90th percentile. UnitedHealthcare stated they would continue to monitor concurrent (prospective) HEDIS® reports to identify any areas of concern or opportunities for improvement. The Patient Care Opportunity Report (PCOR) is a preventive health care information report run by Tax ID Number (TIN) that includes a list of attributed members based on claims data and their compliancy with certain HEDIS® measures. The PCOR is updated on a monthly basis and is available on UnitedHealthcare's provider portal. In addition, UnitedHealthcare's Clinical Practice Consultants (CPCs) deliver the PCOR monthly to providers who participate in the Community Plan–Primary Care Practitioner Incentive (CP-PCPi) program and discuss the		

open care opportunities and quality improvement practices related to incentive/P4P HEDIS® measures. In addition, members are made aware of UnitedHealthcare's Quality Improvement program and related goals to improve quality on an annual basis through the member newsletter. **Required Actions:** None.		
5. Accessibility of Services: An analysis and evaluation of: i. Average Speed of Answer; ii. Call Abandonment Rate; iii. Non-Symptomatic-Routine Needs Appointments; iv. Symptomatic-Routine Needs Appointments; v. Access to Emergent and Urgent Care; vi. Network Adequacy - Provider/Enrollee Ratios; vii. 24 Hour Access/After Hours Availability; viii. Open/Closed Panels; ix. Cultural Competency; and x. Requests to Change Practitioners.	2019 Annual State Quality Improvement Program Evaluation: Pages-27 to 42 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-41 to 56	Partially Met
Findings: i. Average speed of Answer. Comparison of the CY 2018 to CY 2019 data shows that the goal of less than 30 seconds was met across all four quarters for both years. The increases can be attributed to more member advocates working in Quarter 1 of CY 2018 than were working in Quarter 1 of 2019 and additional Hospital Assessment and Retention Center (HARC) maternity call duties taken on by the member advocates in 2019. ii. Call Abandonment Rate. Comparison of the CY 2018 to CY 2019 data shows that the goal (of less than 5%) was met across all 4 quarters for both years and indicates no significant change year over year. iii. Non-symptomatic routine appointments availability with PCPs was 88.73% in CY 2018 (member survey) and 95.54% in CY 2019 (CAHPS survey). The appointment availability for specialty care was at 89.02% in CY 2019 (CAHPS survey) vs 78.87% in CY 2018 (member survey conducted by the UnitedHealthcare). The goal of 80% was met in CY 2019. iv. UnitedHealthcare did not provide information about appointment availability for routine symptomatic patients. CAHPS survey result about "getting care quickly" showed 96.78% in CY 2019.		

v. Access to urgent care services was 91.98% in CY 2018 (member survey by UnitedHealthcare) and 98.01% in CY 2019 (CAHPS survey). The goal of 80% was met.

vi. The number of PCPs to enrollees ratio in CY 2019 was 1:6 (goal 1:1000, ratio targets are set based on analysis of published literature and trend performance for the UnitedHealthcare network). Ratio of Pediatrician: enrollee was 1:15 (goal 1:1000). Ratio of High Impact providers-Cardiologists and Oncologists-was 1:10 (goal 1:2000) and 1:22 (goal 1:4000) respectively. Analysis of the network indicates the plan has a robust network of practitioners to meet members' needs. The UnitedHealthcare will continue to monitor availability of practitioners to identify any future opportunities for improvement.

vii. After hours care access was 93.10% in CY 2018 which decreased to 78.66% in CY 2019. This was a decrease of 14.44 percentage points from the previous year's member survey. The CY 2019 assessment of the appointment complaints; however, did not identify any issues related to appointment access. Although the decrease year over year was significant, the result was only slightly below goal (80%). Possible reasons for the plan not meeting the after-hours goal could be a lack of understanding by members on how to receive after-hours care. There were no member complaints regarding appointment access.

viii. UnitedHealthcare met the required threshold of at least 80% of PCPs (93.19%) and Psychiatrists (99.44%) in network accepting new patients.

ix. UnitedHealthcare has 4.11% providers (1278) who can speak languages in addition to English. Of these 1278, Spanish speaking are (29.11%), Hindi (10.56%), Urdu (6.36%), Arabic (6.24%), other languages including American Sign language are below 4%. Providers who had the ability to serve disabled patients, Americans with Disabilities Act (ADA) compliant were 91.46% and those who provided care to senior members were 97.39%. UnitedHealthcare does not have an action plan at this time as no member complaints were received regarding cultural competency in CY 2019. UnitedHealthcare will continue to monitor and assess cultural competency of providers and member complaints related to cultural competency.

x. UnitedHealthcare received 58,234 requests to change providers in CY 2019, which is down from 68,743 requests in CY 2018. Some of the most common reasons were initial PCP assignment (42678), member convenience (4610), provider ID changed, other PCP (3001), provider termination (2586); state assignment (1238). United Healthcare targeted projects for providers to better align membership with their proper PCPs. This is demonstrated in the improvement seen in the member request convenience category going down from 19,219 requests in CY 2018 to 4,610 requests in CY 2019. This improvement is due to special provider projects that have been completed, listening to members and working with provider network team to ensure UnitedHealthcare has enough provider coverage, and aligns auto assignment to state guidelines.

Required Actions: UnitedHealthcare should report data and analysis on availability of appointments for routine symptomatic patients per MHD contractual requirements.

