The Carolinas Center *for* Medical Excellence

Annual Comprehensive Technical Report

Mississippi External Quality Review

Contract Year
June 1, 2015 – May 31, 2016

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Executive Summary

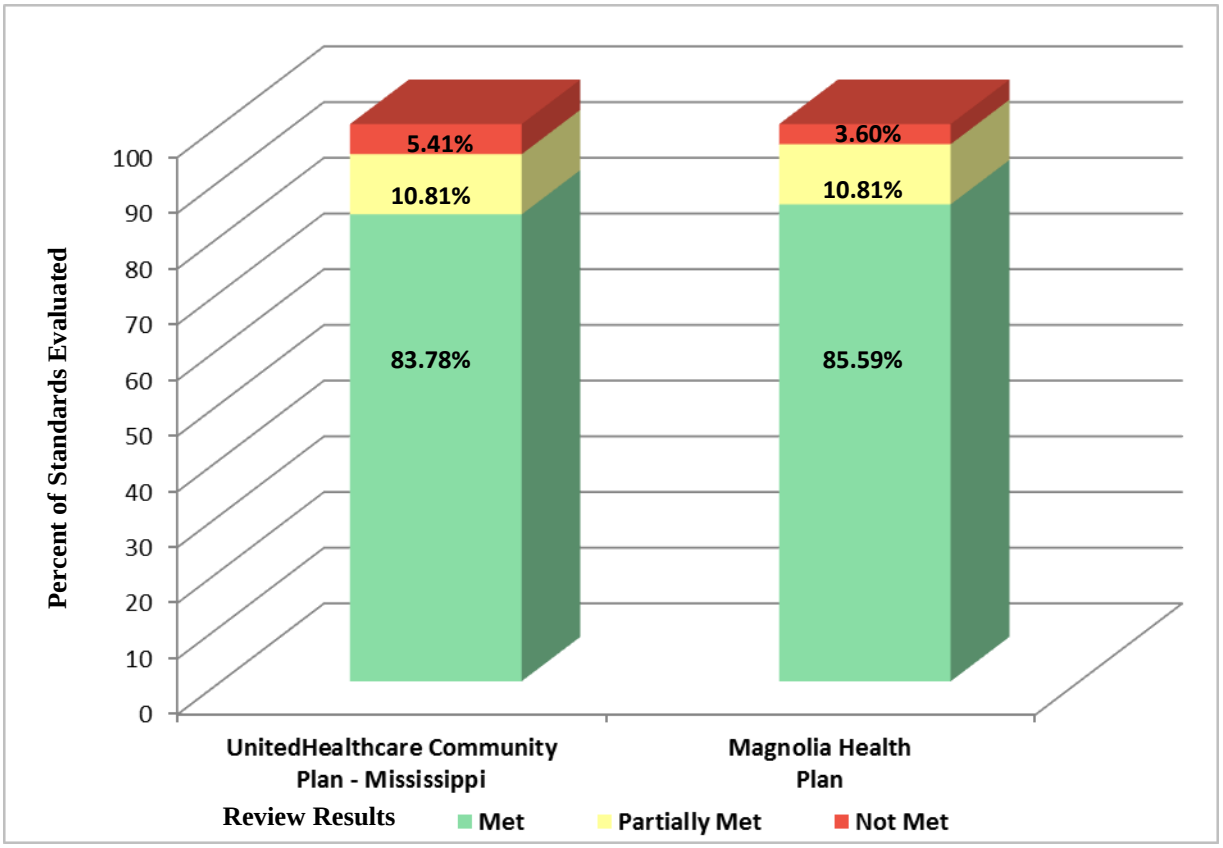
The Balanced Budget Act of 1997 (BBA) requires that each State Medicaid Agency that contracts with Managed Care Organizations (MCO) evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. To meet this requirement, the Mississippi 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, 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, 2015 through May 31, 2016.

Findings

Findings from the EQRs indicate that Magnolia slightly increased their percentage of Met scores from the previous review by 0.6 percent, from 86.3 percent to 86.9 percent. The percentage of Met scores for United decreased by 0.5 percent, from 83.7 percent to 83.2 percent. Both health plans had uncorrected deficiencies from the previous external quality review, resulting in Not Met scores for several standards. Both Magnolia and United were noted to have issues related to credentialing, provider services, the member and provider satisfaction surveys, information in the Member Handbooks, member rights and responsibilities, the Quality Improvement Program, performance measures and quality improvement projects, grievances, appeals. Many errors and inconsistencies were noted in policies and member and provider materials.

