Primaris
Healthcare Business Solutions

2020 External Quality Review

Performance Measures Validation

UnitedHealthcare®

Measurement Period: Calendar Year 2019

Validation Period: June-August 2020

Publish Date: October 19, 2020

MoHealthNet

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1.0 Purpose and Overview

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 Managed Care for eligible populations, while controlling the program's cost. Participation in Managed Care is mandatory for certain eligibility groups within the regions in operation.

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. Validation of Performance Measures is one of three mandatory External Quality Review (EQR) activities the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. Primaris validated a set of performance measures identified by MHD that were calculated and reported by the MCOs for their Medicaid population. MHD identified the measurement period as calendar year (CY) 2019. Primaris conducted the validation in accordance with the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures,* version Oct 2019.[1]

2.0 Managed Care Information

Information about UnitedHealthcare is presented in Table 1, including the office location(s) involved in the EQR 2020 performance measure validation that occurred on July 30, 2020.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocol 2: Validation of Performance Measures: October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

Table 1: MCO Information	
MCO Name:	UnitedHealthcare
MCO Location:	13655 Riverport Dr. Maryland Heights, MO 63043
On-site Location:	Virtual Meeting: WebEx
Audit Contact:	Katherine Whitaker, Associate Director, Compliance
Contact Email:	katherine_whitaker@uhc.com
Plan:	MCO
Program:	Medicaid (Title XIX)

3.0 Performance Measures Validation Process

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

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

For the hybrid measure, W34, Primaris requested either 45 or all (in case of less than 45) medical records for hybrid review. Primaris conducted over-reads of the 14 available medical records to validate compliance with both the specifications and abstraction process.

4.0 Description of Validation Activities

4.1 Pre-Audit Process

Primaris prepared a series of electronic communications that were submitted to UnitedHealthcare outlining the steps in the performance measure validation process based on CMS Performance Measure Validation Protocol 2. The electronic communications included a request for samples, medical records, numerator and denominator files, source code, if required and a completed Information System Capability Assessment (ISCA). Additionally, Primaris requested any supporting documentation required to complete the performance measure validation review. The communications addressed the medical record review methodology of selecting a maximum of 45 records for over read and the process for sampling and validating the administrative measure during the review process. Primaris provided specific questions to UnitedHealthcare during the measure validation process to enhance the understanding of the ISCA responses during the virtual site visit. Primaris submitted an agenda prior to the virtual visit, describing the activities and suggested that subject matter experts attend each session. Primaris exchanged several pre-onsite communications with UnitedHealthcare to discuss expectations, virtual session times and to answer any questions that UnitedHealthcare staff may have regarding the overall process.

4.2 Validation Team Members

Table 3: Validation Team Members

Name and Role	Skills and Expertise
Allen Iovannisci, MS, CHCA, CPHQ *Lead Reviewer*	Performance Measure knowledge, Data Integration, Systems Review, and Analysis.
Kaitlyn Cardwell Quality Data Systems Analyst	Healthcare Data and Systems Integration for external applications; IT Operations, Analytical and Software Development, Project Management.

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

4.3 Methodology, Data Collection and Analysis

The CMS performance measure validation protocol identifies key components that should

be reviewed as part of the validation process. The following bullets describe these components and the methodology used by Primaris to conduct its analysis and review:

- CMS's ISCA: UnitedHealthcare completed and submitted the required and relevant portions of its ISCA for Primaris' review. Primaris used responses from the ISCA to complete the onsite and pre-onsite assessment of their information system.
- Medical record verification: To ensure the accuracy of the hybrid data being abstracted by UnitedHealthcare, Primaris requested UnitedHealthcare secure a maximum sample of 45 medical records for the W34 measure. UnitedHealthcare had a high rate of administrative claims capture for W34, therefore only 14 records were collected during their medical record abstraction process. Primaris used those 14 medical records to determine the validity of the positive results.
- Source code verification for performance measures: UnitedHealthcare contracted with a software vendor to generate and calculate rates for the two administrative performance measures, Inpatient Mental Health Readmissions and CHL. There were no changes to the source code since the previous review in 2019 and therefore, no source code review was necessary for any of the measures under review.
- Additional supporting documents: In addition to reviewing the ISCA, Primaris also reviewed UnitedHealthcare's policies and procedures, file layouts, system flow diagrams, system files, and data collection processes. Primaris reviewed all supporting documentation and identified any issues requiring further clarification.
- Administrative rate verification: Upon receiving the numerator and denominator files for each measure from UnitedHealthcare, Primaris conducted a validation review to determine reasonable accuracy and data integrity.
- Primaris took a sample of 45 administrative claims for each administrative measure, Chlamydia Screening in Women and Inpatient Mental Health Readmissions, in order to conduct primary source verification to validate and assess UnitedHealthcare's compliance with the numerator objectives.