6. Multilingual Services: An analysis and evaluation of the multilingual services provided, to include, at a minimum: i. A count by language of how many members declared a language other than English as their primary language; ii. A summary by language of translation services provided to members (oral and in-person); iii. A count of members identified as needing communication accommodations due to visual or hearing impairments or a physical disability; iv. A summary of services provided to members with visual or hearing impairments or members who are physically disabled (Braille, large print, cassette, sign interpreters, etc.); v. An inventory by language of member material translated; vi. An inventory of member materials available in alternative formats; and vii A summarization of grievances regarding multilingual issues and dispositions.	2019 Annual State Quality Improvement Program Evaluation: Pages-16 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-53, 54 Inventory by Language of Member Materials Translated-Attachment 4	Fully Met

Findings: i. UnitedHealthcare identified members who speak languages other English (99.78%) as their primary language: Spanish (0.19%), Vietnamese and Arabic (0.01%).

ii. Total interpreter services provided in CY 2019 were 4421. Majority of interpreter services, 89.66% were performed onsite, 7.83% were via phone (7.83%) and 2.51% were video services. Spanish was the most frequently utilized language (58.18%). The next two were Arabic and Somali, comprising 9.14% and 7.76% respectively.

iii. iv. There were no member requests for communication accommodations due to a visual or hearing impairment or physical disability in CY 2019. If a member requests material in a different format, that material will be made available per the contractual guidelines per MHD contractual guidelines. UnitedHealthcare will continue to monitor requests and multilingual service data to identify additional opportunities for enhancement of their communications.

v. UnitedHealthcare has provided a list of documents that are translated in Spanish and English.

vi. No requests related to other formats were made by members (see iii, iv above).

vii. UnitedHealthcare did not specifically mention if there were any grievances related to multilingual issues. However, they stated that there were no complaints or grievances related to communication accommodations due to any physical impairment or due to any cultural incompetency at the provider level.

Required Actions: None. However, Primaris recommends that the UnitedHealthcare should explicitly address each section in the QAPI in future.

7. Fraud and Abuse: An analysis and evaluation of the health plan's fraud, waste, and abuse program. (Prevention, Detection, Investigation Training and Education.)	2019 Annual State Quality Improvement Program Evaluation: Pages-43, 47 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-56 to 58 Attachment D-UHC MO FWAE CCR (Compliance Committee Report) Attachment E-UHC Annual FWA Training	Fully Met

Findings: Prevention. During CY 2019, UnitedHealthcare reviewed approximately 4,036 MO Medicaid claims as a part of their prospective claim review process. These claims were identified by pre-pay flags as being potential Fraud, Waste, and Abuse (FWA). Following medical record review by certified coders, about 53% claims were paid, 25% were denied. About 2.8% (117 out of 4036) were hard denials for reasons such as previous investigations or sanctions. About 12.5% (504) claims were denied for non-receipt of medical records. As a part of FWA program UnitedHealthcare runs Provider Awareness Campaigns throughout the year. As a part of these campaigns a potential billing issue is chosen and then run analytics to identify providers to educate on a large scale across all identified states.

Detection. During CY 2019, there were approximately 433 cases of potential FWA entered into the tracking system. They were reviewed by UnitedHealthcare's Validation team. An initial investigation was started to determine if there was a need to perform a complete retrospective investigation. Of the 433 cases, 354 were closed without findings. The cases that are closed with findings are moved to one of our Special Investigation Units (SIU) for a complete investigation. In CY 2019, approximately 28 cases were transferred to a SIU

Investigation. UnitedHealthcare monitors progress of the investigations on a monthly basis. The report provides information such as the provider, allegation, dates of medical record requests, case status and details, exposure, overpayments and closed date. Approximately 66 SIU investigations that included MO Medicaid were closed during CY 2019. Of those 66 cases, 17 were closed with the recovery or offset was completed. Cases were also closed for no findings, appeal, duplicate case, and other reasons. Training and Education. UnitedHealthcare has FWA training for all UnitedHealthcare employees to be completed. **Required Actions**: None.		
8. Information Management: An analysis and evaluation of MCO's claims processing (timeliness, membership, providers) and Management Information System.	2019 Annual State Quality Improvement Program Evaluation: Pages-47, 48 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-56 to 58	Fully Met
Findings: UnitedHealthcare processed 1.59 million clean claims for Medicaid in CY 2019. 99.98% to 100% claims were processed within the turnaround time of 30 days each month. There were 25 claims processed outside of the 30-day turn-around-time requirements. Of the 25, 10 were due to manual errors made by the claims processing teams. Individual coaching was provided on each of these items, and documentation was updated to provide clearer directions when necessary. The remaining 15 errors were tied to 2 system issues identified in quarter 4 of CY 2019. These issues were resolved through system configuration changes and process updates. For CY 2020, the areas of focus will continue to be on processor education and training, along with automation opportunities to reduce the risk of manual processing errors. The health plan continues to partner with IT and system configuration to resolve any system issues identified timely and reduce the risk of errors from configuration errors. **Required Actions:** None.		
9. Quality Management:		
i. Provider Satisfaction.	2019 Annual State Quality Improvement Program Evaluation: Pages-52, 53	Fully Met
Findings: UnitedHealthcare administered a provider satisfaction survey from September 9 – October 31, 2019. The sample size for Missouri in CY 2019 was 2,027. The response rate was 3%. Analysis was based on questions with the highest response rate of a 9 or 10 (Likert scale of 0-10). The satisfaction results for claims processing were around 38%, care coordination (less than 38% for various criteria surveyed), and communications (less than 36% on various criteria surveyed). These are areas noted for improvement in CY 2020. The primary concern involved assisting providers with fewer transfers and understanding how		

to best improve the usefulness of information provided. These had the lowest ratings. Specifically, provider comments suggest the need for better trained, more knowledgeable representatives. Information was shared with the Quality Management Committee, Provider Advisory Committee, and Call Center management. Physician survey interventions included UnitedHealthcare's real time interactive provider portal, which offers practitioners/providers resources to assist with the collaboration and coordination of care. Additionally, UnitedHealthcare published articles that stressed the importance of exchange of information and the role of the patient and physician in the HealthTalk member newsletter and Practice Matters physician newsletter. **Required Actions:** None.		
ii. Member Care Management Services for both Physical and Behavioral Health.	2019 Annual State Quality Improvement Program Evaluation: Pages-53 to 56 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-65 to 80 2019 Annual Collaborative Analysis Continuity and Coordination between Behavioral Health and Medical Care	Fully Met
Findings: UnitedHealthcare formed a collaborative work group in June 2018 and continued to meet throughout CY 2019 on a Bi-monthly/frequent basis. Data and work group activities reviewed were related to exchange of information between medical and behavioral health practitioners. The work group's objectives are to review and discuss annual exchange of information, measure results, share information on barriers, collaborate on existing interventions, and discuss and implement new interventions. Low satisfaction rates across the board indicate that opportunities for improvement exist. Key interventions will continue and additional behavioral health, medical and enrollee education will be pursued in 2020. In general, performance decreased for both the initiation and continuation phases of HEDIS Antidepressant Medication Management Measure. Implemented interventions were not sufficient to meet the performance goal of the 75th percentile. Based on the results for the most recent barrier analysis, continued opportunities for improvement have been identified. As the majority of noncompliance is found in enrollees who were treated in primary care, UnitedHealthcare will continue to identify opportunities to work with primary care medical prescribers. Data from national, state and HEDIS® measure results from both CY2018 and CY 2019 justified a need to create and continue an opioid risk prevention program. The Opioid Risk		

