Annual Comprehensive Technical Report

Mississippi External Quality Review

Contract Year
June 1, 2013 through May 31, 2014

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Executive Summary

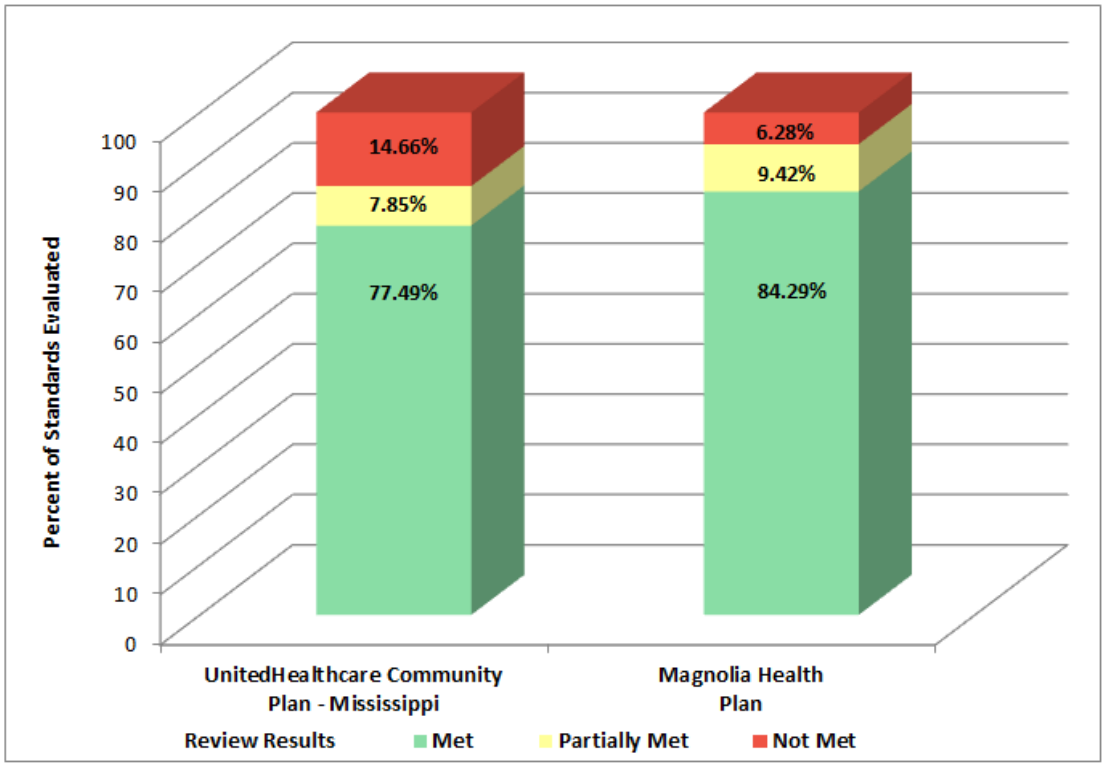
The Balanced Budget Act of 1997 (BBA) requires that each State Medicaid Agency that contracts with Managed Care Organizations (MCO) evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. To meet this requirement, the Mississippi Division of Medicaid (DOM) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all Coordinated Care Organizations (CCO) participating in the MississippiCAN Medicaid Managed Care Program. The CCOs include UnitedHealthcare Community Plan – Mississippi (United) and Magnolia Health Plan (Magnolia).

The purpose of the external quality review was to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. This was accomplished by conducting the following activities: validation of performance improvement projects, performance measures, surveys, and compliance with state and federal regulations, and access studies for each health plan. This report is a compilation of the annual review findings for each CCO conducted during the period of June 1, 2013 through May 31, 2014.

Findings

Findings from the EQRs indicate that Magnolia increased their percentage of Met scores from the previous review by 4.19 percent, while the percentage of Met scores for United stayed the same. Both health plans did not fully implement their corrective action plan that addressed the deficiencies identified during the previous EQR. This resulted in several standards receiving a Not Met score. United and Magnolia continue to have deficiencies in the areas of credentialing, grievances, and appeals. Overall, how the plans handle grievances and appeals was appropriate. However, their policies were deficient and found to be non-compliant. Both plans met the validation requirements for their consumer and provider surveys and performance measures. Magnolia's performance improvement projects failed validation.

The graph that follows illustrates a summary of the results for each of the health plans reviewed. A total of 191 standards were evaluated for each plan, with 148 standards receiving a Met score for United, and 161 standards were scored as a Met for Magnolia.



Percentages may not total 100% due to rounding

Overall Score

In an attempt to objectively compare the plans, CCME applied numerical scores to each standard. The rating scale assigned a point value of two for the standards scored as Met, and Partially Met scores were assigned a point value of one. No points were assigned for standards scored as Not Met. The scores were then averaged for each section and the health plans were assigned an overall score as shown below. The results show a decrease in overall scores for both plans from the previous year.

Health Plan	2012 Score	2013 Score
UnitedHealthcare Community Plan	**88.5%**	**83.7%**
Magnolia Health Plan	**92.5%**	**86.3%**

STRENGTHS

Some of the strengths of United and Magnolia include the following:

- Both plans have the benefit of support from larger parent companies.

- Staffing levels are appropriate to ensure enrollees are receiving the care they deserve.
- Both plans seem to have well-run, in-control, information technology (IT) operations. They both have solid management oversight of critical functions and have standards in place for the handling of claims and reports.
- Adequate disaster recovery plans are in place, and both test regularly.
- Provider educational materials and support were well documented. Detailed Provider Manuals, and educational and support information were available via the plan website provider portal.
- Satisfaction surveys were performed using an NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) vendor as required. Both plans met the validation requirements.
- Both CCOs used NCQA-certified Healthcare Effectiveness Data and Information Set (HEDIS®) software vendors for their performance measures and were found to be fully compliant and met all the validation requirements.
- Topics selected for the performance improvement projects were relevant to the Mississippi Medicaid population.
- Both plans have extensive member education and outreach programs, particularly the prenatal programs developed for their members to provide pregnancy education and support.
- Both United and Magnolia have comprehensive Case Management programs that encompass prevention, care coordination, intensive care planning, and monitoring. Case management files demonstrate good documentation of assessments, care planning, and monitoring for the members enrolled in Case Management.

WEAKNESSES

Some of the weaknesses identified during this contract year's review included:

- Both United and Magnolia had deficiencies from the previous EQR that had not been corrected.
- Both plans continued to have issues relating to credentialing and recredentialing. Some common themes between the plans were that neither plan had implemented a process for addressing ownership disclosure, office site visits at initial credentialing, and proof of primary source verification.
- The access standards were incorrectly applied in the GEO access reports received for both plans.
- The performance improvement project documentation was not always consistent with the project plan. Results of rapid cycle improvement in the initial phases of the project are not always included in the project documents.
- Neither plan was using a provider survey that had been tested for reliability or validity.
- The Member Handbooks for both plans contained errors and/or incomplete information.
- Incorrect or inconsistent information regarding the process for handling grievances and appeals was prevalent throughout materials for both United and Magnolia.

RECOMMENDATIONS

CCME recommends that DOM consider the following:

- The health plans should ensure that deficiencies identified in the EQR are corrected so they do not recur year after year.
- Continue to emphasize and require statewide performance improvement initiatives across the plans so that these projects can reach a larger percentage of the State's Medicaid population.
- Additional work is needed in documenting rapid cycle improvement in the initial phases of performance improvement projects to understand what impact interventions are having on improvement or lack of improvement in the projects.
- A standardized provider satisfaction survey should be adopted by DOM for the plans to use. This would increase the reliability and the validity of the survey and allow for better cross plan comparisons.