4.4 Virtual Onsite Activities

Primaris conducted UnitedHealthcare's virtual performance measurement visit on July 30, 2020. The information was collected using several methods, including interviews, system demonstrations, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- Opening Conference: The opening meeting included an introduction of the validation team and key UnitedHealthcare staff members involved in the performance measure

validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.

- Review Information System Underlying Performance Measurement: The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure rates, including accurate numerator and denominator identification and algorithmic compliance which evaluated whether a) rate calculations were performed correctly, b) data were combined appropriately, and c) numerator events were counted accurately.
- ISCA Review, Interviews and Documentation: The review included processes used for collecting, storing, validating, and reporting performance measure rates. The review meetings were interactive with key UnitedHealthcare staff members, in order to capture UnitedHealthcare's steps taken to generate the performance measure rates. This session was used by Primaris to assess a confidence in the reporting process and performance measure reporting as well as the documentation process in the ISCA. Primaris conducted interviews to confirm findings from the documentation review and to ascertain that written policies and procedures were used and followed in daily practice.
- Assess Data Integration and Control Procedures: The data integration session was comprised of system demonstrations of the data integration process and included discussions around data capture and storage, reviewing backup procedures for data integration, and addressing data control and security procedures.
- Complete Detailed Review of Performance Measure Production: Primaris conducted primary source verification to further validate the administrative performance measures.
- Assess Sampling Procedures for Hybrid Measures: Primaris verified UnitedHealthcare utilized appropriate sampling methodology using certified vendor software, Inovalon.
- Closing conference/Communicate Preliminary Findings: The closing conference included a summation of preliminary findings based on the review of the ISCA and the on-site visit.

5.0 Data Integration, Control and Performance Measure Documentation

MHD provided Primaris with the Healthcare Quality Data Instructions for CY 2019, which consisted of requirements and specifications for validation of Inpatient Mental Health Readmissions. Additionally, MHD instructed the MCO's to utilize the HEDIS specifications for the CHL and W34 measures.

As part of the performance measure validation process, Primaris reviewed UnitedHealthcare's data integration, data control, and documentation of performance

measure rate calculations. Several aspects involved in the calculation of the performance measures are crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. Each of the following sections describes the validation processes used and the validation findings. The scores (Table 4) are adopted from CMS EQRO Protocol 2.

Met	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met	The MCO's measurement and reporting process was not fully compliant with State specifications. This designation should be used for any validation component that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All components with this designation must include explanation of the deviation in the comments section.
N/A	The validation component was not applicable.

5.1 Data Integration

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

Met	Not Met ☐	N/A ☐

5.2 Data Control

Data control procedures ensure the accurate, timely, and complete integration of data into the performance measure database by comparing samples of data in the repository with

transaction files. Good control procedures determine if any members, providers, or services are lost in the process and if the organization has methods to correct lost/missing data. The organization's infrastructure must support all necessary information systems and its backup procedures. Primaris validated the data control processes UnitedHealthcare used which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, Primaris determined that the data control processes in place at UnitedHealthcare were acceptable.

Met ●	Not Met ☐	N/A ☐

5.3 Performance Measure Documentation

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

Met ●	Not Met ☐	N/A ☐

6.0 Validation Analysis

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

6.1 Medical Service Data (Claims and Encounters)

UnitedHealthcare's FACETs system underwent an upgrade during the measurement year. The upgrade did not materially affect the processing of claims other than to streamline real-time work distribution and improve auto-adjudication rates by efficiently correcting repetitive errors. Coding updates to the FACETs system were made annually. UnitedHealthcare only used standard claims and/or encounter forms when receiving administrative data from their hospital, physician, home health, mental health, and dental sources. UnitedHealthcare was able to distinguish between the primary and secondary coding schemes. Incomplete claims submitted from providers were promptly rejected and returned for additional information. Incomplete claims were not allowed in the claims system until all required fields were present and valid. UnitedHealthcare's pre-processing

edits verified the accuracy of submitted information on all claims and encounters. Claims containing errors such as invalid Current Procedural Terminology (CPT) or diagnosis codes were rejected and returned to the provider of service for correction. There were no circumstances where a processor was able to update or change the values on a submitted claim. All medical and behavioral claims were processed using an industry standard paper and electronic means. Medicaid claims were audited regularly for financial and procedural accuracy by randomly selecting thirty-two (32) claims on a weekly basis to validate accuracy and data quality. Quality errors are rectified, and additional training is provided to the claims examiners when issues arise.