Management Task Force, which includes medical and behavioral health medical directors, as well as senior leaders from the clinical, pharmacy, and behavioral health departments, met throughout CY 2018 and CY 2019 and continued to develop and implement new prevention opportunities that center on robust enrollee, staff and practitioner education to raise awareness on appropriate use and disposal, warning signs and resources for treatment and clinical best practices. **Required Actions:** None.		
iii. Credentialing and Re-Credentialing.	2019 Annual State Quality Improvement Program Evaluation: Page-62 2019 Annual State Quality Improvement Program Evaluation (revised): Page-90	Fully Met
Findings: UnitedHealthcare met 99% the goal of 60 days set by State for credentialing practitioners and facilities. Recredentialing was completed within 3 years for 99.6% of providers. Seven practitioners and 3 facilities did not meet the turn-around-time: the delay was due to staff prioritization of working files and not addressing follow up with the provider timely. UnitedHealthcare has put a process into place with their workforce management that daily monitors and begins to work approximately a month ahead of time to recredential practitioners and facilities in order to meet goal. In regard to the follow ups, staff have been re-trained on the monitoring of files based on the status codes to ensure files that require follow-up are not missed. **Required Actions:** None.		
iv. Medical Record Review.	2019 Annual State Quality Improvement Program Evaluation: Page-62 to 64	Fully Met
Findings: UnitedHealthcare conducted Medical Record Review for 33 PCPs who were randomly selected from claims data from 9.1.18 to 9.30.19. The purpose was to determine whether the provider is following the policies and procedures related to advance directives (required per MHD contract as a part of recredentialing). The results were as follows: Total Number of Ambulatory MRRs Completed: 33 Total Number of PCPs Achieving 84.5% or Higher: 33 Total Number of PCPs Requiring Follow-Up MRR: 0 There were no failed providers for the 2019 review. The barriers and limitations were noted, and interventions were taken: • Education was provided by the Quality Department's Clinical Practice Consultants (CPCs) regarding the MRR, required attestation forms, and the providers' contractual responsibility to provide records for the MRR. • Providers were directed to the MRR section of the UnitedHealthcare's Provider Manual.		

• CPCs discussed EMR access and the benefits of obtaining EMR access with all of the providers and obtained EMR access for 3 providers out of 33. **Required Actions:** None.		
v. Disease Management: Clinical Practice Guidelines	Whole Person Care (WPC) Program Description: Pages-19, 20 QI Program Description: Page-27 2019 Annual State Quality Improvement Program Evaluation: Page-58	Fully Met
Findings: The UnitedHealthcare Medical Technology Assessment Committee (MTAC) reviews and approves evidence-based clinical practice guidelines for use within UHC through defined procedures and requirements on an annual basis. The National Quality Oversight Committee (NQOC) adopts the approved clinical guidelines on an annual basis and oversees the implementation and compliance of the clinical program content with the guidelines. All WPC Management care plan decisions are supported by relevant clinical information appropriate to each case dependent upon the complexity of the case. Care Management tools include clinical protocols, guidelines and resource information to support the collection of the necessary information to conduct care management processes. **Required Actions:** None.		
10. An analysis and evaluation of the disease management programs to include the following information for each disease management program:		
i. A narrative description of the eligibility criteria and the method used to identify and enroll eligible members. ii. The active participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility).	2019 Annual State Quality Improvement Program Evaluation: Pages-56 to 61 Whole Person Care Program Description: DM components 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-80 to 85	Partially Met

iii. The total number of active members having one or more of the diagnosis codes (ICD-10 Codes) relating to each of the disease management programs. iv. Information on the programs' activities, benchmarks, and goals; the number of disease management cases closed due to non-compliance with treatment plans; and a description of activities aimed at engaging members and reducing non-compliance rates.		

Findings: i. Data is analyzed at least monthly to identify members for Care Management/Disease Management programs. Data sources, depending on applicability, can include, but are not limited to: Medical and behavioral claims or encounter data; Pharmacy claims/Pharmacy data; Laboratory data; Health appraisal results/risk appraisals/scoring tool; Electronic health records or data supplied by practitioner; Health services with the organization/medical management programs, including data collected through the UM management process; and Data supplied by member, caregiver, discharge planner, state partner, or practitioner referral.

ii. The total number of members having ICD-10 Codes related to each of the disease management programs in CY 2019: ADHD (3,698); Asthma (5,602); Depression (5,602); Hypertension (HTN-2,263); Diabetes (1,532); Obesity (4,521). These identified members were then further risk stratified into low, medium and high based on claims data and referred for intervention. UnitedHealthcare has not reported on NCQA participation rate. UnitedHealthcare stated that it is unavailable due to technology upgrade allowing such reporting.

iii. The total number of active members having one or more of the diagnosis codes (ICD-10 Codes) relating to each of the disease management programs in CY 2019 was as follows: Asthma-3611; Depression-4070; Diabetes-1382; Obesity-2,187; ADHD-2,259; and HTN-1,253.

iv. UnitedHealthcare has reported noncompliant members as follows: ADHD-2; Asthma-11 members; Depression-3; Diabetes-3; HTN-8; Obesity-6. These cases were closed later due to "unable to contact." To increase compliance throughout management, the care manager:

- Uses motivational interviewing skills.
- Uses Member input in the development of the care plan.
- Provides education on supporting member incentives, supporting DM goals such as completion of HRA, Adolescent Well Child Visit, Comprehensive Diabetic Care.
- Provides education on value- add benefits Join For Me, Boys & Girls Club.