Background

The Mississippi Division of Medicaid contracted with two coordinated care organizations (CCOs) to administer the Mississippi Coordinated Access Network (MississippiCAN), a Medicaid managed care program. The CCOs include UnitedHealthcare Community Plan – Mississippi (United) and Magnolia Health Plan (Magnolia). The Balanced Budget Act of 1997 requires State Medicaid agencies that contract with Medicaid managed care organizations evaluate their compliance with state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. To fulfill this requirement, DOM contracted with CCME to conduct an annual external quality review for each CCO plan. This contract requires CCME to perform a validation of the performance measures, validation of performance improvement projects, validation of consumer and provider surveys, access studies and a review to determine the CCOs' compliance with federal and state requirements. This report is a compilation of the individual annual review findings conducted by CCME during the period of June 1, 2013 through May 31, 2014.

Process

The process used for each EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO. The review included a desk review of documents, a three-day onsite visit to the health plan office, validation of performance improvement projects , validation of performance measures, validation of consumer and provider surveys, information systems capability assessment (ISCA) review, and an access and availability survey. After completing the required activities, a detailed technical report was submitted to the State and the plans. This report described the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to the care furnished by the plans. The report also contained the plan's strengths, weaknesses, and recommendations for improvement. Areas of review and standards are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between the health plan and DOM.

The tables in each section that follows reflect the scores for each standard evaluated in the review. Each standard was scored as fully meeting a standard (Met), acceptable but needing improvement (Partially Met), or failing a standard (Not Met). The arrows indicate a change in the score from the previous review. For example, an arrow pointing up would indicate the score for that standard improved from the previous review, and the down arrow indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score or the standard was Not Evaluated in the previous review. The CCO plans are required to submit a corrective action plan to CCME to address any standards that were scored as Partially Met or Not Met.

I. ADMINISTRATION

The Administration section included a review of the health plans policies and procedures, organizational structure and staffing, information systems, compliance, and confidentiality. Both United and Magnolia have the benefit of being a part of large corporations that provide support:

UnitedHealthcare Community Plan is backed by its parent company UnitedHealthcare, and Magnolia Health Plan is backed by Centene. Both plans have staff in Mississippi and also utilize staff from their parent companies. Overall, staffing levels appeared sufficient to meet the needs of enrollees for each plan.

Both plans have a comprehensive set of policies which are written and organized in a consistent manner and reviewed annually. At the time of the review, United was in the process of reviewing and implementing local policies when national policies did not address Mississippi guidelines or requirements. Since the plan uses standard operating procedures to define many of their processes, CCME suggested that the policies should reference the applicable standard operating procedure.

As part of its contracted agreement with Mississippi's Division of Medicaid, CCME reviews the IT capabilities and capacity of each plan. This review examines not only the required Information Systems Capabilities Assessment (ISCA) document, but a number of ancillary and supporting documents as well. The aim is to try and form a well-rounded picture of each organization's ability to manage its IT resources. Based on the contents of the ISCA and the additional documentation submitted, we evaluated UnitedHealthcare's and Magnolia's ability to handle and process claims appropriately and in a timely manner, meet the state guidelines for the delivery of health care services, collect health care data securely and accurately, and provide reports on those activities. Both plans' systems function well for their intended purposes and appear to be capable of delivering the required performance.

Both plans have established guidelines for monitoring the timeliness and accuracy of claims processing and handling, and reviewing their performance data shows that they consistently perform above the targeted levels. Both plans also perform extensive analyses of the demographics and enrollment of their members. Additionally, both plans have solid disaster recovery programs in place. They test regularly and make the necessary revisions to their plans to reflect the test findings. In short, Magnolia and UnitedHealthcare appear to be capable (from an IT perspective) of fully meeting the needs of the Medicaid beneficiaries and the State's reporting requirements.

Both plans demonstrated compliance in the Administration section and continued to meet all of the standards as illustrated in *Table 1 – Administration.*

TABLE 1: ADMINISTRATION

Section	Standard	UnitedHealthcare	Magnolia
General Approach to Policies and Procedures	The CCO has in place policies and procedures that impact the quality of care provided to enrollees, both directly and indirectly	Met	Met
Organizational Chart / Staffing	Full time Chief Executive Officer, and/or Chief Operations Officer located in Mississippi	Met	Met
	Chief Financial Officer	Met	Met
	Chief Information Officer	Met	Met

Section	Standard	UnitedHealthcare	Magnolia
	Information Systems personnel	Met	Met
Organizational Chart / Staffing	Claims Administrator	Met	Met
	Provider Services Manager	Met	Met
	Enrollee Services Manager	Met	Met
	Intake, investigation, resolution, and reporting of enrollee and provider complaints and grievances	Met	Met
	Utilization management functions	Met	Met
	A designated health care practitioner, qualified by training and experience, to serve as Quality Management Director	Met	Met
	Provider credentialing and education	Met	Met
	Enrollee service and education	Met	Met
	Marketing and/or Public Relations	Met	Met
	A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities	Met	Met
	A designated compliance officer and a compliance committee that are accountable to senior management and that have effective lines of communication with all the CCO's employees	Met	Met
	Medical records system supervisor/director	Met	Met
	Operational relationships of CCO staff are clearly delineated	Met	Met
	Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions	Met	Met
	A professionally staffed all service/HelpLine/Nurse Line which operates 24 hours per day, 7 days per week	Met	Met
Management Information System	The CCO processes provider claims in an accurate and timely fashion	Met	Met
	The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met

Section	Standard	UnitedHealthcare	Magnolia
Management Information System	The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met
	The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met
Confidentiality	The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met

II. PROVIDER SERVICES

The Provider Services section included a review of both health plans materials related to their network providers such as training and educational materials, network access and availability, practice guidelines, and credentialing and recredentialing files. Both United and Magnolia continued to have issues in the area of credentialing and recredentialing. Some of the issues that were identified in the prior EQR were never corrected or implemented. The plans utilize their national or corporate credentialing plans. These credentialing documents did not address the specific MS requirements and/or contained errors previously identified. This resulted in a Not Met score for some of the standards related to credentialing and recredentialing. Some common themes found between the plans were that neither plan had implemented a process for addressing ownership disclosure, office site visits at initial credentialing, and credentialing/recredentialing files did not consistently contain proof of primary source verification. Also, the files reviewed for United did not contain copies of the signed attestations. There were not as many deficiencies found in Magnolia's files compared to the files reviewed for United.

Both plans measure member access to their network providers. However, both plans were using the wrong standard for measuring their member's access to two primary care physicians. Another area of concern regarding access involved both health plans' members being able to contact their primary care physician (PCP). No improvement was shown in the number of PCPs that could be reached by telephone in the access and availability study conducted by CCME. Results actually showed a decline in the percentage of successfully answered calls. A detail of this study is discussed further in the Provider Access and Availability Study below.