FACETS provided the claims examiner with specific error messages when a pre-authorization request did not match the service rendered by the provider or when the provider did not request a pre-authorization prior to rendering the service. In either circumstance, the claim required medical review and was pended for Utilization Management for review.

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

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

6.2 Enrollment Data

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

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

There is only one circumstance where a Medicaid member can have multiple identifiers. If MHD sends a subscriber under different identification elements, the system may create a duplicate entry. A weekly report is run to identify members with more than one Subscriber ID record. If a member is found having more than one Subscriber ID record, the additional record is voided, and a note added with the correct CSP Subscriber ID.

Additional enrollment system criteria were evaluated under the ISCA report.

There were no issues identified with UnitedHealthcare's enrollment data processes as it pertains to performance measurement.

6.3 Provider Data

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

6.4 Medical Record Review Validation (MRRV)

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

and regularly monitored the accuracy through inter-rate reliability checks. UnitedHealthcare provided adequate oversight of its vendor and Primaris had no concerns. The validation team selected all 14 numerator positive records from the total numerator positive records abstracted during the HEDIS medical record validation process. The records selected were numerator positive hits. These records were used to evaluate the abstraction accuracy and to validate the rates submitted for the W34 measure. The MRR findings and final results are presented in the Table 5.

Table 5: MRRV Results

Performance Measure	Sample Size	Findings	Results
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	14	14/14 Compliant	Pass

6.5 Supplemental Data

Numerator positive hits through supplemental data sources W34 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record acquisition.

6.6 Data Integration

UnitedHealthcare utilized the CSP FACETS system as well as its relational database/data warehouse to collect and integrate data for reporting.
The CSP FACETS production database contained claims, provider and member data. These data streams were extracted weekly and loaded into the data warehouse and consumed with vendor data (e.g., laboratory and vision providers). FACETS and encounter data were linked using unique identifiers in FACETS linking all other identifiers from external sources such as state Medicaid identifiers and social security numbers. All identifiers were tracked and captured in a central data warehouse where they linked members with their encounter and claims transactions.
UnitedHealthcare utilized senior analysts or managers to examine and approve code for quality and validation. Results were compared to prior year's metrics when available or Medicaid benchmarks to determine reasonableness of results. Per UnitedHealthcare's maintenance cycle, data was reviewed and validated by the assigned analyst and the business owner after requirements were verified and approved. Although

UnitedHealthcare utilized a source code quality validation process, it did not prevent a critical error from occurring. In the previous year's review, a critical error was found in the Inpatient Mental Health Readmission measure (i.e., the numerator contained members that were not in the Medicaid population). Ultimately, the error was corrected for the Inpatient Mental Health Readmission measure prior to the submission date and the rates were finalized and approved. There were no such errors detected in this year's review and UnitedHealthcare was able to report the measure without incident.
There were no other concerns with UnitedHealthcare's ability to consolidate and report data.

7.0 Performance Measure Specific Findings

Table 6 shows the key review findings and final audit results for UnitedHealthcare for each performance measure.
Primaris determined validation results for each performance measure rate based on the definitions listed below. The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "NOT MET." Consequently, it is possible an error for a single audit element may result in a designation of "Do Not Report (DNR)" because the impact of the error materially biased the reported performance measure. Conversely, it is also possible several audit element errors may have little impact on the reported rate, thus the measure is "Reportable (R)." The following is a list of the validation findings and their corresponding definitions:
R = Reportable: Measure was compliant with State specifications.
DNR = Do not report; UnitedHealthcare rate was materially biased and should not be reported.
NA = Not applicable; the UnitedHealthcare was not required to report the measure.
NR = Measure was not reported because the UnitedHealthcare did not offer the required benefit.

