Primaris
Healthcare Business Solutions

2021 External Quality Review

Performance Measures Validation

UnitedHealthcare®

Measurement Period: Calendar Year 2020
Validation Period: June-August 2021
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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 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). The 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).

The 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 the MHD that were calculated and reported by the MCOs for their Medicaid population. The MHD identified the measurement period as calendar year (CY) 2020/Measurement year (MY) 2020. 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 OBJECTIVES

Primaris validated the performance measures selected by the MHD (Table 1) with the following objectives:

1. Evaluate the accuracy of the performance measures based on the measure specifications and State reporting requirements.
2. Evaluate if UnitedHealthcare followed the rules outlined by the MHD for calculating the performance measures (42 C.F.R. § 438.358(b)(ii)).
3. Review Information Systems underlying performance measurement.

[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.

4. Assess data integration and control for performance measures calculation
5. Review performance measure production.
6. Determine UnitedHealthcare's ability to process claims, enrollment, provider and supplemental data accurately.
7. Determine UnitedHealthcare's ability to identify numerator and denominator eligible members accurately.
8. Determine if UnitedHealthcare has adequate processes in place to ensure data completeness and data quality.

The performance measures were validated using the data collection specifications for each measure as listed in Table 1. All performance measures selected by the MHD were administrative only which required primary source verification (PSV) from UnitedHealthcare's administrative systems (claims and supplemental data). Each administrative measure required a random selection of 45 records for PSV. For the inpatient readmission measures, a total of 15 records were selected from each sub-measure (Mental Health, Substance Abuse and Medical) to meet the total of 45 records reviewed.

Table 1: Performance Measures

Performance Measure	Method	Specifications Used	Validation Methodology
Chlamydia Screening in Women (CHL)	Admin	HEDIS	Primary Source Verification
Well-Child Visits in the First 30 Months of Life (W30)	Admin	HEDIS	Primary Source Verification
Inpatient Readmissions-Mental Health (MH), Substance Abuse (SA), and Medical (MED)	Admin	MHD	Primary Source Verification

3.0 MANAGED CARE INFORMATION

Contact Information about UnitedHealthcare is presented in Table 2. A virtual meeting was conducted on July 15, 2021, for validation of the performance measures.

Table 2: MCO Information	
MCO Name:	UnitedHealthcare
MCO Location:	13655 Riverport Dr, Maryland Heights, MO 63043
On-site Location:	Virtual Meeting: Web-Ex
Audit Contact:	Katherine Whitaker, Associate Director, Compliance

Contact Email:	katherine_whitaker@uhc.com
Plan:	UnitedHealthcare
Program:	Managed Care (Medicaid/Children's Health Insurance Program)

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, 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 methodology of selecting a maximum of 45 records for PSV and the process for sampling and validating the administrative measures 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

The Primaris team consisted of a Lead Auditor, Allen Iovannisci, MS, CHCA, CPHQ, who possessed the knowledge, skills, and expertise in the Performance Measures, Data Integration, Systems Review, and Analysis required to complete the validation and requirements review for UnitedHealthcare. The Lead Auditor participated in a virtual onsite meeting using web-based technologies to visually inspect the systems and communicate with UnitedHealthcare staff.

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.
- Source code verification for performance measures: UnitedHealthcare contracted with a software vendor to generate and calculate rates for the three administrative performance measures, Inpatient Readmissions (MH, SA, and MED), W30 and CHL. There were no changes to the source code since the previous review in MY 2020 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 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, CHL, Inpatient Readmissions (MH-15 samples, SA–15 samples, MED-15 samples) and W30, and conducted 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 15, 2021. 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 to capture UnitedHealthcare's steps taken to generate the performance measure rates. This session was used by Primaris to assess a confidence level 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.
- 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

The MHD provided Primaris with the Healthcare Quality Data Instructions for Inpatient Readmissions (MH, SA, and MED) in MY 2020, which consisted of requirements and specifications for validation of the Inpatient Readmission measure (MH, SA, and MED). Additionally, the MHD instructed UnitedHealthcare to utilize the HEDIS specifications for the CHL and W30 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 3) are adopted from CMS EQR Protocol 2.

Table 3: Scoring Criteria for Performance Measures

Met	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met	The MCO's measurement and reporting process was not 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. Primaris determined that the data control processes in place at UnitedHealthcare were acceptable.

Met ●	Not Met ☐	N/A ☐

5.3 Performance Measure Documentation

Sufficient and 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 the MHD performance measure rates. General findings are indicated below.

6.1 Medical Service Data (Claims and Encounters)

There were no system or process changes from the previous year's review of the claims and encounters systems for UnitedHealthcare.

UnitedHealthcare's continued to use the Facets system during MY 2020. UnitedHealthcare only updated the procedure and diagnosis coding along with usual maintenance of Facets during the MY 2020. These coding updates were done annually. Primaris confirmed that UnitedHealthcare only used standard paper claim forms, CMS-1500 and UB-94 and standard 837P and 837I for electronic submissions. Primaris also confirmed that all vendors used these standard claim forms. 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 a medical review and was pended for Utilization Management for review.
UnitedHealthcare maintained that 99% of all claims were processed within 90 days.
Primaris had no concerns with UnitedHealthcare's claims/encounter processing.