Overall, provider educational materials and support was well documented. Both plans had detailed Provider Manuals, and educational and support information was available via the plan website provider portal. An overview of the scores for the Provider Services section is illustrated in *Table 2 – Provider Services.*

TABLE 2: PROVIDER SERVICES

Section	Standard	UnitedHealthcare	Magnolia
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Not Met ↓	Not Met ↓
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the CCO	Met	Not Met ↓
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Not Met ↓	Not Met ↓
	Current valid license to practice in each state where the practitioner will treat enrollees	Not Met ↓	Met
	Valid DEA certificate and/or CDS Certificate	Not Met ↓	Met
	Professional education and training, or board certification if claimed by the applicant	Not Met ↓	Met
	Work history	Met	Met
	Malpractice claims history	Not Met ↓	Partially Met ↓
	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Not Met ↓	Met
	Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM)	Met	Met
	Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)	Not Met ↓	Met
	Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)	Not Met ↓	Met ↑
	In good standing at the hospital designated by the provider as the primary admitting facility	Partially Met ↑	Met ↑
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Not Met	Partially Met ↓

Section	Standard	UnitedHealthcare	Magnolia
Credentialing and Recredentialing	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Not Met	Not Met
	Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Not Met ↓	Not Met
	Recredentialing every three years	Met	Met
	Current valid license to practice in each state where the practitioner will treat enrollees	Not Met ↓	Partially Met
	Valid DEA certificate and/or CDS Certificate	Not Met ↓	Partially Met
	Board certification if claimed by the applicant	Not Met ↓	Met
	Malpractice claims since the previous credentialing event	Not Met ↓	Met
	Practitioner attestation statement	Not Met ↓	Met
	Query of the National Practitioner Data Bank (NPDB); and/or System for Award Management (SAM)	Met	Met
	Query for state sanctions and/or license or DEA limitations; (State Board of Examiners for the specific discipline)	Not Met ↓	Met
	Query for Medicare and/or Medicaid sanctions; (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)	Not Met ↓	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Not Met ↓	Partially Met
	Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space if the health plan established complaint/grievance threshold has been met	Met	Met ↑
	Review of practitioner profiling activities	Met	Met
	The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues	Met	Not Met ↓

Section	Standard	UnitedHealthcare	Magnolia
Credentialing and Recredentialing	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Met	Met
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the enrollees assigned	Met ↑	Not Met ↓
	The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met
	The PCP to enrollee ratio does not exceed one (FTE) PCP per every 2500 enrollees	Met	Met ↑
	Enrollees have a PCP located within a 30-mile radius or travel no more than 30-minutes of their residence. For rural regions, Enrollees have a PCP located within a 60-mile radius or travel no more than 60-minutes of their residence	Partially Met ↓	Partially Met ↓
	Enrollees have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the enrollee may utilize an out-of-network specialist with no benefit penalty	Met	Met
	The sufficiency of the provider network in meeting enrolleeship demand is formally assessed at least biennially	Met ↑	Met
	Providers are available who can serve enrollees with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met
	The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting enrolleeship demand	Met	Met
	The CCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Partially Met ↓
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers	Met ↑	Met
	CCO health care program goals	Met	Met
	Billing and reimbursement practices	Met	Met
	Enrollee benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Met	Met
	Procedure for referral to a specialist	Met	Met
	Accessibility standards, including 24/7 access	Met	Met
	Recommended standards of care	Met	Met

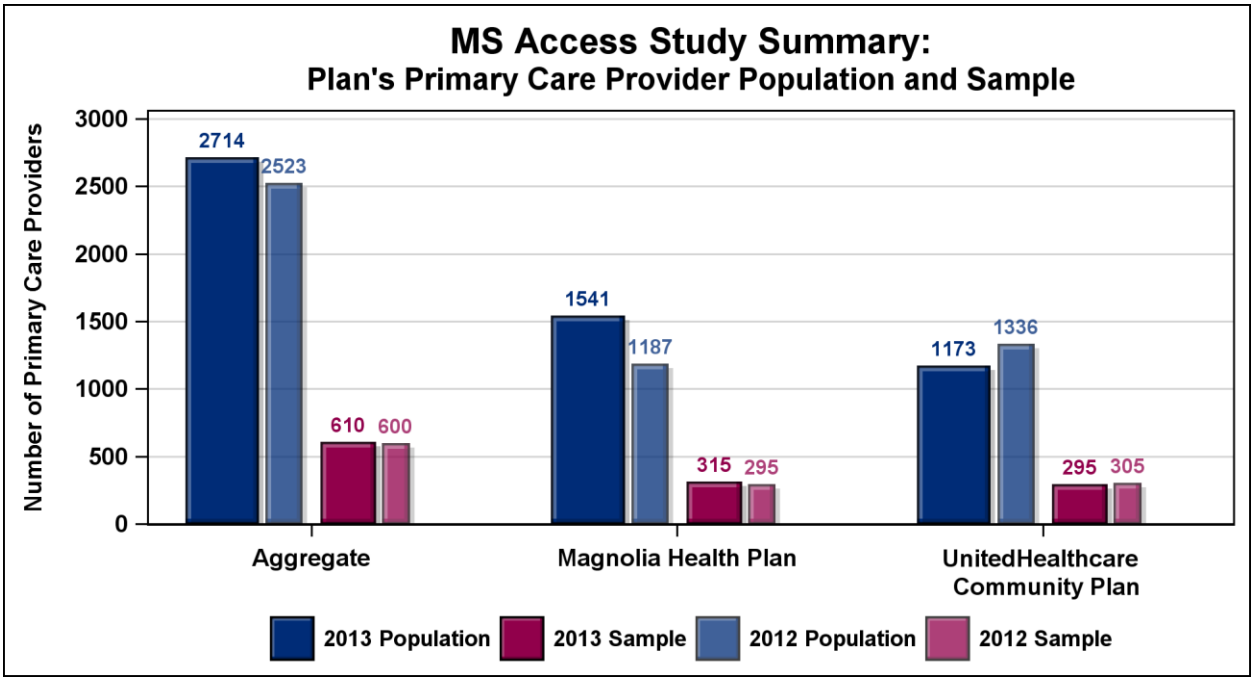
Section	Standard	UnitedHealthcare	Magnolia
Provider Education	Medical record handling, availability, retention and confidentiality	Met	Met
	Provider and enrollee grievance and appeal procedures	Met	Met ↑
	Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met
	Reassignment of an enrollee to another PCP	Met	Met
	Medical record documentation requirements	Met	Met
	The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, enrollee benefits, standards, policies and procedures	Met	Met
Primary and Secondary Preventive Health Guidelines	The CCO develops preventive health guidelines for the care of its enrollees that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met
	The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO enrollees to providers	Met ↑	Met ↑
	Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Met
	Recommended childhood immunizations	Met	Met
	Pregnancy care	Met	Met
	Adult screening recommendations at specified intervals	Met	Met
	Elderly screening recommendations at specified intervals	Met	Met
	Recommendations specific to enrollee high-risk groups	Met	Met
	The CCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data	Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO develops clinical practice guidelines for disease and chronic illness management of its enrollees that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met ↑	Met

Section	Standard	UnitedHealthcare	Magnolia
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO enrollees to providers	Met	Met
	The CCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data	Met	Met
Continuity of Care	The CCO monitors continuity and coordination of care between the PCPs and other providers	Met	Met
Practitioner Medical Records	The CCO formulates policies and procedures outlining standards for acceptable documentation in the enrollee medical records maintained by primary care physicians	Met ↑	Met ↑
	The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Not Met ↓
	The CCO ensures that the enrollees' medical records or copies thereof are available within 14 business days from receipt of a request to change providers	Met ↑	Met ↑