The graph that follows illustrates a summary of the results for each of the health plans reviewed. A total of 222 standards were evaluated for each plan, with 186 standards receiving a Met score for United, and 190 standards were scored as a Met for Magnolia.



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 score for United but an increase in score for Magnolia from the previous review.

Health Plan	2013 Score	2015 Score
UnitedHealthcare Community Plan	83.7%	83.2%
Magnolia Health Plan	86.3%	86.9%

STRENGTHS

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

- Member education and outreach programs are well-developed for both plans, particularly for women who are pregnant or have a high risk for premature birth.
- Both plans utilize an NCQA-certified vendor to conduct their member and provider satisfaction surveys.
- Topics selected for the performance improvement projects are appropriate for each health plan's member population.
- Although there were errors in policies and other documentation, review of UM approval, denial, and appeal files reflected that both plans follow appropriate processes and timeframes, and use appropriate criteria.
- Both CCOs have well-developed and well-implemented case management programs. Policies, procedures, program descriptions, and other documentation are thorough, detailed, and reflect that all new requirements for case management have been incorporated. Case management files were thoroughly documented and reflected that staff meet all case management requirements for their members.
- The plans have adequate delegation agreements in place. The delegation agreements specify the delegated activities; requirements for corrective action plans for substandard or non-performance, up to and including termination of the contract; and contain appropriate Mississippi-specific credentialing and recredentialing requirements.

WEAKNESSES

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

- The member and provider satisfaction surveys exhibited low response rates; therefore, response bias may be an issue for both health plans.
- Issues were noted with the credentialing committees for both plans. Magnolia's documents had inconsistencies regarding committee membership and did not define voting members, and United's Chief Medical officer did not chair or oversee the functions of the credentialing committee as required by the *DOM Contract*.
- Member access to their PCPs was an area of concern for both health plans.
- The quality improvement program descriptions were detailed but contained several errors.
- The non-HEDIS® measures did not meet the validation requirements.
- Results of the validation of the performance improvement projects revealed several errors, and Magnolia's projects failed to meet the validation protocol requirements.
- Inconsistencies and/or omissions were noted in documentation in policies, procedures, the Member Handbooks, the Provider Manuals, and in other documents.
- Documentation of appeals requirements in policies and manuals continues to be problematic for both Magnolia and United.
- Oversight documents and auditing tools used for delegated credentialing and other oversight functions did not address all Mississippi-specific requirements.

RECOMMENDATIONS

CCME recommends the following:

- Both plans should work with their survey vendors to develop strategies to improve response rates to member and provider satisfaction surveys.
- Processes to improve member access to their primary care providers need to be implemented by both plans.
- The plans should ensure that documentation and calculations are correct so that non-HEDIS measures and performance improvement projects fully meet validation requirements.
- Both plans should work to reinforce their understanding of appeals requirements and processes, and to ensure that documentation of those processes and requirements is correct.
- The plans should revise their delegation oversight tools and documents to ensure they contain all measures that should be monitored and that the requirements for those measures are correct.

Background

The Mississippi Division of Medicaid (DOM) 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, 2015 through May 31, 2016.

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 to determine the health plans' compliance with federal and state requirements; and to validate the performance improvement projects, performance measures, and the consumer and provider satisfaction surveys. The desk review also included an evaluation of each health plan's information systems, a telephone access study, and file review. Once the desk review was completed, a two day onsite visit was conducted in each health plan's office located in Mississippi. The onsite visit focused on staff interviews to answers questions not addressed in the desk materials and to allow each health plan the opportunity to provide clarifying information.

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 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 a 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 health 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.

United and Magnolia have the benefit of support from larger parent companies and the necessary staff located in Mississippi to meet the needs of their enrollees. Both plans have a complete set of policies and procedures which are well-organized and reviewed on an annual basis. Previously these documents lacked state-specific requirements; however, both plans have added these requirements as policy attachments, addendums, or have developed Mississippi specific policies.

