Provider Evaluation of Performance

Plan

Tennessee

2020

Executive Summary

UnitedHealthcare Community Plan is committed to ensuring the services members receive from network providers meet the requirements detailed in the UnitedHealthcare Community Plan provider manual, provider contracts, federal and state laws, rules and regulations, and the National Committee for Quality Assurance (NCQA) accreditation standards. UnitedHealthcare Community Plan will conduct site visits at network provider locations to review the providers' policies and procedures, the UnitedHealthcare Community Plan member(s) records and to assess compliance with all requirements. UnitedHealthcare Community Plan will work with providers to ensure quality services are being rendered in accordance with these standards. The Provider Evaluation of Performance (PEP) Plan details the content of the audit processes that will be utilized during a review so that Providers will have a summary of the requirements which may be utilized to review their own performance and implement change.

Table of Contents

Types of Audits

Type of Audit	Brief Description
Outpatient Agency/Facility	During the year the provider is due for recredentialing, a full PEP audit is completed (see page 12). If the provider is determined to be high volume*, auditing will be completed on an annual basis. Record Documentation and Appointment Access, will be included in annual reviews.
Inpatient/Residential Treatment Center (RTC)	Inpatient/ RTC will require a site audit at the time of recredentialing (every 3 years).
Individual/Group	High volume individual and group providers will be audited every 2 years. Record Documentation, Rights and Responsibilities, and EPSDT will be reviewed
Supported Housing/Supported Community Living (SCL)	Supported Housing /SCL locations will be reviewed based on the number of supported housing sites per agency. All Supported Housing/SCL locations are site audited prior to contracting.
Credentialing and Recredentialing for Unaccredited Facility/Agency	Any facility/agency that is unaccredited will require a site audit prior to credentialing and at the time of recredentialing (every 3 years). The recredentialing audit will be completed as part of the PEP audit.
Quality of Care	A quality of care audit is completed to investigate complaints or concerns related to the quality of care provided.
Re-Audits	A re-audit is completed for any scores below 80%. A re-audit may also be completed following any quality of care audit.

*High Volume is determined by claims submitted from the previous calendar year

Appointment Access & Availability

All providers should have a process to ensure appointment access is available based on member need, including access to appointments for routine and urgent situations. Additionally, all providers should have a process for linking members to mobile crisis services in the event of emergency situations.

Routine, urgent and emergency appointments are defined in the UnitedHealthcare Provider Administrative Guide, as follows:

Routine: This category consists of non-urgent, non-emergent, medical or behavioral health care such as screenings, immunizations, or health assessments within 10 business days of the request for service.

Urgent: This category consists of covered services for an illness or injury manifesting itself by acute symptoms that are of lesser severity than emergent but requires care within 24-48 hours or covered services for medical care or treatment for an illness or injury that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Emergency: A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Providers will be audited using the Appointment Access Tool. Only providers of mobile crisis services will be audited on emergency appointment access.

High volume providers and CMHAs will be reviewed at least annually and a sampling of at least 5 member records will be reviewed for each type. Records reviewed will be based on appointment logs/records kept by the provider.

Clinical Records

As part of the documentation review process during all audits, providers of behavioral health services will have a sample of clinical records reviewed to ensure they are following the appropriate documentation standards as outlined by UnitedHealthcare Community Plan, TDMHSAS, and TennCare.

All CMHAs should expect at least 10 records will be pulled for review (5 for adult and 5 for children and youth). Group providers should expect to pull a minimum of 10 records for the review; for individual providers, the minimum number of records to be pulled is 5. An over sampling of 5 for high volume and 3 for low volume will also be pulled in the event one or more records from the original sample cannot be used. Any record for any member receiving services is eligible for review.

There are two ways records are selected for review. The provider may be asked to pull a sample of random records of active members from the past 6-12 months (or further back if needed) or the sample will be randomly selected from claims data submitted by the provider.