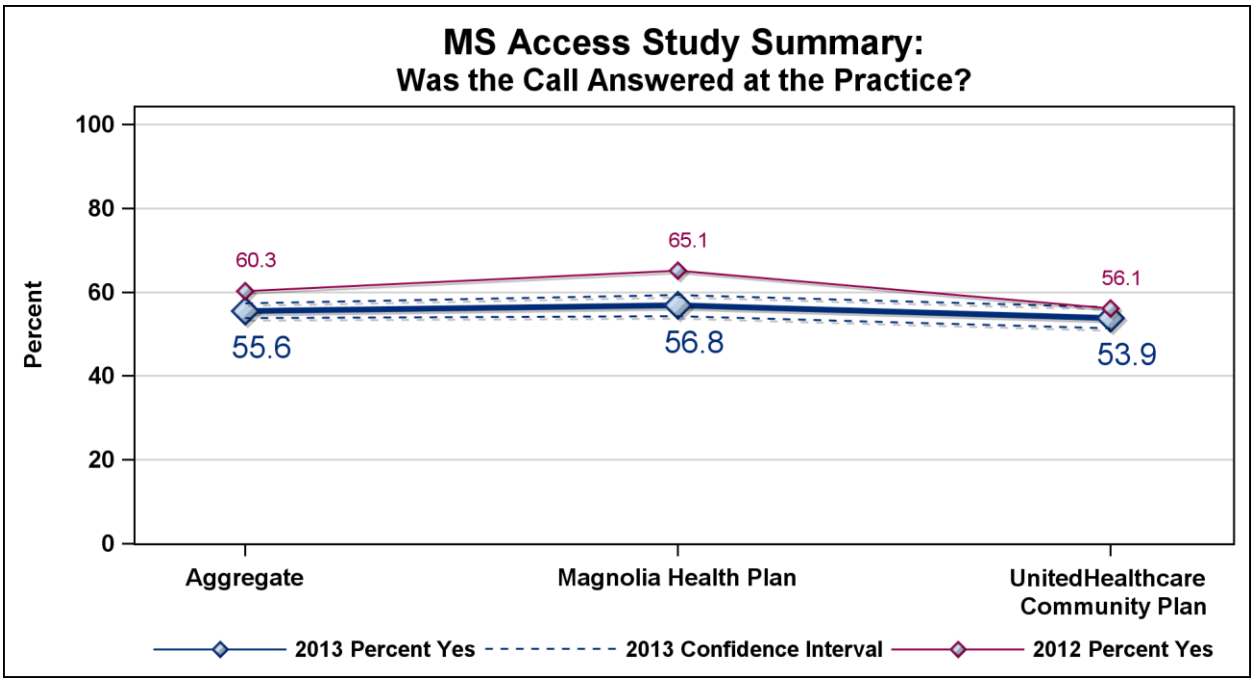
Provider Access and Availability Study

One of the optional EQR activities CCME conducts for DOM is a provider access and availability study. This study is used to help DOM and the plans determine if Medicaid beneficiaries enrolled in the MississippiCAN program have access to their primary care physician and to determine if the providers are in compliance with the availability standards outlined in the DOM contract with the CCOs. To help us determine if improvements had been made, CCME followed the same project plan used in the previous study. This allowed us to compare the results received last year with this year's results.

The study was conducted during the desk review for each plan. A list of network providers and contact information was requested and received with the desk materials for each of the health plans. From this list, a population of primary care providers was determined for each plan. CCME randomly selected a sample of providers from each population for the study. Attempts were made to contact these providers to ask a series of questions regarding the access that enrollees have with the contracted primary care physician. The following summarizes these findings and compares the two Mississippi plans to each other and their results from last year.

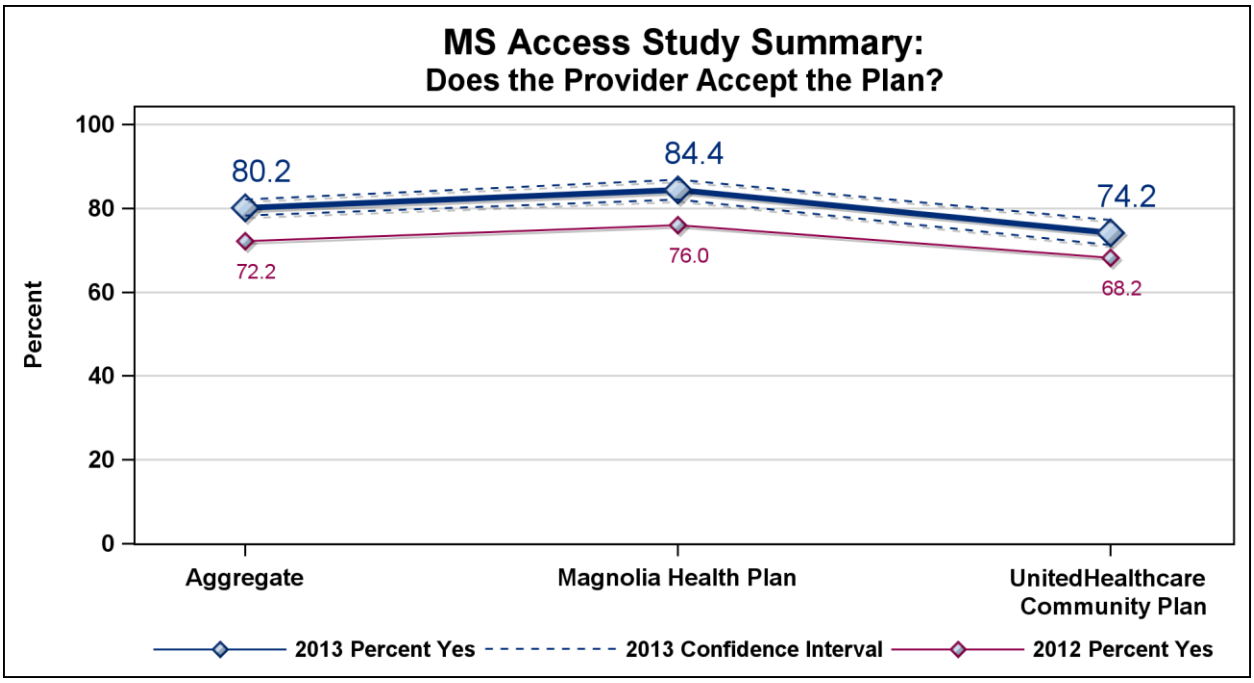


From the two coordinated care organizations reviewed this contract year; a total population of 2,714 plan unique primary care providers was identified. From each plan's population, a sample was randomly drawn, and in total, 610 providers were selected. In aggregate, these numbers were slightly higher than from the year previous. Magnolia had the largest identified population and sample selected from the two plans. This is reversed from last year, where UnitedHealthcare had the largest population and sample.

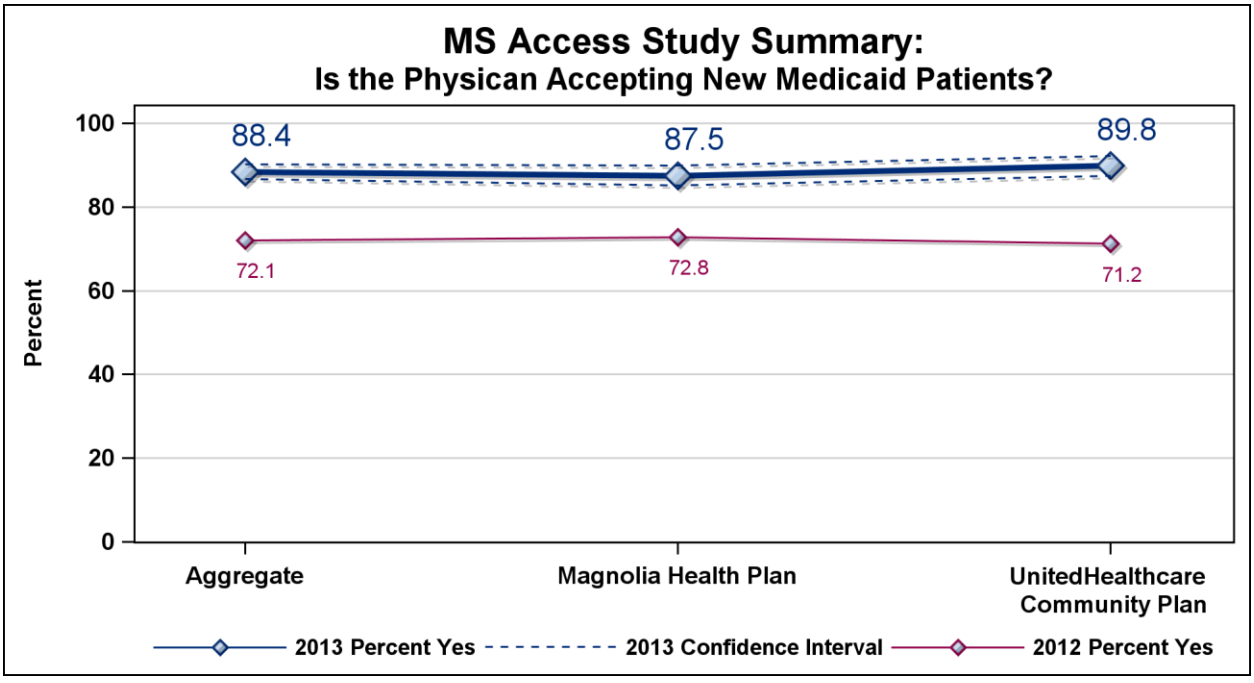


Using the telephone contact information provided by the plans, each provider was called and a series of questions was asked. In aggregate, 56 percent of these calls were successfully answered by the provider. UnitedHealthcare, again this year, had the lowest answer rate of the two plans. Both plans