The program activities include ongoing communication with practitioners regarding their patients, including discussion of treatment plans and progress reports. Regular communication and feedback are provided to the member regarding their progress towards plan of care completion. Fulfillment materials such as disease education are made available to members based on identified need and/or state contractual requirements. Disease education materials can be distributed pertaining to but not limited to Asthma, Diabetes, ADHD, Depression, Hypertension and Obesity. **Required Actions:** Active participation rate is not calculated by UnitedHealthcare. UnitedHealthcare stated they need a technical upgrade to provide that data. Primaris recommends these rates to be projected in QAPI and communicate with MHD regarding any difficulties they have in obtaining these rates.		
11. Rights and Responsibilities. An analysis and evaluation of: i. Member grievances and appeals. ii. Provider complaints and appeals. iii. Confidentiality.	2019 Annual State Quality Improvement Program Evaluation: Pages-64 to 70 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-92 to 95, 99	Fully Met
Findings: i. The number of member grievances increased from 2.39 (SFY 2018) to 3.09 (SFY 2019) per 1000 members which is an increase of 29.28%. The number of member appeals increased from 1.2 (SFY 2018) to 1.7 (SFY 2019) per 1000 members which is an increase of 41.66%. The increase in grievances and appeals were in the areas of Access, Attitude/Service, and Billing/Financial. There were no/or decreased number of grievances and appeals from previous year related to Quality of Care and Quality of Practitioner Office Site. Overall, the UnitedHealthcare did not exceed the threshold of four total grievances per 1,000 members. UnitedHealthcare was also below the overall threshold of four total appeals per 1,000 members. Remediation efforts for balance billing issues are addressed by the Resolving Analyst assigned to the case. ii. The appeal and grievance department did not receive any provider complaints in CY 2019. Providers have many options for resolving issues before filing a provider complaint, such as working with the provider advocates. Issues that are received in the provider call center are not logged into the A&G (Appeals and Grievances) tracking system if they are resolved by a representative during the call, the provider is satisfied with the outcome, and the provider does not wish to file a complaint. In CY 2019 an average of 186 provider appeals were received per month which is a decrease from 237 in CY 2018. The top drivers were Notification/Authorization (average of 28 receipts per month) and Utilization Review Determination (average of 18 receipts per month). Provider overturn rate was 16.5% per month (average 31 appeals per month). Trends are projected on a monthly basis by the Account Manager and shared with the Provider Advocates if a provider trend is identified so that education can be given to reduce appeal volume.		

iii. In CY 2019, there were two instances of a breach of confidentiality affecting two members. Both instances were found to be low impact. The first instance was due to misdirected mail and the second instance was a misdirected manual fax. The root cause of both instances was human error and counseling was provided to emphasize the importance of maintaining our members' confidentiality and following HIPAA rules. UnitedHealthcare stated that they provide privacy and confidentiality training for all employees. This practice will be continued through CY 2020. Additional training will be provided should the need arise. **Required Actions:** None.		
12. An analysis and evaluation of utilization and clinical performance data that supports use of evidenced based practice. There should be mechanisms to detect both underutilization and overutilization of services.		
The MCO must include the following areas in their QAPI program: i. Utilization Improvement Program; ii. Scope; iii. Discharges Per Year/1000 members; iv. Inpatient Visits/1000 members; v. Average Length of Stay; vi. Re-Admissions/1000 members; vii. Emergency Department Utilization/1000 members; viii. Outpatient Visits/1000 members; ix. Over/Under Utilization; x. Inter-Rater Reliability; xi. Timeliness of Care Delivery; and xii. Timeliness of Prior Authorization/Certification Decision Making	2019 Annual State Quality Improvement Program Evaluation: Pages-70 to 76 QA003 Provider Profiling and Monitoring of Over & Under Utilization 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-99 to 109	Fully Met
Findings: i. The UM program provides a structure to monitor and facilitate the delivery of high quality, individualized care to program participants. It has systems and processes in place to monitor under and overuse of services and to communicate information on member utilization using provider profiles to PCPs. Chief Medical Officer and quality staff		

utilize the data to build relationships with network providers and educate them about expectations relative to utilization and the quality of care (ref. QA003 for details)

ii. The program includes end-to-end processes such as:

- Intake/Notification.
- Prior Authorization/Prospective/Pre-Service Review/Clinical Coverage Review.
- Inpatient Care Management/Concurrent Review/Discharge Planning.
- Letter Management Program.
- Post Service Review.
- Readmission Management.
- Integrated Services: Transitional Care Management (Transition to Skilled Nursing Facility and Transition to Home Services), Complex Population Management, Case Management, Health/Disease Management, Complex Care Management and Health Management/Nurse line/Care24, House Calls, Behavioral Health, and Long Term Services and Support provided under separate entities' license and control.
- Medical Technology Assessment Reviews.
- External Review Services.
- Physician Consultation.
- Medical Claims Review.
- Clinical Appeals/Quality of Care/Peer Review.

iii. iv. UnitedHealthcare has reported discharges/1000 members (same as Inpatient Visits/1000 members) in CY 2019 for Maternity (4.51), Medicine (1.67), Surgery (0.33), and Inpatients (6.5). Comparison of CY 2018 and CY 2019 data reflects an overall slight decrease in the number of discharges per year, with Maternity showing the greatest decrease of 3.15 discharges/1,000 member months. Comparison of the total 2019 rates to the NCQA Quality Compass ® 50th percentile shows that Maternity and Inpatient are above the benchmark by 1.65 and 0.12 respectively. Medicine and Surgery discharges are both below the benchmark by 1.22 and 0.99 respectively. Since there is no significant change in the rate of discharges year over year, UnitedHealthcare will continue monitoring these rates to identify any potential areas for improvement.

v. Average Length of Stay. UnitedHealthcare reported on HEDIS® Inpatient Utilization (IPU) General Hospital/Acute Care measure, broken down by Maternity (2.79), Medicine (5.41), Surgery (7.70), and Inpatient (3.69) ALOS. Comparison of CY 2018 and 2019 data shows minor changes (< 1.0) in the ALOS for all areas. The rates for all regions and the overall rate fell below the NCQA Quality Compass® 50th percentile benchmark.

vi. Readmissions. Total readmission rate (HEDIS® Plan All-Cause Readmissions (PCR) measure) for CY 2019 for all regions was 9.71% which was an increase of 1.61% points as compared to CY 2018. While the rate increased slightly, the Observed to Expected Ratio for the total (all regions) remained 0.7 (goal < 1) meaning there were overall fewer readmissions than expected given the case mix. No concerns were identified.