Clinical Records will be reviewed in accordance with the standards outlined in the UnitedHealthcare Community Plan Provider Manual located at https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/TN-TennCare-Care-Provider-Administrative-Manual.pdf

As part of the documentation review process, treatment plans will be reviewed to ensure providers are following appropriate guidelines for treatment plan development as outlined by UnitedHealthcare Community Plan, Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), and TennCare. The treatment plan review will occur as part of the documentation review process.

The treatment plan should include the following elements:

- Identification of the reason the member is seeking treatment
- Identification of long and short term goals related to the problem(s)
- The goals are measurable and address the problem(s)
- Target dates for completion of the goals are included
- Specific measurable action steps to accomplish each goal are identified individualized
- Steps for the prevention and/or resolution of crisis, which includes, but is not limited to, identification of crisis triggers; active steps or self-help methods to prevent, de-escalate, or defuse crisis situations; names and phone numbers of contacts that can assist member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Member involvement in treatment plan development and treatment plan updates/reviews
- The treatment plan is based on member strengths
- The individualized treatment plan is updated whenever goals are achieved or new problems are identified.

Complaints & Appeals

Complaint (Inquiry) Process - All providers will be audited to ensure compliance with the appropriate process for member complaints (including both the internal complaint process and the TennCare complaint process). During the course of PEP audits, the auditor will review the provider's comprehensive complaint process and policy rather than individual cases where complaints have been filed. Individual cases will be reviewed through UnitedHealthcare Community Plan's Quality Department if and when complaints rise to the level of requiring review and follow up due to quality of care concerns.

Appeal Process - Providers of inpatient and residential treatment will be reviewed on both the complaint process and the appeals process during PEP audits. This type of audit will focus on the provision of due process notices to any member receiving a notice of adverse action while in care and those adverse actions that have resulted in appeals. If the provider has any appeals, a sample of three to six charts will be pulled for review. An over-sampling of three charts will also be pulled in the event one or more records from the original sample cannot be used. These samples will be pulled randomly from the UnitedHealthcare Community Plan utilization management system for services authorized to the given provider. A review of the due process notices will focus on the completion of notices, documentation, and timely delivery to members of: 1) Provider Initiated Notices of Termination; 2) MCO Initiated Notices of Termination; and 3) Waivers.

Appeals samples will be selected for review from the UnitedHealthcare Community Plan appeals data base and will be based on the number of appeals received within the past year for services rendered by that provider. The sample size will depend on the number of appeals received by provider. Appeals files will be evaluated to ensure the timely and comprehensive handling of appeals prior to and after notification by UnitedHealthcare Community Plan that an appeal has been filed for services on behalf of a member in care or proposing to be in care with the given provider.

Applied Behavioral Analysis

All Applied Behavioral Analysis (ABA) providers will be audited at least every three (3) years through the credentialing or recredentialing process. UnitedHealthcare Community Plan will randomly select a sample from claims or UnitedHealthcare Community Plan's utilization management system. The number of charts reviewed will vary based on whether the provider is a high or low volume provider.

UnitedHealthcare Community Plan will ensure that the Behavioral Analyst and the Behavioral Specialists have the appropriate education and experience to provide ABA services. The personnel files and supervisory relationship/interface between the Behavioral Analyst and the Behavioral Specialists will be examined to ensure it is consistent with the TennCare medical necessity guidelines for Applied Behavioral Analysis services found at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/pro

viderinformation/TN-Provider-Information/TN_BehavorialHealth_Applied_Behavioral_Analysis_Level_of_Care_Guidelines.pdf

The auditor will review the selected records for documentation that staff members have provided the following services:

- An assessment that determines the relationship between environmental events and behaviors
- A written behavior support/maintenance plan and skill development plan
- Assistance to caregivers or others to carry out the approved behavior support/maintenance plans
- Observation of all the caregivers and the members' behaviors for correct implementation of the behavior support/maintenance
- Observation of the members' behaviors to determine effectiveness of the behavior support/maintenance plan
- Provision of on-site assistance in difficult or crisis situations

Facility/Agency Site Review

All providers who provide specialized services and are in network will be reviewed to ensure specialized services are performed in accordance with UnitedHealthcare Community Plan, TDMHSAS, and TennCare requirements. The frequency of the site visits will vary based on whether the provider is considered a high or low volume provider.