Table 6: Key Review Findings and Audit Results for UnitedHealthcare

Performance Measures	Key Review Findings	Audit Results
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	No concerns identified	Reportable
Chlamydia Screening in Women (CHL)	No concerns identified	Reportable
Inpatient Mental Health Readmissions	No concerns identified	Reportable

8.0 Documentation Worksheets

Worksheet 1: Data Integration and Control Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
Accuracy of data transfers to assigned performance measure data repository.				
UnitedHealthcare accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the calculations of the performance measure rates have been completed and validated.	●	☐	☐	
Samples of data from the performance measure data repository are complete and accurate.	●	☐	☐	
Accuracy of file consolidations, extracts, and derivations.				
UnitedHealthcare's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	●	☐	☐	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	●	☐	☐	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	●	☐	☐	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary for performance measure reporting are lost or inappropriately modified during transfer.	●	☐	☐	
If UnitedHealthcare uses a performance measure data repository, its structure and format facilitates any required programming necessary to calculate and report required performance measure rates.				
The performance measure data repository's design, program flow charts,	●	☐	☐	

Worksheet 1: Data Integration and Control Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
and source codes enable analyses and reports.				
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	●	☐	☐	
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including UnitedHealthcare production activity logs and UnitedHealthcare staff review of report runs, is adequate.	●	☐	☐	
Prescribed data cutoff dates are followed.	●	☐	☐	
UnitedHealthcare retains copies of files or databases used for performance measure reporting in case results need to be reproduced.	●	☐	☐	
The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	●	☐	☐	
UnitedHealthcare's processes and documentation comply with UnitedHealthcare standards associated with reporting program specifications, code review, and testing.	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
For each performance measure, all members of the relevant populations identified in the performance measure specifications (who were eligible to receive the specified services) were included in the population from which the	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
denominator was produced. The eligible population included members who received the services as well as those who did not. The same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.				
For each measure, adequate programming logic or source code identifies, tracks, and links member enrollment within and across product lines by age and sex, as well as through possible periods of enrollment and disenrollment) and appropriately identifies all relevant members of the specified denominator population for each of the performance measures.	●	☐	☐	
UnitedHealthcare's calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable)	●	☐	☐	
UnitedHealthcare used proper mathematical operations to determine patient age or age range	●	☐	☐	
UnitedHealthcare can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and can explain what classification is carried out if neither of the required codes is present	●	☐	☐	
Exclusion criteria included in the performance measure specifications are followed.	●	☐	☐	
UnitedHealthcare has correctly calculated member months and	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
member years, if applicable to the performance measure				
Identifying medical events. UnitedHealthcare has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	●	☐	☐	
Time parameters. Any time parameters required by the performance measure specification were followed by the UnitedHealthcare (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital).	●	☐	☐	
Exclusion criteria. Performance measure specifications or definitions that exclude members from a denominator were followed. (For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service, or the service is contraindicated.)	●	☐	☐	
Population estimates. Systems or methods used by the UnitedHealthcare to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	●	☐	☐	
Identifying the at-risk population. The UnitedHealthcare has used the appropriate data, including linked	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
data from separate data sets, to identify the entire at-risk population.				
Services provided outside the UnitedHealthcare. The UnitedHealthcare has adopted and followed procedures to capture data for those performance measures that could be easily under-reported due to the availability of services outside the UnitedHealthcare. (For some measures, particularly those focused on women and children, the member may have received the specified service outside of the UnitedHealthcare provider base, such as children receiving immunizations through public health services or schools, access to family planning services. An extra effort must be made to include these events in the numerator.)	●	☐	☐	
Inclusion of qualifying medical events. The UnitedHealthcare's use of codes to identify medical events (e.g., diagnoses, procedures, prescriptions) are complete, accurate, and specific in correctly describing what transpired and when. This included:	●	☐	☐	
The UnitedHealthcare correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	●	☐	☐	
The UnitedHealthcare avoided or eliminated all double-counted members or numerator events	●	☐	☐	
The UnitedHealthcare mapped any non-standard codes used in determining the numerator in a	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
manner that is consistent, complete, and reproducible. The EQRO assesses this through a review of the programming logic or a demonstration of the program				
Any time parameters required by the specifications of the performance measure were adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	●	☐	☐	
Medical record data. Medical record reviews and abstractions were carried out in a manner that facilitated the collection of complete, accurate, and valid data by ensuring that:	●	☐	☐	
Record review staff have been properly trained and supervised for the task	●	☐	☐	
Record abstraction tools required the appropriate notation that the measured event occurred	●	☐	☐	
Medical record data from electronic sources was accurately extracted according to measure specifications	●	☐	☐	
Data included in the record extract files are consistent with data found in the medical records based on a review of a sample of medical record for applicable performance measures	●	☐	☐	
The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid	●	☐	☐	