vii. Emergency Department (ED) Utilization/1000 members. UnitedHealthcare has reported data per 1000 member months: 55.53 in CY 2019 as compared to 56.99 in CY 2018 which is a decrease of 1.46 visits/1,000 member months for all regions combined. The CY 2019 rate for all regions is 2.7 lower than the NCQA Quality Compass® 50th percentile rate of 58.23. Overall, the ED Utilization rates remained relatively stable in CY 2019. UnitedHealthcare will continue to use the ED diversion program as an intervention to impact inappropriate ED utilization.

viii. Outpatient Visits/1000 members. The rates reported are for HEDIS® Ambulatory Care (AMB) measure which is outpatient visits/1000 member months. In CY 2019, total for all regions was 337.53 as compared to 325.91 in CY 2018 which is an increase of 11.62/1000 member months. The CY 2019 total of 337.53 fell below the NCQA Quality Compass® 50th percentile by 18.9 visits per 1,000 member months. There was no cause for concern.

ix. Over/Under Utilization. Provider profiles were generated and shared with PCPs having 200 or more members bi-annually. UnitedHealthcare's Chief Medical Officer (CMO) and quality staff utilize the data to build relationships with network providers and educate them about expectations relative to utilization and the quality of care. The report includes provider-or group-specific data for key utilization measures with a peer comparison percentile ranking. Providers are encouraged to reach out to the CMO with any questions about the report or suggestions for improving utilization.

x. Inter Rater Reliability. Clinical staff including medical directors participated in an online Milliman Clinical Guidelines (MCG) Inter-rater Reliability Assessment in which the goal is for each staff person to score 90% or better. The IRR evaluates three MCG products: Inpatient Care, Ambulatory Care, and Recovery Facility Care. The total number of people who passed the tests was 99%. Technical issues with LearnSource (IRR training tool) continued, including loss of second or third attempts; application time-outs; and results not appearing accurately in LearnSource compared to proof retained upon completion of IRR. These issues require manual intervention to correct. UnitedHealthcare reached out to LearnSource Support and worked with them to troubleshoot and resolve issues to the extent possible.

xi. Timeliness of Care Delivery. Since there is no definite instruction from MHD on timeliness of delivery care, Primaris is evaluating the UnitedHealthcare based on the information presented in QAPI for this criterion.

The Acute Inpatient Audit Team or manager audited a minimum case sample size based on a 95% confidence level across all Acute Inpatient Care Managers to assess compliance to inpatient care management approved procedures. The measures included:

- Case review per the Priority Review guidelines.
- Correct use of the established internal processes.
- Timely Initial Review.
- Escalation to medical director.
- Pro-active discharge planning.

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• Adverse determination process.
• Adherence with regulatory turn-around times and business unit standards.
The overall accuracy for Inpatient Care Management Audits was 95.0% (target set 95.0%).

xii. Timeliness of Prior Authorization/Certification Decision making. In CY 2019, for routine determinations: 90% cases met the timeliness requirements; and 89% cases met the expedited determinations. UnitedHealthcare analyzed the reasons for untimely notifications as:
• Requesting physicians did not uniformly include sufficient clinical information to make a determination. Cases are sometimes untimely when pended for clinical information.
• Physician offices were accessible only during business hours which may have delayed case handling over weekends and holidays.
• Cases were sometimes misrouted which may have caused processing delays contributing to late turnaround time.
• Reporting logic presumed not to capture all processing exceptions.

Required Actions: None. However, Primaris recommends UnitedHealthcare to report on Emergency Department (ED) Utilization and Outpatient Visits data per 1000 members instead of member months for future reporting as required by MHD.
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<tr><td>13. MCOs should conduct performance improvement projects (PIPs), including any performance improvement projects required by CMS, that focus on both clinical and nonclinical areas. Each MCO must report the status and results of each project conducted per State as requested, but not less than once per year. The outcomes and trended results of each PIP should be reported.</td><td>2019 Annual State Quality Improvement Program Evaluation: Pages-76 to 84

2019 Annual State Quality Improvement Program Evaluation (revised): Pages-110, 111, 113, 114</td><td>Fully Met</td></tr>
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Findings: UnitedHealthcare conducted two State mandated PIPs for CY 2019: clinical (Childhood Immunization Status); and non-clinical (Improving Oral Health).
The results and trends of both the PIPs are reported. CIS combo 10 rate in CY 2019 is reported as 25.06% (interim rate as on 5.4.2020, will finalize around mid-Jun 2020). This is an increase of 3.41% points from CY 2018. The ADV measure in CY 2019 is reported as 53.70% (interim rate as on 5.4.20) which is an increase of 5.46% points from CY 2018.

Required Actions: None.
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<tr><td>14. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction,</td><td>2019 Annual State Quality Improvement Program Evaluation: Pages-76 to 84</td><td>Fully Met</td></tr>
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and must include the following elements: (i) Measurement of performance using objective quality indicators. (ii) Implementation of interventions to achieve improvement in the access to and quality of care. (iii) Evaluation of the effectiveness of the interventions based on the performance measures. (iv) Planning and initiation of activities for increasing or sustaining improvement.	2019 Annual State Quality Improvement Program Evaluation (revised): Pages-113, 115	

Findings: (Note**:** Detailed evaluation of PIPs will be done by Primaris when UnitedHealthcare submits PIPs for CY 2019 by end of June 2020. The score assigned here only indicates that the criteria listed above were addressed in QAPI.)

i. The HEDIS® performance measure indicators were used to assess the PIP for improving childhood immunization status (CIS Combo 10) and for improving oral health PIP (Annual Dental Visit-ADV).

ii. Interventions for CIS Combo 10 PIP:

- High-touch EPSDT member outreach by dedicated UnitedHealthcare staff.
- CIS Combo 10 Focused Member Outreach/Q4 Push Activities– Outreach was conducted by dedicated MCO staff for 242 parents/guardians of members under the age of 2 who were non-compliant with the series of immunizations for Combo 10. Education about the need to complete the series before their child's 2nd birthday was provided as well as assistance with appointment scheduling was offered. If staff were unable to reach the parent/guardian a reminder letter was sent.