6.2 Enrollment Data

There were no changes to the enrollment process from the previous year. UnitedHealthcare reported an increase in membership during MY 2020. The membership increase can be attributed to Covid-19. The State halted the redetermination process for Medicaid eligibles in MY 2020 which led to members not being disenrolled. Additionally, Covid-19's forced business shut-downs and layoffs created new Medicaid eligible members. UnitedHealthcare denied having any negative impact on enrollment processing due to the increase in membership. There were no concerns with UnitedHealthcare's accuracy nor were there any significant backlogs of enrollments due to the pandemic.
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 Facets eligibility module. Once UnitedHealthcare received notification of a member's disenrollment, a termination date was 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. This occurs when the MHD sends an existing member using different Medicaid identifiers. In this scenario, UnitedHealthcare's enrollment system could potentially create a duplicate entry using that information. Duplicates are resolved by informing the MHD that a potential duplicate exists and then rectifying it manually first until a new corrected record is submitted from the MHD and voiding of the previous duplicate record.
There were no issues identified with UnitedHealthcare's enrollment data processes as it pertains to performance measurement.
Primaris had no concerns with UnitedHealthcare's ability to capture member information.

6.3 Provider Data

UnitedHealthcare continued to update its provider directories weekly. 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 of 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 maintains provider profiles in their information system. The Network Database (NDB) is used as a 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 synchronized with providers' education and board certifications.
Primaris reviewed the process for mapping provider specialties and verified primary care specialties during the virtual onsite review, primary source verification session. All provider specialties matched the certified provider taxonomy. Primaris also found UnitedHealthcare to be compliant with the credentialing and assignment of individual providers at the Federally Qualified Health Centers (FQHCs).
There were no changes to UnitedHealthcare's provider data processes, including how it captured provider data through its delegated entities. UnitedHealthcare did not report any issue related to the Covid-19 pandemic.

6.4 Medical Record Review Validation (MRRV)

Medical record review was not part of the review for MY 2020 as the measures under review were strictly administrative only measures and did not require a medical record component.

6.5 Supplemental Data

Numerator positive hits through supplemental data sources W30 and CHL were considered standard administrative records. Primaris had no concerns with the data sources or record

acquisition.

6.6 Data Integration

UnitedHealthcare used the Inovalon QSI-XL software to produce the performance measure rates under the scope of the review. UnitedHealthcare utilized the CSP Facets system and its relational database/data warehouse to collect and integrate data for reporting.
The 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. There were no critical errors detected in any of the measures under review.
There were no concerns with UnitedHealthcare's ability to consolidate and report performance measure data.

7.0 PERFORMANCE MEASURE SPECIFIC FINDINGS

Table 4 shows the key review findings and final audit results for UnitedHealthcare for each performance measure.
Primaris determined validation results for each performance measures 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 that 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

Performance Measures: UnitedHealthcare

NA = Not applicable; UnitedHealthcare was not required to report the measure.
NR = Measure was not reported because UnitedHealthcare did not offer the required benefit.

Table 4: Key Review Findings and Audit Results for UnitedHealthcare		
Performance Measures	**Key Review Findings**	**Audit Results**
Chlamydia Screening in Women (CHL)	No concerns identified	Reportable
Well-Child Visits in the First 30 Months of Life (W30)	No concerns identified	Reportable
Inpatient Readmissions (MH, SA, MED)	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.	●	☐	☐	

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

Worksheet 1: Data Integration and Control Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
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 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,	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
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 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 UnitedHealthcare to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	●	☐	☐	
Identifying the at-risk population. UnitedHealthcare has used appropriate data, including linked data from separate	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
data sets, to identify the entire at-risk population.				
Services provided outside the UnitedHealthcare. 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 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. 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:	●	☐	☐	
UnitedHealthcare correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	●	☐	☐	
UnitedHealthcare avoided or eliminated all double-counted members or numerator events.	●	☐	☐	
UnitedHealthcare mapped any non-standard codes used in determining the numerator in a manner that is consistent, complete, and reproducible. The EQRO assesses this through a review of the programming logic or a demonstration of the program.	●	☐	☐	
All time parameters required by the specifications of the performance measure were adhered to (i.e., that the measured	●	☐	☐	

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
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:	☐	☐	☒	Medical record review was not conducted for MY 2020 performance measures as they were administrative measures.
Record review staff have been properly trained and supervised for the task.	☐	☐	☒	Medical record review was not conducted for MY 2020 performance measures as they were administrative measures.
Record abstraction tools required the appropriate notation that the measured event occurred.	☐	☐	☒	Medical record review was not conducted for MY 2020 performance measures as they were administrative measures.
Medical record data from electronic sources was accurately extracted according to measure specifications.	☐	☐	☒	Medical record review was not conducted for MY 2020 performance measures as they were administrative measures.
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.	☐	☐	☒	Medical record review was not conducted for MY 2020 performance measures as they were

Worksheet 2: Measure Validation Findings for UnitedHealthcare				
Data Integration and Control Element	**Met**	**Not Met**	**N/A**	**Comments**
				administrative 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 PERFORMANCE MEASURES

Worksheets 3a-c show the results of the performance measures in the format adopted from the CMS EQR Protocol 2.