Services to be reviewed are listed below. Each service has a separate audit tool. Additionally, the Facility/Agency Site Review Audit Tool is used for all audits that include one or more of the services below.

- Facility/Agency Site Tool
    - Crisis Stabilization Services
    - Psychiatric Inpatient Hospital Services
    - 24 Hour Psychiatric Residential Services
    - Psychosocial Rehabilitation Services
    - Illness Management and Recovery Services
    - Member Complaints and Appeals
    - EPSDT Tool
- Rights and Responsibilities
- Appointment Access
- Facility/Agency Site Tools by LOC:
    - Supported Housing
    - Family Support Services
    - Seclusion and Restraint (RTF)
    - Substance Use Disorder Services
    - Applied Behavioral Analysis;

- Home Office

Behavioral Health Clinical Supervision of Non-licensed Clinicians

UnitedHealthcare expects that ongoing supervision will be provided by Mental Health/Substance Abuse facility/CMHA providers who employ non-licensed clinical staff. The facility should ensure that all non-licensed clinicians who complete clinical activities, such as clinical assessments and therapy are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person and/or via televideo/teleconference in both group and one-on-one supervision with the non-credentialed clinician to review the treatment and/or services provided to members.

- Supervision must be clinical in nature
- Supervision must be documented and kept on file

All supervision of non-licensed clinicians must be completed by a licensed clinician.

Early and Periodic Screening, Diagnosis & Treatment (TennCare Kids)

All providers who treat members who are under 21 years of age will be audited to ensure services are provided in accordance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. UnitedHealthcare Community Plan will review the providers' policies and procedures to ensure the following:

- The provider contacts UnitedHealthcare Community Plan in the event a screening reveals the need for other health care services when the provider is unable to make an appropriate referral for those services
- The provider communicates screening results to the Primary Care Physician if the member or member's guardian has agreed to communication and/or release of treatment information

In the event a member that is under sixteen (16) years of age is seeking behavioral health TennCare Kids services and the member's parent(s) or legally appointed representative is unable to accompany the member to the assessment, UnitedHealthcare Community Plan requires that the provider:

- Contacts the member's parent(s) or legally appointed representative to discuss the findings and inform the family of any other necessary behavioral health treatment recommended for the member. If the member's parent(s) or legally appointed representative cannot be contacted, the provider will inform the Managed Care Company (MCO) and the MCO will contact the parent(s) or legal representatives.

Coordination of Care

As part of the documentation review process, UnitedHealthcare Community Plan will review a sampling of member records to evaluate documentation regarding the communication and coordination of care between the provider and the primary care physician. The records should indicate whether or not members were informed of their rights regarding the exchange of treatment information with other medical care professionals (including primary care physicians and other medical specialists) and/or other behavioral health care clinicians such as psychiatrists and therapists. The records should clearly indicate if the members agree to an exchange of information or communication with other health care professionals. If the member refuses to allow the release of treatment information or communication, the refusal should be clearly documented in the records.

It is expected that Behavioral Health Care Providers will communicate with Primary Care Providers within 30 days of the member's initial assessments. The following information should be included in the initial communication:

- Diagnosis
- Primary provider treating the member
- Medications prescribed (when applicable)

Additional updates should occur when the member's condition or medications change and at the termination of treatment.

The Coordination of Care reviews will occur simultaneously with the Clinical Record reviews and will utilize the same sample.

