Provider Evaluation of Performance (PEP) Plan

Tennessee
2024

United Healthcare Community Plan

Executive Summary

UnitedHealthcare Community Plan is committed to ensuring the services that 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 National Committee for Quality Assurance (NCQA) accreditation standards.

UnitedHealthcare Community Plan will conduct site visits at network provider locations to review providers' policies and procedures, UnitedHealthcare Community Plan member(s) records, and 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 utilized during a review, so Providers will have a summary of requirements which may be utilized to review their performance and implement change.

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Types of Audits

Outpatient Agency/Facility	A full PEP audit is completed during the year the provider is due for recredentialing (Page 11). 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)	Site audit required at time of recredentialing (every 3 years).
Individual/Group	Annual sample audit of high-volume individual and group providers. None of these providers will be audited any more than every 2 years. Record Documentation, Rights and Responsibilities, and EPSDT will be reviewed.
Supported Housing/Supported Community Living (SCL)	Locations will be reviewed based on the number of supported housing sites per agency. All locations are site audited prior to contracting.
Credentialing and Recredentialing for Unaccredited Facility/Agency	Site audit required prior to credentialing and at time of recredentialing (every 3 years); recredentialing audit will be completed as part of PEP audit.
Quality of Care	Completed to investigate complaints or concerns related to quality of care provided.
Re-Audit	Completed for any scores below 80%; may also be completed following any quality of care audit.
BESMART	Scored at 80% passing, with additional individual scores per section.

**High volume determined by claims submitted from 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:** 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**: covered services for an illness or injury manifesting itself by acute symptoms that are of lesser severity than emergent but requiring 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**: 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 mobile crisis services providers will be audited on emergency appointment access.

Clinical Records & Treatment Plans

As part of the documentation review process during all audits, behavioral health service providers will have a sample of clinical records reviewed to ensure they are following the appropriate documentation standards as outlined by UnitedHealthcare Community Plan, Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), and TennCare. Records will be reviewed in accordance with standards outlined in the UnitedHealthcare Community Plan Provider Manual.

- CMHAs should expect a minimum of 25 records or 1% of all program records to be pulled for review.
- Group providers should expect a minimum 10 records to be pulled for review.
- Individual providers should expect a minimum of 5 records to be pulled for review.
- An oversampling of 3 records (low-volume providers) or 5 (high-volume providers) 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.
- The auditor will provide member names for a sample of records of active members.

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, TDMHSAS, and TennCare.

Each treatment plan should include the following elements:

- Reason member is seeking treatment
- Measurable short- and long-term goals related to issue(s), based on member strengths
- Individualized, specific, and measurable action steps to accomplish each goal
- Target dates for completion of goals
- Member involvement in treatment plan development and review
- Updates when goals are achieved, or new problems are identified
- Steps for prevention and/or resolution of crisis, including but 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 to assist the member in resolving crisis
    - Member’s preferred treatment options, including psychopharmacology

Complaints & Appeals

Complaint (Inquiry) Process

- All providers will be audited to ensure compliance with the appropriate member complaint process, including internal and TennCare processes.
- During PEP audits, the auditor will review the provider's comprehensive complaint process and policy.
- Individual cases will be reviewed by UnitedHealthcare Community Plan's Quality Department when a complaint requires review and follow up due to quality of care concerns.

Appeal Process

- Inpatient and residential treatment providers will be reviewed on the complaint and appeals processes during PEP audits.
- A review of due process notices focuses on the completion, documentation, and timely delivery to members receiving a Provider Initiated Notice of Termination, MCO Initiated Notice of Termination, or Waiver.
- If the provider has any appeals, a sample of three to six charts will be pulled for review. An oversample of three charts will also be pulled, in the event one or more records from the original sample cannot be used.
- Appeal samples will be selected from the UnitedHealthcare Community Plan appeals database and will be based on the number of appeals received within the past year for services rendered by that provider.
- Appeal files will be evaluated to ensure timely and comprehensive handling of appeals prior to/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 (ABA)

All Applied Behavioral Analysis (ABA) providers will be audited at least every three (3) years through the credentialing or recredentialing process. The auditor will select a random sample from claims or UnitedHealthcare Community Plan's utilization management system. The sample size will be determined by the provider's low- or high-volume status.

UnitedHealthcare Community Plan will ensure the Behavioral Analyst and Behavioral Specialists have the appropriate education and experience to provide ABA services. Personnel files and supervisory relationship/interface between the Behavioral Analyst and Behavioral Specialists will be examined to ensure consistency with TennCare's medical necessity guidelines for Applied Behavioral Analysis services.

The auditor will review sample records for staff member documentation of providing the following services:

- Assessment to determine the relationship between environmental events and behaviors
- Written behavior support/maintenance and skill development plans
- Assistance to caregivers or others to carry out approved behavior support/maintenance plans
- Observation of caregiver and member behaviors for correct implementation of behavior support/maintenance
- Observation of member behaviors to determine effectiveness of behavior support/maintenance plan
- Provision of onsite assistance in difficult/crisis situations

Facility/Agency Site Review

All in-network specialized service providers will be reviewed to ensure services are performed in accordance with UnitedHealthcare Community Plan, TDMHSAS, and TennCare requirements. Site visit frequency will be based on the provider's low- or high-volume status.