Interventions for ADV PIP:

- Monthly Dental Clinical Quality Task Force meetings with dental vendor (Skygen)
- Implementation of Dental Care Opportunity Reports (DCOR) for targeted FQHCs in CY 2019.

iii. The results of the CIS Combo 10 Focused Member Outreach/Q4 Push Activities referenced above represent the Southwest and Central regions (23% of non-compliant members for this measure) as their CIS Combo 10 rates were lower compared to the other regions. Of those 242 non-compliant members only 3 (1.23%) received immunizations. Important to note: 208/242 (86%) outreach attempts were unsuccessful due to no answer, incorrect/no phone number.

ADV PIP. DCOR reports were distributed to targeted FQHCs in June and October of 2019. Implementation of the DCOR reports demonstrated significant improvement in gap closures as follows: ADV–closure of care gaps of 16.20%, overall. iv. CIS Combo 10 PIP-UnitedHealthcare will continue to conduct real-time EPSDT member outreach and launch Member Rewards programs to educate and incentivize members to receive preventive care. The EPSDT Coordinator has collaborated with the Clinical Practice Consultants (CPCs) to implement pilot projects with targeted providers in each region based upon the rapid-cycle improvement methodology. ADV PIP- UnitedHealthcare will continue to provide DCOR reports to targeted FQHCs in 2020, as well as monitor concurrent (prospective) HEDIS® rates to identify additional opportunities for implementation of rapid-cycle improvement activities. **Required Actions:** None. Primaris recommends UnitedHealthcare to select strategies that should be evidence-based, that is, there should be existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the variables). For the CIS Combo 10 PIP the intervention did not contribute to the increase in CIS Combo 10 rate. UnitedHealthcare should reconsider the ground to continue with this intervention in future.		
15. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under §438.340.	2019 Annual State Quality Improvement Program Evaluation: Page15 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-17 to 19 Attachment 7 SCHN narrative	Fully Met
Findings: Members with Special Healthcare Needs (SHCN) are identified by a report sent from MHD. Members are subsequently engaged in outreach by a variety of different teams comprised of care managers, care coordinators, community health workers, and behavioral health advocates. If a member is already participating in care management, the member is contacted by his/her assigned case owner. If a member is in state custody, is a former foster care youth, or receives adoption subsidy, the member is contacted to by the foster/adopt team. All other members are contacted by a member of the medical or behavioral care management team. Each member/caregiver who agrees to participate in care management following assessment develops an individualized care plan to address the member's special healthcare need with the member's assigned care manager. SHCN members who successfully achieve their goals, who have previously declined services, who were previously unable to be reached or were lost to contact may always have a new triggering event, self-refer, or be referred by a provider, and will be contacted again for a new episode of care management.		

Based on the CY 2019, the foster/adopt program implemented a member/caregiver mailing for members identified for Special Healthcare Needs as most of these members are either new to foster care or new to the health plan, explaining the foster/adopt care management program and how it differs from the state Children's Division and contracted case workers. The foster/adopt team is developing additional training platforms in conjunction with recently approved trainings for trauma and foster caregivers through the National Child Traumatic Stress Network to better assist foster caregivers and adoptive parents with understanding the special needs of these members. **Required Actions:** None.		
16. An analysis and evaluation of quality issues and actions identified through the quality strategy and how these efforts were used to improve systems of care and health outcomes.	2019 Annual State Quality Improvement Program Evaluation: Page 5	Fully Met
Findings: The evaluation process includes a review of all aspects of the QI Program, emphasizing demonstrated improvements in the quality and safety of care and quality of service provided to members as well as opportunities for improvement. For all goals that are not met a root cause or barrier analysis is conducted to identify the underlying reason. This information is utilized to determine changes or restructuring of the QI Program as necessary. The annual evaluation includes: • An assessment of how the year's goals and objectives were met. • A summary of QI activities. • The impact of the QI process on improving the quality and safety of clinical care and service provided to members. • An overview of potential and actual barriers to achieving goals. Throughout CY 2019, performance data were systematically collected and analyzed as defined in QI Program Description (QIPD). This measurement and analysis contributed information used to guide decision-making related to improving the overall safety, quality of clinical care, and quality of service provided to members. Multiple resources, both inter-departmental and cross-functional, along with corporate resources were effectively leveraged to guide the structure and processes implemented to improve outcomes for members. **Required Actions:** None.		
17. Trends identified for focused study; results of focused studies; corrective action taken; evaluation of the effectiveness of the actions and outcomes; description of how the results of the focused studies will impact the health plan's Quality		N/A

Improvement Program during the upcoming year.		
Findings: MHD did not set an expectation/requirement for this section. UnitedHealthcare stated that they are not aware of this requirement, but they did conduct a focus study to identify root cause and remediate issues that were causing delays in claims payment, resulting in additional interest and penalty payments. Primaris marks this section as N/A for EQR 2020. However, Primaris acknowledges the information presented by UnitedHealthcare in QAPI about the study. **Required Actions:** Primaris recommends UnitedHealthcare to request guidance from MHD on study topic(s) around which the UnitedHealthcare will be required to conduct a focus study and report results in QAPI. UnitedHealthcare can identify trends for their focus studies even if a topic or statewide trend is not identified by MHD. These trends may be within the UnitedHealthcare's population, based on how they conduct business or is a physician/provider specific.		
18. An analysis and evaluation of subcontractor relationships that addresses integration with MCO's QAPI program. This analysis and evaluation is not a replication of the Subcontractor Oversight Annual Evaluation report.	2019 Annual State Quality Improvement Program Evaluation: Pages-84 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-119 to 127	Fully Met
Findings: UnitedHealthcare creates Service Level Agreements with all subcontractors that comply with any additional State/Medicaid program related requirements attached to the administrative service agreements. These are reviewed at least annually and anytime there is an addendum to the contract between the State and UnitedHealthcare to ensure that the subcontractor's agreements are aligned with any new requirements. UnitedHealthcare monitors and evaluates the subcontractor's ability through established reporting, monthly Joint Oversight Committee meetings, annual oversight surveys and ad hoc audits. The vendors for Dental, Vision, Transportation, Call Center services are evaluated for Fraud, Waste, and Abuse (FWA); Encounter data; Prior Authorization Denials; Timely payment; and PIPs and HEDIS® measures (Dental Vendor); Customer Satisfaction and Member Experience (Transportation Vendor). Transportation vendor reported 19 cases of FWA in CY 2019 which have reduced from 25 cases in CY 2018 and 36 cases in CY 2017. UnitedHealthcare stated all vendors have a good relationship with UnitedHealthcare and met established performance requirements related to quality in CY 2019. **Required Actions:** None.		
19. Work Plan for next year.	2020 National Quality Work Plan Goals 2019 Quality Improvement Program Description: Pages-4, 5	Fully Met