Member's Rights & Responsibilities

UnitedHealthcare Community Plan's network providers must be committed to treating members in a manner that acknowledges their rights and informs them of their responsibilities while receiving care. Members are to be given a written copy of these rights and responsibilities at the time of enrollment with UnitedHealthcare Community Plan as well as during intake at any UnitedHealthcare Community Plan network provider agency. UnitedHealthcare Community Plan network providers must obtain documentation indicating members' rights and responsibilities were provided to and explained to the members in a manner that is culturally sensitive and appropriate relative to the s' level of functioning, with adequate provisions for members with disabilities (e.g., hearing impairment), when applicable.

UnitedHealthcare Community Plan will utilize the sample of member records selected for clinical record reviews to assess adherence to standards surrounding member's rights and responsibilities. There will also be an evaluation of the provider's policies and procedures to ensure the documented rights and responsibilities being used to inform members are comprehensive and being completed as required.

Recovery and Resiliency

Recovery is cited, within *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, as the "single most important goal" for the mental health service delivery system.

Recovery has been identified as a primary goal for behavioral health care. In August 2010, leaders in the behavioral health field, consisting of people in recovery from mental health and substance use problems and SAMHSA, met to explore the development of a common, unified working definition of recovery. Ten guiding principles of recovery were identified.*

- Hope
- Person Driven
- Many Pathways
- Holistic
- Peer Support
- Relational
- Culture
- Addresses Trauma
- Strengths/Responsibility
- Respect

*Reference:
https://store.samhsa.gov/system/files/pep12-recdef.pdf

The following audit tools address issues related to Recovery and Resiliency:

- Supported Housing
- Illness Management and Recovery
- Psychosocial Rehabilitation
- Peer Support

Seclusion & Restraint in Psychiatric Residential Treatment Facilities

The Pro-Children Act of 2000 instituted federal regulations regarding the use of seclusions and restraints within psychiatric residential treatment facilities (PRTFs). As a requirement of UnitedHealthcare Community Plan's contract with the Bureau of TennCare, we must ensure that the providers within our network are complying with State and federal rules, regulations, policies, and procedures. The consequences of even one seclusion or restraint being handled inappropriately by a PRTF can be fatal and therefore, we are committed to ensuring our network PRTFs comply with the federal requirements.

These audits will be conducted during the PEP audit process, at a minimum of every three years. An ad-hoc site visit may occur when a report is received of a seclusion or restraint being handled improperly or complaint/concern is raised about a given provider's services. While onsite, the auditor will examine the provider's policies and procedures and records

where the provider used seclusion and/or restraint on a UnitedHealthcare Community Plan member. Provider records that are reviewed will be pulled consistent with the clinical records audit. For any record that involves a seclusion or restraint, the Seclusion and Restraint Clinical Record Tool will be utilized. This tool focuses on the documentation in the record related to the seclusion or restraint.

Frequency of Site Visits and Scoring of Audits

The frequency of site visits depends on volume of members the provider serves. PEP audits may occur annually or triennially.

All high volume outpatient facility providers will be reviewed on an annual basis for appointment access and clinical records using the corresponding tools.

Every 3 years, regardless of the volume of members that are served, providers will receive a full Provider Evaluation of Performance (PEP) audit. The full PEP audit will coincide with the year the provider is due for recredentialing. For any unaccredited providers, the PEP audit will also serve as their required recredentialing audit. Each year, a PEP schedule is developed. The schedule will run from January-December and include CMHAs, Facilities, Groups, and Individuals.

During this review, the following tools are utilized, as applicable, or when levels of care (LOC) are offered by a provider:

- Clinical Record Tool
- Clinical Record Tools by LOC:
    - Crisis Stabilization Unit;
    - Psychosocial Rehabilitation;
    - Peer Support;
    - Seclusion and Restraint (RTF);
    - Supported Housing;
    - Family Support Services;
    - Supported Community Living Placement;
    - Applied Behavioral Analysis;
    - Systems of Support;
- Facility/Agency Site Tool (as indicated above p.8-9)

Each audit tool is scored individually. All questions have the same value (unless they are designated as non-scored questions.) A passing score on each tool is 80% or higher. Scores between 80%-84% require a corrective action plan and scores below 80% require a corrective action plan and a re-audit.