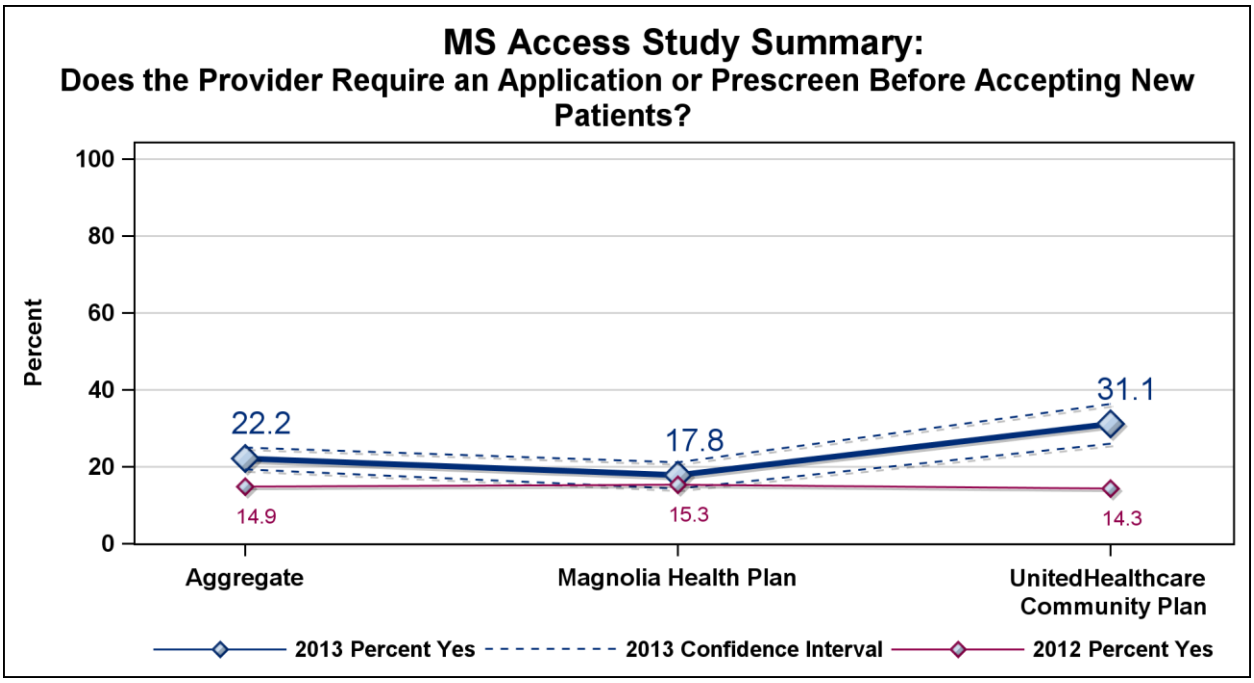
had lower answer rates than from the previous year. In aggregate, the largest reason that a call was not successfully answered was that the caller was informed that the physician was no longer at the number/practice (about 26 percent of the calls).



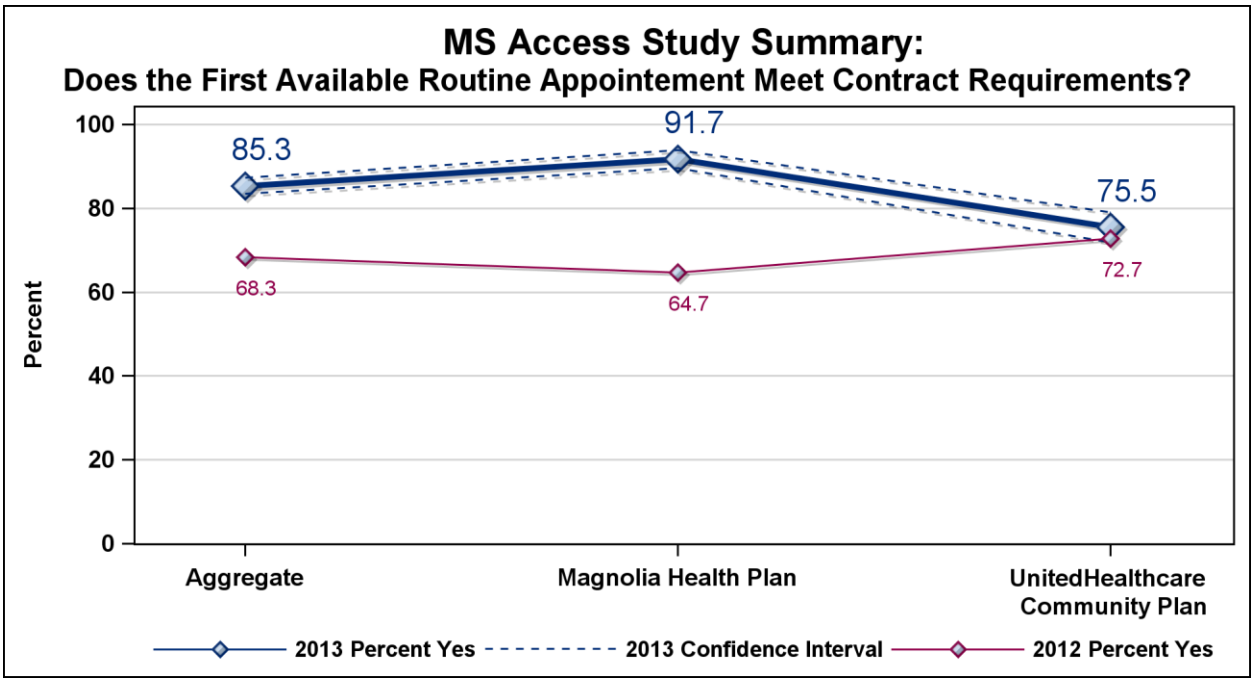
Of the calls that were successfully answered, when asked if the provider accepted the respective plan, 80 percent reported that the plan was accepted; an eight percentage point increase from the previous year. Both plans saw this percentage increase from the previous year's access study.



Of those who accepted the plan, around 88 percent responded that they were accepting new Medicaid patients, an increase from the previous study of 16 percentage points. Both plans were at similar levels and both increased this response from the previous survey.



Of those accepting new Medicaid patients, about 22 percent of the calls indicated they require an application or some form of screening before the patient is accepted into the practice. This was seven percentage point increase in aggregate, while UnitedHealthcare saw nearly a 17 percentage point increase for their study. Magnolia only saw a slight increase of less than three percentage points.



Also, of those accepting new Medicaid patients, when asked when the next available non-urgent appointment for the provider was, the overall results showed that over 85 percent gave an appointment time that met the State's timeframe requirements for routine (well care) appointments. This was a 17 percentage point increase over last year with Magnolia showing the majority of the strides in increasing their position, going from having the lowest percent of the two plans in the previous year to now having the highest percent, an increase of 27 percentage points.