Findings: QI Work Plan identifies planned activities related to program priorities that address and improve the provision of quality and safety of clinical care and service. Action steps include specific interventions with target dates for completion, identification of responsible parties, and oversight committees. Monitoring activities include tracking and trending of identified issues as well as planned interventions. The QI Work Plan is reviewed and updated at least quarterly. **Required Actions:** None.		
B. The QAPI program is composed of: i. Results, conclusions, team recommendations, and implemented system changes which are reported to the MCO's governing body at least quarterly. ii. Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members (MHD contract 2.18.2)	2019 Quality Improvement Program Description: Pages-5, 14 2019 Quality Improvement Program Description (revised): Pages-10, 11, 14 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-36, 106	Fully Met
Findings: i. An annual review of the overall effectiveness of the QI Program is conducted using the QI Evaluation to assess how well resources have been deployed to improve the quality and safety of clinical care and service provided to members. The QI Evaluation addresses all aspects of the QI Program described in the prior year's QI Program Description and QI Work Plan, focusing on the overall effectiveness compared to goals and objectives. The results of the annual QI Evaluation are used to develop and prioritize activities for the next year's QIWP and determine if revisions are necessary. QMC meets at least quarterly and reports to the BOD (the highest governing body of UnitedHealthcare Midwest, Inc.) at least annually. The QI Evaluation is annually approved by the BOD, and the QMC, and is submitted to state and/or federal agencies as required. QMC is the decision-making body that is ultimately responsible for the implementation, coordination, and integration of all QI activities for UnitedHealthcare in MO. They meet quarterly to provide oversight of all QI activities. ii. The Member Advisory Committee (MAC) is a forum for members to provide feedback and insights about services and experiences, including but not limited to cultural and linguistic needs. This information is used to modify the QI program and enhance how care and services are delivered to members. Additionally, members are made aware of UHCCP MO's Quality Improvement program and related goals to improve quality on an annual basis through the member newsletter. The Patient Care Opportunity Report (PCOR) is a preventive health care information report run by the providers' Tax ID Number (TIN) that includes a list of attributed members based		

on claims data and their compliancy with certain HEDIS® measures. The PCOR is updated on a monthly basis and is available on the UHC provider portal. In addition, the UHCCP MO Clinical Practice Consultants (CPCs) deliver the PCOR monthly to providers who participate in the Community Plan – Primary Care Practitioner Incentive (CP-PCPi) program and discuss the open care opportunities and quality improvement practices related to incentive/P4P HEDIS® measures. Additionally, on a bi-annual basis UnitedHealthcare provides a Utilization and Quality Management Provider Profile report to providers and provider groups. The report includes provider- or group-specific data for key utilization measures with a peer comparison percentile ranking. Providers are encouraged to reach out to the CMO with any questions about the report or suggestions for improving utilization. **Required Actions:** None. Primaris acknowledges that the data for QAPI are reported to governing body annually. However, as QMC is the decision-making authority for QAPI in MO and meets quarterly, Primaris has assigned a score of "Met" for i. of this section.		
C. MCO shall implement a Quality Improvement strategy that includes components to monitor, evaluate, and implement the contract standards and processes to improve the following: Quality management; Utilization management; Records management; Information management; Care management; Member services; Provider services; Organizational structure; Credentialing; Network performance; Fraud, waste, and abuse detection and prevention; Access and availability; and Data collection, analysis, and reporting. (MHD contract 2.18.3)	2019 Quality Improvement Program Description: Pages-9 to 29 2019 Annual State Quality Improvement Program Evaluation	Fully Met
Findings: UnitedHealthcare has addressed all the criteria listed above either in program description or in QAPI Evaluation report. **Required Actions:** None. However, Primaris recommends UnitedHealthcare should include all the procedures for assessment/monitoring/evaluation/improvement related to the points listed in the section above, in QI Program Description. The report on QAPI Evaluation		

should include analysis/evaluation/results/barriers/interventions/recommendations for next year.		
D. MCO shall have written quality assessment and improvement program procedures. The procedures shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas (MHD Contract 2.18.8a):		
1. Ensure that the utilization management and quality assessment committees have established operating parameters. The committees shall meet at least quarterly, on a regular schedule. Committee members must be clearly identified and representative of the MCO's providers. The committee shall be accountable to the Medical Director and governing body. The committees must maintain appropriate documentation of the committees' activities, findings, recommendations, actions, and follow-up.	2019 Quality Improvement Program Description: Pages-9 to 22 Supporting Documents: • Healthcare Quality & Utilization Management Committee (HQUM) Minutes • Quality Management Committee (QMC) Minutes	Fully Met
Findings: QMC is the decision-making body that is ultimately responsible for the implementation, coordination, and integration of all QI activities for UnitedHealthcare. QMC Oversees the Provider Advisory Committee, Healthcare Quality Utilization Management Committee, Service Quality Improvement Subcommittee, and Member Advisory Committee. Reports annually or more frequently as needed, on UnitedHealthcare's quality activities to the BOD. QMC meets at least quarterly and reports to the BOD at least annually. The Healthcare Quality and Utilization Management Committee (HQUM) monitors clinical QI and UM activities within the UnitedHealthcare. The HQUM meets at least four times per year and reports to the QMC. HQUM reviews and accepts the UM Program Description and UM Program Evaluation at least annually. **Required Actions:** None.		
2. Provide for regular utilization management and quality assessment reporting to the management and	QA003 Provider Profiling and Monitoring of Over & Under Utilization: Pages-1, 5, 6	Fully Met