9.0 UnitedHealthcare Measure Specific Rates

Table 7: Inpatient Mental Health Readmissions Calendar Year 2018 2019*		
Age Cohort All Regions	**2018**	**2019**
Age 0-12	46	63
Age 13-17	83	96
Age 18-64	53	36
Age 65+	0	0
Total	182	195

Worksheet 3. Performance Measure Results		
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)**		
Data Element/CY	**2018**	**2019**
Numerator	**220**	**249**
Denominator	**411**	**411**
Rate	**53.53%**	**60.58%**
Chlamydia Screening in Women All Ages (CHL)		
Numerator	**2,481**	**2,275**
Denominator	**5,514**	**4,921**
Rate	**44.99%**	**46.23%**

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

10.0 Conclusions

10.1 Quality, Timeliness, and Access to Healthcare

Strengths

- UnitedHealthcare staff was well prepared for an onsite review and had all claims and preparation completed ahead of schedule.
- UnitedHealthcare was able to demonstrate and articulate their knowledge and experience of the measures under review.
- UnitedHealthcare continues to update their systems with most current diagnoses and procedures as they become available during the year.
- UnitedHealthcare updated their source code and implemented additional quality assurance steps in place to ensure the correct population is being reported. This addressed the concerns found in the previous year's review where Medicare members were counted in the Inpatient Mental Health Readmission measure.

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

Weakness

UnitedHealthcare experienced an increase in readmissions for mental illness from the previous year, mainly in the pediatric cohort (0-17 years of age). Program development in this area may be necessary to avoid readmissions for the same diagnosis.

10.2 Improvement by UnitedHealthcare

- UnitedHealthcare implemented safeguards in place to ensure accurate reporting of the Medicaid population. This addressed the concerns found in the previous year's review where Medicare members were counted in the Inpatient Mental Health Readmission measure.
- Significant improvements were noted in the W34 measure (rate changed >5% from 53.35% to 60.58%).
- Minimal improvements were noted in the CHL measure (rate changed <5% as from 44.99% to 46.23%).

Response to Previous Year's Recommendations

Table 8: Previous Year's Recommendations

Recommendation	Action by UnitedHealthcare	Comment by EQRO
UnitedHealthcare should examine measure specifications and programming language in more detail to avoid any inclusion or exclusion of members in the measures. It is recommended that UnitedHealthcare include a data quality review prior to final submission and onsite review.	UnitedHealthcare corrected the coding error that allowed DSNP members into the Inpatient Readmissions measure.	Issue corrected and no concerns.

UnitedHealthcare should continue to engage members through outreach programs to ensure they are informed of upcoming service requirements. However, there are still concerns with reaching all members. UnitedHealthcare's chlamydia screening rates are significantly lower in the Central and Southwest Regions. It seems these two regions would be good candidates for deeper dives into why compliance is lower than other regions.	UnitedHealthcare continues to send reminders to providers and members. Regional reporting has been eliminated for these two measures.	Continue to observe open gaps for measures to ensure member are offered every opportunity to get the required care.
Members should be encouraged to seek outpatient mental health services and follow up once a member is discharged from the hospital following an admission for mental health reasons.	UnitedHealthcare staff advised Primaris that they have conducted outreach through HEDIS programs around the Follow Up after Hospitalization for Mental Illness measure. There was no overall reduction in the readmissions for mental illness.	Enhanced care management and outreach is needed to reduce readmissions for mental illness within 30 days of discharge.

11.0 Recommendations

UnitedHealthcare

While it was noted as a weakness, many of the readmissions are from individual members with severe mental illness being readmitted multiple times. Primaris recommends UnitedHealthcare conduct further examination into solutions for the continuous readmissions by individual members, especially in the pediatric cohort.

MHD

MHD is advised that the W34 measure has been retired by NCQA for CY 2020. A new measure should be selected for review in future. MHD should consider including other Medicaid measures from CMS Adult Core Set, Child Core Set, and Behavioral Health Core Set measures.