The results of this year's access and availability studies provided insight regarding the quality of information that enrollees receive from the plans and the plans' continued strides to improve this. If the plans do not provide correct contact information for providers, access does become limited. Maintaining accurate and up-to-date contact information is difficult and is a fluid task given the nature of providers' movements. However, with the percentage of calls successfully answered declining from last year (56 percent this year versus 60 percent last year), no improvement has been shown. And the largest reason for an unsuccessful call remains because the provider was no longer at the practice/number provided by the plan. This back track is not a positive sign for beneficiaries' access to providers in Mississippi.

III. ENROLLEE SERVICES

The review of Enrollee Services included policies and procedures, enrollee rights, enrollee orientation and educational materials, enrollee satisfaction, and the processes for handling grievances and practitioner changes. Both United and Magnolia provide 24-hour access to a nurse line and have developed very detailed websites that include health and wellness information, provider search functionality, and links to resources for medical information and disease management. Both plans offer a secure member portal for members to access their personal health information. Magnolia's website contained incorrect information on what is and isn't considered to be an emergency condition warranting an emergency room visit. This has since been corrected.

Documentation of grievance processes provides a challenge for both of the health plans, although onsite review confirms that overall they are processing grievances correctly. The concerns are primarily related to the timeframes for grievance acknowledgement, resolution and notification, and the timeframe to request a State Fair Hearing in policies and other program materials. Both health plans appropriately monitor, track, trend, and analyze the grievances to identify potential quality of care issues and improvement opportunities.

Overall, United's percentage of Met scores in the Enrollee Services review improved by eight percent, while Magnolia's percentage of Met scores remained the same. *Table 3 – Enrollee Services* provides an overview of the scores each health plan received by standard.

TABLE 3: ENROLLEE SERVICES

Section	Standard	UnitedHealthcare	Magnolia
Enrollee Rights and Responsibilities	The CCO formulates and implements policies outlining enrollee rights and responsibilities and procedures for informing enrollees of these rights and responsibilities	Met ↑	Met

Section	Standard	UnitedHealthcare	Magnolia
Enrollee Rights and Responsibilities	All Enrollee rights included	Met	Partially Met ↓
	All Enrollee responsibilities included	Partially Met ↓	Met
Enrollee CCO Program Education	Enrollees are informed in writing within 14 days from CCO's receipt of enrollment data from the Division of all benefits to which they are entitled	Not Met ↓	Partially Met
	Enrollees are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Partially Met ↑	Met
	Enrollee program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract	Met	Met
	The CCO maintains and informs enrollees of how to access a toll-free vehicle for 24-hour enrollee access to coverage information from the CCO, including the availability of free oral translation services for all languages	Met	Met
	Enrollee grievances, denials, and appeals are reviewed to identify potential enrollee misunderstanding of the CCO program, with reeducation occurring as needed	Met	Met
	Materials used in marketing to potential enrollees are consistent with the state and federal requirements applicable to enrollees and enrollees	Met	Met
Enrollee Disenrollment	Enrollee disenrollment is conducted in a manner consistent with contract requirements	Partially Met ↓	Met
Preventive Health and Chronic Disease Management Education	The CCO enables each enrollee to choose a PCP upon enrollment and provides assistance as needed	Met	Met
	The CCO informs enrollees about the preventive health and chronic disease management services that are available to them and encourages enrollees to utilize these benefits	Met	Met
	The CCO identifies pregnant enrollees; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant enrollees in their recommended care, including participation in the WIC program	Met	Met

Section	Standard	UnitedHealthcare	Magnolia
Preventive Health and Chronic Disease Management Education	The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages enrollees to utilize these benefits	Met	Met
	The CCO provides educational opportunities to enrollees regarding health risk factors and wellness promotion	Met	Met
Enrollee Satisfaction Survey	The CCO conducts a formal annual assessment of enrollee satisfaction with CCO benefits and services	Met	Met
	Statistically sound methodology, including probability sampling to insure that it is representative of the total enrolleeship	Met	Met
	The availability and accessibility of health care practitioners and services	Met	Met
	The quality of health care received from CCO providers	Met	Met
	The scope of benefits and services	Met	Met
	Adverse decisions regarding CCO claim decisions	Met	Met
	The CCO analyzes data obtained from the enrollee satisfaction survey to identify quality problems	Met	Met
	The CCO implements significant measures to address quality problems identified through the enrollee satisfaction survey	Met	Met
	The CCO reports the results of the enrollee satisfaction survey to providers	Met ↑	Met
	The CCO reports to the Quality Improvement Committee on the results of the enrollee satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met
Grievances	The CCO formulates reasonable policies and procedures for registering and responding to enrollee grievances in a manner consistent with contract requirements, including, but not limited to	Met	Met
	Definition of a grievance and who may file a grievance	Partially Met	Met
	The procedure for filing and handling a grievance	Met ↑	Partially Met ↓

Section	Standard	UnitedHealthcare	Magnolia
Grievances	Timeliness guidelines for resolution of the grievance as specified in the contract	Partially Met ↑	Partially Met
	Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met	Met
	Notification to the enrollee of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated	Partially Met	Met ↑
	Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met ↑	Met
	The CCO applies the grievance policy and procedure as formulated	Met ↑	Met ↑
	Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met
	Grievances are managed in accordance with the CCO confidentiality policies and procedures	Met	Met
Practitioner Changes	The CCO investigates all enrollee requests for PCP change in order to determine if such change is due to dissatisfaction	Met	Met
	Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee	Met	Met

IV. QUALITY IMPROVEMENT

Both health plans have established Quality Improvement (QI) programs that involve their entire organizations. Their program descriptions, work plans, and program evaluations demonstrate that quality improvement activities are ongoing. Magnolia's QI program documents lacked consistency regarding their committee structure and requirements. Both plans evaluated the effectiveness of their programs and identified that some of the Healthcare Effectiveness Data and Information Set (HEDIS®) goals were not being met. Barriers were identified and both health plans have implemented interventions to help improve their rates. Both plans involve their network providers in the QI program; however, only UnitedHealthcare's providers receive feedback regarding their performance data. Magnolia has a plan in place, but has not implemented the plan, to educate their network providers on performance data.

Both plans are required to collect performance measures and conduct performance improvement projects and satisfaction surveys. Magnolia failed to meet the validation requirements for their performance improvement projects and received a *Not Met* score. Further details of the validation

reviews conducted by CCME follow *Table 4*. An overview of the CCO scores for the Quality Improvement section is illustrated in *Table 4 – Quality Improvement.*

TABLE 4: QUALITY IMPROVEMENT

Section	Standard	UnitedHealthcare	Magnolia
The Quality Improvement (QI) Program	The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to enrollees	Met	Partially Met ↓
	The scope of the QI program includes monitoring of provider compliance with CCO wellness care and disease management guidelines	Met	Met
	The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met
	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met
Quality Improvement Committee	The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met
	The composition of the QI Committee reflects the membership required by the contract	Met	Met
	The QI Committee meets at regular quarterly intervals	Met	Met
	Minutes are maintained that document proceedings of the QI Committee	Met	Met
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met
Quality Improvement Projects/Focused Studies	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the enrollee population	Met	Met
	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met ↑	Not Met ↓

Section	Standard	UnitedHealthcare	Magnolia
Provider Participation in Quality Improvement Activities	The CCO requires its providers to actively participate in QI activities	Met	Met
	Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Partially Met ↓
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Met
	The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors and DOM	Met	Met

Validation Review

Mississippi Division of Medicaid requires the health plans to conduct performance improvement projects and to monitor the plan's performance using measures defined or selected by the State that are applicable to the Medicaid population. In addition, the plans are required to perform both an enrollee and a provider satisfaction survey. In order to evaluate the soundness and results of the performance improvement projects and the surveys, and the accuracy of the performance measures reported, a validation review is required as part of the annual EQR. The validation review conducted by CCME uses the following protocols, all developed by CMS:

- *EQR Protocol 2: Validation of Measures Reported by the MCO*
- *EQR Protocol 3: Validation of Performance Improvement Projects (PIPs)*
- *EQR Protocol 5: Validation and Implementation of Surveys*

This validation balances the subjective and objective parts of the review in order to provide a review that is fair to the plans and gives the State information on how each plan is operating. An overview and the scoring results for each health plan are provided below beginning with the performance improvement projects.