Services to be reviewed:

- Crisis Stabilization
- Psychiatric Inpatient Hospital
- 24 Hour Psychiatric Residential Treatment
- Psychosocial Rehabilitation
- Illness Management and Recovery
- Supported Housing
- BESMART

Behavioral Health Clinical Supervision of Non-Licensed Clinicians

Mental health facilities, substance abuse facilities, and CMHC care providers who hire non-licensed clinical staff to perform clinical activities (i.e., clinical assessments and psychotherapy) must have a licensed clinician supervising them.

The supervisor must have regular, in-person, one-on-one contact with non-credentialed clinicians to review treatment and/or services provided.

Supervision must be specific to the rendered service and include direct supervision[1] during the initial service; this may be followed by general supervision[2] for the rest of the service at the supervisory care provider's discretion.

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 tele video/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.

[1] ***Direct supervision:*** *the supervising care provider must be immediately available (i.e., in person, via phone, or via telehealth/video conferencing) to assist and direct throughout the rendered service. This may include the supervisor's review and signing of the treatment plan during the initial service.*

[2] ***General supervision:*** *the service is performed under the overall direction and control of the supervising clinician. However, their presence is not required during the performance of the intervention.*

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

All providers who treat members under 21 years of age will be audited to ensure services are provided in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

UnitedHealthcare Community Plan will review provider policies and procedures to ensure the following:

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

If a member under sixteen (16) years of age seeks 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:

- The provider will contact the member's parent(s) or legally appointed representative to discuss the findings and inform the family of any other recommended necessary behavioral health treatment 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 communication and coordination of care between the provider and Primary Care Physician (PCP).

Coordination of Care reviews will occur simultaneously with Clinical Record reviews, utilizing the same sample.

Records should indicate whether members were informed of their rights regarding the exchange of treatment information with other medical care professionals (i.e., PCPs and other medical specialists) and/or other behavioral health care clinicians (i.e., psychiatrists and therapists). Records should also indicate if members agree to an exchange of information or communication with other health care professionals. If a member refuses to allow the release of treatment information or communication, the refusal should be clearly documented in records.

It is expected that Behavioral Health care providers will communicate with PCPs within thirty (30) days of the member's initial assessments. The initial communication should include:

- Diagnosis
- Primary treatment provider
- Prescribed medications (when applicable)
    - Initial prescribing of new medications should be communicated to other prescribing providers no later than 14 days after initial script is written.

Additional updates should occur when the member's condition or medications change, and at the termination of treatment; updates should be sent no less than annually.

Member's Rights and 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 their 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 member's rights and responsibilities were provided to/explained to the member in a manner that is culturally sensitive and appropriate relative to the member'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 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

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

- Supported Housing
  - Locations will be audited separately, consisting of 25% of the locations each audit cycle, but no less than 1-2 locations dependent on provider
  - If a provider scores 90% or above on an audit, they will not be audited the following audit cycle; exceptions would be based on re-credential cycle or required monitoring due to quality of care concerns
- Illness Management and Recovery
- Psychosocial Rehabilitation
- Peer Support

Frequency of Site Visits and Scoring of Audits

Each year, a Provider Evaluation of Performance (PEP) audit schedule is developed, running from January-December, and including CMHAs, Facilities, Groups, and Individuals.

High-volume outpatient facility providers will be reviewed annually for appointment access and clinical records, using the corresponding tools.

Every 3 years, regardless of member volume, providers will receive a full PEP audit. For unaccredited providers, the PEP audit will also serve as the required recredentialing audit.

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

- Treatment Record Tool
- Level of Care (LOC) Treatment Record Tool
    - Psychosocial Rehabilitation
    - Peer Support
    - Supported Housing
    - Applied Behavioral Analysis
- Organizational Site Tool
- BESMART Member Audit Tool

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% and 84% require a corrective action plan. Scores below 80% require a corrective action plan and re-audit.

BESMART audit tools are scored at 80% passing, with additional scores per section. See the below Specification Guide for details:

BESMART Specification Guide

BESMART Quality Reviews will be conducted for providers or practices with a minimum of 3 member charts. If there are less than 3 member charts to review, check-ins will occur (providing education and support, as needed).

A sliding scale will be used to determine how many charts are reviewed, based on the number of providers within a practice and/or number of members. The sliding scale is as follows:

- 1-3 providers in one practice: Minimum of 10 charts per provider (or all charts, if the provider has <10)
- 4-6 providers in one practice: Minimum of 6 charts per provider (or all charts, if the provider has <6)

- 7-9 providers in one practice: Minimum of 4 charts per provider (or all charts, if the provider has <4)
- 10+ providers in one practice: Minimum of 3 charts per provider (or all charts, if the provider has <3)

Charts for review must be selected by the MCO. It is not appropriate to allow the provider to select the charts for review.

BESMART Quality Reviews may be conducted via in-person or virtual format. The MCO will determine which format is the best vehicle to assess the provider/provider group.

BESMART Quality Reviews are an annual requirement unless a provider has met criteria for skipping a year.

- The criteria for skipping a year is to achieve a minimum of 2 years of scores > or = to 80% overall and no failed sections (at least 80% for each of the 5 sections).
- The minimum numbers of charts (per the above sliding scale) must have been reviewed in both years.
- It is up to the MCO to keep track of the providers/provider groups that skipped a year and when to restart the annual BESMART Quality Review.

A pass/fail score is based on an overall score of 80%. Pass/fail scoring will be at the NPI and TIN level, and a CAP may be placed at the NPI or TIN level. A CAP may be issued in the following instances:

- The overall score is <80%; or
- Any of the 5 sections score <80% on the BESMART Quality Review Tool