Worksheet 3a: Inpatient Readmissions			
Age Cohort	**Mental Health**	**Substance Abuse**	**Medical**
Age 0-12 – Numerator	68	0	380
Age 0-12 – Denominator	1,225,123	1,225,123	1,300,020
Age 13-17 – Numerator	111	1	43
Age 13-17 – Denominator	407,388	407,388	445,268
Age 18-64 – Numerator	76	8	358
Age 18-64 – Denominator	470,909	470,909	481,387
Age 65+ - Numerator	0	0	0
Age 65+ - Denominator	52	52	52
Total – Numerator	255	9	781
Total - Denominator	2,103,472	2,103,472	2,226,727

Worksheet 3b: Performance Measure Results			
Well-Child Visits in the First 30 Months of Life (W30)*			
Data Element/MY	**2018**	**2019**	**2020**
First 15 Months Numerator	NA	NA	3,412
First 15 Months Denominator	NA	NA	7,330
First 15 Months Rate	NA	NA	46.55%
15 – 30 Months Numerator	NA	NA	2,943
15 – 30 Months Denominator	NA	NA	4,558
15 – 30 Months Rate	NA	NA	64.57%

*New Measure in MY 2020

Worksheet 3c: Chlamydia Screening in Women All Ages (CHL)			
Data Element/MY	**2018**	**2019**	**2020**
Numerator	2,481	2,275	3,727
Denominator	5,514	4,921	8,232
Rate	44.99%	46.23%	45.27%

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 continues to review their source code to ensure it is error free.
- Appropriate services such as laboratory, primary care and hospital access, are readily available in all regions.
- UnitedHealthcare was able to demonstrate its ability to capture the specific diagnosis codes for each Inpatient readmissions (MH, SA and MED), CHL, and W30.

Weakness

Table 5: Inpatient Mental Health Readmissions MY 2018-2020			
Age Cohort	**2018**	**2019**	**2020**
Age 0-12	46	63	68
Age 13-17	83	96	111
Age 18-64	53	36	76
Age 65+	0	0	0
Total	182	195	255

UnitedHealthcare experienced an increase in readmissions for mental health from the previous year, increasing from 195 readmissions in MY 2019 to 255 readmissions in MY 2020 (lower the better) (Table 5).

UnitedHealthcare's CHL rate in MY 2020 dropped just under 1 percentage point compared to MY 2019 (Worksheet 3c above). Although, it should be noted that this percentage drop in CHL is within the 5% statistically significant threshold.

10.2 Improvement by UnitedHealthcare

Although there were no significant improvements in the CHL or Inpatient readmissions (MH) this year, much of that is due to the Covid-19 pandemic and is not data capture related. This information was substantiated by UnitedHealthcare staff that indicated routine screenings were heavily impacted by office closures during the pandemic. It should also be noted that there was also a significant increases in enrollment which likely compounded the negative impact on rates as new members may have been eligible but not seeking services due to Covid-19 office closures.

Response to Previous Year's Recommendations: Table 7 describes actions taken by UnitedHealthcare in response to EQRO recommendations during previous EQR 2020.

Table 7: Previous Year's Recommendations

Recommendation	Action by UnitedHealthcare	Comment by EQRO
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 appears these two regions would be good candidates for a deeper dive into why compliance is lower than other regions.	UnitedHealthcare continues to send reminders to providers and members. Regional reporting has been eliminated for CHL.	UnitedHealthcare must 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	Enhanced care management and outreach is needed to reduce readmissions for mental illness within 30 days of discharge.

	readmissions for mental illness.	

11.0 RECOMMENDATIONS

UnitedHealthcare

- Primaris continues to recommend UnitedHealthcare pursue outpatient mental health services following a discharge from a hospital for MH, SA and MED reasons. Further program development for Inpatient readmission (MH, SA and MED) may be necessary to avoid readmissions for the same diagnosis.
- Primaris recommends UnitedHealthcare continue to address readmissions for medical services by coordinating care plans with primary care providers to ensure discharge planning is followed up on within 24 hours of a discharge.
- UnitedHealthcare should incentivize providers to meet with members for the W30 measure.
- Primaris recommends UnitedHealthcare continue education and outreach efforts to members and providers to increase Chlamydia screenings.

MHD

- The MHD should consider including other Medicaid measures from CMS Adult Core Set, Child Core Set and Behavioral Health Core Set in addition to the measures required by HEDIS reporting.
- The MHD should work with UnitedHealthcare to track, monitor, and measure the interventions taken to improve performance of Inpatient Readmissions, W30, and CHL and measures.