Performance Improvement Projects

Each health plan is required to submit to CCME their performance improvement projects (or quality improvement projects) for review each year. The submitted projects are validated and scored using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The projects reviewed during the past year for each of the two plans are displayed in the table that follows.

Results of the Validation of CCO Performance Improvement Projects

Plans	Reviewed Projects and Protocol Scores with Confidence Level				
	Project 1	Project 2	Project 3	Project 4	Project 5
Magnolia	Obesity 112 / 124 = 90% HIGH CONFIDENCE	Asthma 83 / 99 = 84% CONFIDENCE	Congestive Heart Failure 99 / 104 = 95% HIGH CONFIDENCE	Diabetes 107 / 124 = 86% CONFIDENCE	Hypertension 92 / 124 = 74% LOW CONFIDENCE
UnitedHealthcare	Reducing Adult, Adolescent and Childhood Obesity 119 / 124 = 96% HIGH CONFIDENCE	Use of Appropriate Medications for People with Asthma 99 / 99 = 100% HIGH CONFIDENCE	Annual Monitoring for Patients on ACE/ARB Inhibitors 105 / 106 = 99% HIGH CONFIDENCE	Comprehensive Diabetes Care 114 / 124 = 92% HIGH CONFIDENCE	

The confidence levels determined by each review ranged from two projects scoring in the Confidence level, six projects scoring in the High Confidence level, and one scoring in the Low Confidence level. Scores ranged from 74% to 100%.

For the standards represented in the review, all CCOs met the standard of appropriate topics being selected based on each plans specific member population. However, Magnolia did not meet the standard of complying with the CMS protocol for performance improvement projects. There were numerous errors found in the project documents regarding the measure indicators, source data, data analysis plan, the study question, measurement methodology, sample size, interventions, numerators, and denominators. For Magnolia's hypertension project, there were multiple issues in the project documentation with interventions and the project population being documented for other chronic diseases such as diabetes and CHF.

In general, both plans should be more consistent with their documentation when new projects start and should follow the data analysis plan they outline for themselves in the project documentation. When plans use rapid cycle improvement they need to document all the cycles in the project forms.

Performance Measures

Performance measures are submitted for review each year. A CMS-designed protocol is used to evaluate the data collection and reporting methods used by each plan producing these measures. The following table presents the findings for each CCO for this review year.

Results of the Validation of CCO Performance Measures

	Magnolia Health Plan	UnitedHealthcare
CMS Performance Measure Protocol Score and Audit Designation	Certified HEDIS® Vendor 50 / 50 = 100% FULLY COMPLIANT	Certified HEDIS® Vendor 50 / 50 = 100% FULLY COMPLIANT

Both CCOs were found to be fully compliant with the performance measure validation standards. Both plans are currently using a HEDIS®-certified vendor or software to collect and calculate the measures. Both plans are augmenting the administrative only calculations by using the "Hybrid" data collection and calculation method for respective measures.

Satisfaction Surveys

DOM, in its desire/goal to improve quality of services delivered across the state, requires each health plan to conduct a consumer and provider satisfaction survey. As part of the annual EQR of both health plans, CCME conducted a validation review of the consumer and provider satisfaction surveys using the protocol developed by CMS titled *EQR Protocol 5 Validation and Implementation of Surveys: A Voluntary Protocol for External Quality Review.* The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol is broken down into seven activities:

1. Review survey purpose(s), objective(s) and intended use
2. Assess the reliability and validity of the survey instrument
3. Review the sampling plan
4. Assess the adequacy of the response rate
5. Review survey implementation
6. Review survey data analysis and findings/conclusions
7. Document evaluation of the survey

The consumer and provider surveys for Magnolia and United met the CMS protocol requirements and were found to be valid. In the table that follows we have identified areas that should be corrected to improve the survey documents and process.

Results of the Validation of CCO Satisfaction Surveys

Enrollee Satisfaction Survey Validation	
Magnolia	UnitedHealthcare
The statistical logic for the sample was not well documented.	Documentation for the sample size does not include the acceptable margin of error or the level of certainty required.
The response rate for the child survey (26.6%) was lower than the recommended rate of between 40% and 50%. A low response rate could potentially bias the sample and reduce the generalizability of the sample.	The overall response rate was 34.15% for the adult survey and 22.03% for the child survey. This is lower than the target response rate of between 40% and 50%. A low response rate could potentially bias the sample.

Provider Satisfaction Survey Validation	
Magnolia	UnitedHealthcare
There was no documentation to demonstrate reliability of the survey instrument used. A test/retest comparison should have been conducted.	UnitedHealthcare used a survey that they developed. There was no documentation on how the survey was developed or if input from industry experts and/or focus groups was received. Also, there was no documentation for face validity, content validity, construct validity, or predictive validity.
While the sample size was reported, whether the sampling process was simple random, stratified random, or non-probability was not documented.	Documentation for the sample size does not include the acceptable margin of error or the level of certainty required.
The logic for the sample size with the acceptable margin of error and the level of certainty required was not documented.	Details on the strata and how the strata are analyzed were not clearly documented in the procedures used to select the sample.
While sample characteristics were compared to characteristics of other provider satisfaction surveys, there was no comparisons with the characteristics of the population or the frame.	The response rate was low. The documentation did not address the impact of the low response rate nor address the variety of actual respondents and the impact of oversampling of primary care physicians in the survey.
A quality assurance plan was not clearly documented.	

V. UTILIZATION MANAGEMENT

Both plans have policies, procedures, and program descriptions in place detailing their Utilization and Case Management programs. Most of the deficiencies found in the review of their Utilization Management programs were related to inconsistent and/or incorrect information in program materials and policies. As we noted in other areas of the EQR, many of these deficiencies were identified previously and the corrections were not made. All of the failed standards in the Utilization Management section for United were due to deficiencies not corrected.

Overall, the utilization management activities are being conducted as required. Utilization files demonstrated that both organizations complete authorization requests in a timely manner. In fact, Magnolia's overall all turn-around time averaged 2.25 days for 2013.

Although the review of appeals files for both plans demonstrated that requests for an appeal are handled according to requirements, the processes documented in policies and other program materials were inconsistent or contained errors. Some of these included timeframes for requesting appeals, resolving appeals, notifying appellants of a denial of an expedited appeal request, requesting continuation of benefits, and requesting a State Fair Hearing; and incomplete definitions of an action and appeal. United was noted to have several deficiencies identified in appeals that were noted as corrective action items from the previous EQR and not corrected.

United received Met scores on 71.79 percent of the standards in Utilization Management, an increase of 10.25 percent. All of UnitedHealthcare's scores of Not Met in Utilization Management were due to failure to correct deficiencies identified on the previous EQR. Magnolia received Met scores on 84.62 percent of the UM standards, an increase of 5.13 percent.