providers, including profiling of provider utilization patterns.		
Findings: UnitedHealthcare creates provider profiles and monitors Primary Care Provider (PCP) over and under-utilization through Claimsphere using claims from the Facets, Diamond and Cosmos claims systems and supplemental claims sources, as appropriate. UnitedHealthcare has systems and processes in place to monitor under and overuse of services and to communicate information on member utilization using provider profiles to PCPs. The expectation is that the health plan Chief Medical Officer and quality staff will utilize the data to build relationships with network providers and educate them about expectations relative to utilization and the quality of care. At a minimum, the profiles are generated annually (profiles can be created more frequently for plans with a contractual need), profiles are calculated by Medical Quality Applications and Operations and are loaded to the National Quality Management Share Point under Provider Profiles. The UnitedHealthcare staff is notified of these files by the Quality Management and Performance (QMP) Provider Education Manager. Profile data are then sent to the Medical Director and other plan quality staff as appropriate. The Medical Director is responsible for the arranging for the distribution of the profiles to appropriate identified network physicians and other appropriate UnitedHealthcare staff. The corporate quality team can assist in a mailing with a vendor if requested. For over/under utilization purposes, where required by contract or decided by the UnitedHealthcare, a profile is distributed to each PCP whose panel contains 200 or more members. **Required Actions:** None.		
3. Be developed and implemented by professionals with adequate and appropriate experience in quality assessment and improvement: quality assessment, utilization management, and continuous improvement processes.	2019 Quality Improvement Program Description: Pages-22 to 24 2019 Quality Improvement Program Description (revised): Page-4, 24	Fully Met
Findings: Chief Executive Officer (CEO) is responsible for oversight of the implementation of the QI Program and chairs or designates the chair for the QMC. The Chief Medical Officer is a Missouri licensed physician who is responsible for implementation of the QI Program. The CMO reports to the CEO and provides the medical direction for health plan staff. The Senior Director is responsible for oversight of the implementation and evaluation of QI initiatives related to the QI program and meets the contractual requirements of quality certification as a Certified Professional in Healthcare Quality (CPHQ) designated by the National Association of Healthcare Quality (NAHQ). The Associate Director of Clinical Quality reports to the Senior Director of Clinical Quality, is a Certified Professional in Healthcare Quality (CPHQ) designated by NAHQ. This person is responsible for assisting in coordinating and generating the annual Quality trilogy documents (Quality Improvement Program Description, Annual Quality Improvement Evaluation and Quality Improvement Work Plan). Within the Quality Management department, the Associate Director of Clinical		

Quality along with the Clinical Practice Consultants (Registered Nurses) are responsible for developing and implementing Continuous Quality Improvement (CQI) initiatives designed to assist providers in delivering timely and effective health services. **Required Actions:** None.		
4. Provide for systematic data collection, analysis, and evaluation of performance and member results. Provide for interpretation of this data to practitioners.	2019 Quality Improvement Program Description (revised): Page-5 2019 Annual State Quality Improvement Program Evaluation (revised): Pages-36, 106	Fully Met
Findings: UnitedHealthcare evaluates the impact and effectiveness of its QI Program in the following ways: Concurrent (real-time) review of UnitedHealthcare's performance; Prospective Data (e.g., HEDIS®, EPSDT Compliance); Retrospective Data (e.g., CAHPS®, MRR); Quarterly Quality Committees; Annual Reports; and Comprehensive Annual QI Evaluation. Based upon the evaluation process noted above, the QI Evaluation includes: • Quantitative and qualitative analyses, as well as trending of data. • Identified potential and actual barriers to achieving goals. • A summary of the adequacy of resources, committee structure, physician participation and leadership involvement. • The recommendations for QI Program revisions based on the evaluation. Refer to "findings" in section B ii of this evaluation tool for details regarding interpreting this data to practitioners. **Required Actions:** None.		
5. Provide timelines for correction and assign a specific staff person to be responsible for ensuring compliance and follow-up.	2019 Quality Improvement Program Description (revised): Page-5 2019 Annual State Quality Improvement Program Evaluation (revised): Page 6	Fully Met
Findings: The Associate Director, Clinical Quality is responsible for coordination of all QI activities, including timelines for correction and deliverables which meet the contractual requirements. This coordinator is a CPHQ designated by NAHQ. The frequency of evaluation of QAPI is ongoing, quarterly (QI Committees and QI Workplan), and annually (submission of QAPI to MHD). **Required Actions:** None.		
6. Clearly define the roles, functions, and responsibilities of the quality	2019 Quality Improvement Program Description: Pages-10, 22	Fully Met

assessment committee and the Medical Director.		

Findings: The responsibilities of the QMC are:

- Provide program direction and regular oversight of QI activities as related to the unique needs of the members and providers in the areas of clinical care, service, patient safety, administrative processes, compliance, and network credentialing and recredentialing.
- Oversee and approve the annual QIPD, QI Work Plan, and QI Annual Evaluation.
- Review the Work Plan at least quarterly.
- Evaluate, at least annually, the impact and effectiveness of Medicaid-specific Performance Improvement Projects (PIPs) and/or Quality Improvement Project (QIPs) and recommend changes as necessary.
- Report annually or more frequently as needed, on quality activities to the BOD.
- Review and accept decisions of the NQOC, offering feedback as appropriate.
- Review reports and recommendations from other national and QI subcommittees, act upon recommendations as appropriate, and provide feedback, follow-up, and direction to the committees.
- Monitor compliance with regulatory requirements and accrediting organizations.
- Provide local delegation oversight as specified by State regulatory requirements.
- Recommend appropriate resources in support of prioritized activities.
- Oversee the Provider Advisory Committee (PAC), Healthcare Quality Utilization Management Committee, Service Quality Improvement Subcommittee, and Member Advisory Committee.

The CMO participates in various QI committee activities including the credentialing and recredentialing process for the UnitedHealthcare and coordinating review with the PAC. The CMO oversees and implements activities to measure and detect disparities in health services, and to determine the efficacy of the QI program. The CMO, in collaboration with legal and network management, is responsible for the immediate decision and resolution of all situations involving the potential of imminent harm**.**

Required Actions: None.

Compliance Score Quality Assessment and Performance Improvement Program						
Total	Met	=	31	×2	=	62
	Partial Met	=	2	×1	=	02
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	64
Denominator	Total Sections	=	33	×2	=	66
Score %						**96.96**