An overview of the CCO scores for the Utilization Management section is illustrated in *Table 5 – Utilization Management.*

TABLE 5: UTILIZATION MANAGEMENT

Section	Standard	UnitedHealthcare	Magnolia
The Utilization Management (UM) Program	The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Not Met ↓	Met
	Structure of the program	Met	Met
	Lines of responsibility and accountability	Met	Met
	Guidelines / standards to be used in making utilization management decisions	Not Met ↓	Met
	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Not Met ↓	Not Met ↓
	Consideration of new technology	Met	Met
	The appeal process, including a mechanism for expedited appeal	Not Met ↓	Met
	The absence of direct financial incentives to provider or UM staff for denials of coverage or services	Met	Met
	The absence of quotas establishing a number or percentage of claims to be denied	Met	Met
	Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met
	The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met ↑	Met
Medical Necessity Determinations	Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met
	Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met
	Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met
	Utilization management standards/criteria are consistently applied to all enrollees across all reviewers	Met ↑	Met ↑

Section	Standard	UnitedHealthcare	Magnolia
Medical Necessity Determinations	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met ↑	Met
	If the CCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met ↑	Met
	Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met
	Utilization management standards/criteria are available to providers	Met	Met
	Utilization management decisions are made by appropriately trained reviewers	Met	Met
	Initial utilization decisions are made promptly after all necessary information is received	Not Met ↓	Met
	A reasonable effort that is not burdensome on the enroll or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met
	All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met
	Denial decisions are promptly communicated to the provider and enrollee and include the basis for the denial of service and the procedure for appeal	Partially Met ↓	Met
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to enrollee and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including	Met	Met
	The definitions of an action and an appeal and who may file an appeal	Partially Met ↓	Partially Met ↓
	The procedure for filing an appeal	Met ↑	Partially Met
	Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met ↑
	A mechanism for expedited appeal where the life or health of the enrollee would be jeopardized by delay	Partially Met	Met ↑

Section	Standard	UnitedHealthcare	Magnolia
Appeals	Timeliness guidelines for resolution of the appeal as specified in the contract	Not Met ↓	Met ↑
	Written notice of the appeal resolution as required by the contract	Partially Met	Met
	Other requirements as specified in the contract	Partially Met	Not Met ↓
	The CCO applies the appeal policies and procedures as formulated	Met ↑	Partially Met
	Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met
	Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met
Case Management	The CCO utilizes case management techniques to insure comprehensive, coordinated care for all enrollees	Met	Partially Met ↓
	The CCO has disease state management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, hemophilia and organ transplants	Met	Met
Evaluation of Over/ Underutilization	The CCO has mechanisms to detect and document under and over utilization of medical services as required by the contract	Met	Met
	The CCO monitors and analyzes utilization data for under and over utilization.	Met	Met

VI. DELEGATION

Each plan has delegated various functions and services, and has written agreements that define the delegated activities. The plans have established policies and processes to address the delegation, and both presented evidence of annual oversight. The tools both plans use to conduct oversight for their delegated functions did not reflect the Mississippi-specific requirements, or the oversight tool was not received for a particular delegated entity. This resulted in one standard scored as Partially Met as illustrated in *Table 6 – Delegation.*

TABLE 6: DELEGATION

Section	Standard	UnitedHealthcare	Magnolia
Delegation	The CCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met
	The CCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the CCO if the CCO were directly performing the delegated functions	Partially Met	Partially Met

VII. STATE-MANDATED SERVICES

Both plans provide enrollees with all the benefits required by their contract with DOM. Tracking of immunizations, EPSDTs and well visits are monitored by the plans through their performance measures. Our review of both plans found that there were deficiencies identified during the previous EQR that were still found deficient this year. United and Magnolia submitted a plan of correction after receiving last year's results; however, all of the corrections were not made. This resulted in the Not Met score illustrated in *Table 7 – State-Mandated Services.*

TABLE 7: STATE-MANDATED SERVICES

Section	Standard	UnitedHealthcare	Magnolia
State-Mandated Services	The CCO tracks provider compliance with administering required immunizations	Met	Met
	The CCO tracks provider compliance with performing EPSDTs/Well Care	Met	Met
	Core benefits provided by the CCO include all those specified by the contract	Met	Met
	The CCO addresses deficiencies identified in previous independent external quality reviews	Not Met	Not Met

Conclusions

Findings for the contract year 2012-2013 EQR Annual Review activities showed that overall the plans were compliant with *DOM Contract* requirements and federal regulations. Issues with credentialing and recredentialing processes, as well as inconsistencies in health plan materials, continue to be the major reason for not meeting a standard. Other concerns identified were failure to correct deficiencies identified during the previous EQR and members' access to a primary care provider by telephone.

The comparison table that follows shows the total percentage of standards that were scored as Met. The percentages highlighted in green indicate an improvement over the prior year's total for standards met. The scores highlighted in yellow represent a reduction in the Met scores from the prior review. UnitedHeathcare showed improvements in three areas and Magnolia in two.

COORDINATED CARE ORGANIZATION COMPARISON

Standard	UnitedHealthcare Community Plan		Magnolia Health Plan	
	2012	2013	2012	2013
Administration	100.00%	100.00%	100.00%	100.00%
Provider Services	78.26%	66.67%	65.22%	78.26%
Enrollee Services	72.97%	81.08%	89.19%	89.19%
Quality Improvement	93.33%	100.00%	100.00%	80.00%
Utilization Management	61.54%	71.79%	79.49%	84.62%
Delegation	50.00%	50.00%	50.00%	50.00%
State-Mandated Services	75.00%	75.00%	75.00%	75.00%

The percentages highlighted in green show an improvement over the prior EQR results, while the scores highlighted in yellow show a reduction in the Met scores from the prior EQR.

STRENGTHS

Some of the strengths of the health plans' performance includes the following:

1. Both plans have the benefit of support from larger parent companies.
2. Staffing levels are appropriate to ensure enrollees are receiving the care they deserve.
3. Both plans seem to have well-run, in-control, IT operations. They both have solid management oversight of critical functions and have standards in place for the handling of claims and reports.

4. Adequate disaster recovery plans are in place, and both test regularly.

5. Provider educational materials and support were well documented. Detailed Provider Manuals, and educational and support information were available via the plan website provider portal.

6. Satisfaction surveys were performed using an NCQA-certified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) vendor as required. Both plans met the validation requirements.

7. Both CCOs used NCQA-certified HEDIS® software vendors for their performance measures and were found to be fully compliant and met all the validation requirements.

8. Topics selected for the performance improvement projects were relevant to the Mississippi Medicaid population.

9. Both plans have extensive member education and outreach programs, particularly the prenatal programs developed for their members to provide pregnancy education and support.

10. Both United and Magnolia have comprehensive Case Management programs that encompass prevention, care coordination, intensive care planning, and monitoring. Case management files demonstrate good documentation of assessments, care planning, and monitoring for the members enrolled in Case Management.

WEAKNESSES

Some of the weaknesses identified during this contract year's EQR included:

1. Both United and Magnolia had deficiencies from the previous EQR that had not been corrected.

2. Both plans continued to have issues relating to credentialing and recredentialing. Some common themes between the plans were that neither plan had implemented a process for addressing ownership disclosure, office site visits at initial credentialing, and proof of primary source verification.

3. The access standards were incorrectly applied in the GEO access reports received for both plans.

4. The performance improvement project documentation was not always consistent with the project plan. Results of rapid cycle improvement in the initial phases of the project are not always included in the project documents.

5. Neither plan was using a provider survey that had been tested for reliability or validity.

6. The Member Handbooks for both plans contained errors and/or incomplete information.

7. Incorrect or inconsistent information regarding the process for handling grievances and appeals was prevalent throughout materials for both United and Magnolia.

RECOMMENDATIONS

CCME recommends that DOM consider the following:

1. The health plans should ensure that deficiencies identified in the EQR are corrected so they do not recur year after year.

2. Continue to emphasize and require statewide performance improvement initiatives across the plans so that these projects can reach a larger percentage of the State's Medicaid population.

3. Additional work is needed in documenting rapid cycle improvement in the initial phases of performance improvement projects to understand what impact interventions are having on improvement or lack of improvement in the projects.

4. A standardized provider satisfaction survey should be adopted by DOM for the plans to use. This would increase the reliability and the validity of the survey and allow for better cross plan comparisons.