CCME performs an evaluation of the information systems capabilities for each plan as part of the annual review. The evaluation includes an examination of Information System Capabilities Assessment (ISCA) documents submitted as well as a number of other supporting documents. The aim is to ensure that the plans have the ability to manage their resources; meet state guidelines for the delivery of health care services; collect healthcare data securely and accurately; process claims appropriately and in a timely manner; and provide reports on those activities as required by DOM. Both plans have established guidelines for monitoring the timeliness and accuracy of claims processing and they consistently exceed targeted levels. Both plans perform extensive analyses of the demographics and enrollment of their members. Magnolia and United have disaster recovery plans in place and conduct regular testing using various scenarios. Disaster plans are revised based on test findings. Both plans' systems function well and appear to be capable of delivering the required performance and meeting the State's reporting requirements.

An overview of the scores for the Administration section is illustrated in *Table 1 – Administration.*

TABLE 1: ADMINISTRATION

SECTION	STANDARD	UNITED	MAGNOLIA
General Approach to Policies and Procedures	The CCO has in place policies and procedures that impact the quality of care provided to Members, both directly and indirectly	Met	Met
Organizational Chart / Staffing	Full time Chief Executive Officer	Met	Met
	Chief Operations Officer	Met	Met
	Chief Financial Officer	Met	Met
	Chief Information Officer: A professional who will oversee information technology and systems to support CCO operations, including submission of accurate and timely encounter data	Met	Met
	Information Systems personnel	Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Organizational Chart / Staffing	Claims Administrator	Met	Met
	Provider Services Manager	Met	Met
	Provider credentialing and education	Met	Met
	Member Services Manager	Met	Met
	Member services and education	Met	Met
	Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals	Met	Met
	Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions	Met	Met
	Medical/Care Management Staff	Met	Met
	Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities	Met	Met
	Marketing and/or Public Relations	Met	Met
	Medical Director: A physician licensed and actively practicing in the state of Mississippi, providing substantial oversight of the medical aspects of operation, including quality assurance activities, the functions of the Credentialing Committee, and services as Chair of the Credentialing Committee	Met	Met
	Compliance Officer who will act as a primary point of contact for the Division and a compliance committee that are accountable to senior management and that have effective lines of communication with all the CCO's employees	Partially Met ↓	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Organizational Chart / Staffing	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
	The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals	Met	Met
	Call Center scripts are in-place and staff receives training as required by the contract	Met	Met
	Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee	Met	Met
Management Information Systems	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
	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	Partially Met ↓

United and Magnolia met 96.55 percent of the standards in Administration section. Weaknesses were noted in the areas of compliance and committee structure. United submitted a committee matrix that identified voting members for the Compliance Committee; however, onsite discussion indicated that this committee was not a voting committee. Committee minutes demonstrated poor attendance at these meetings. Magnolia's goal for their HIPPAA desk audit was found to be 90 percent. However,

unauthorized disclosure of Protected Health Information (PHI) is strictly prohibited under HIPAA laws and noted in Magnolia's policies. A goal of 90 percent allows for the potential of unauthorized disclosures of PHI. The goal should be set at 100 percent.

II. PROVIDER SERVICES

The Provider Services section included a review of the 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 had issues regarding their credentialing committees. Magnolia received a Partially Met score because of inconsistencies in the committee membership between documents and lack of information that defined the voting members of the committee. Several meetings appeared to have not met the quorum requirement. United's local Provider Advisory Committee, chaired by their Chief Medical Officer, reviews provider appeals and decisions made by the National Credentialing Committee (NCC); however, the NCC is the credentialing decision-making committee. United received a Not Met score because the Chief Medical officer does not chair or oversee the functions of the credentialing committee as required by the *DOM Contract*.

Overall improvement was shown for both United and Magnolia in the area of credentialing and recredentialing file review: files were organized and for the most part contained appropriate documentation. However, Magnolia received Not Met scores because they were not collecting ownership disclosure forms at recredentialing for any of their providers. Both plans also had issues in the area of provider office site assessment due to incorrect appointment timeframes in their review tools.

Both plans have policies and processes for measuring availability and accessibility of their provider networks. GEO access reports are run to determine provider availability, and the standards complied with *DOM Contract* requirements. However, Magnolia received a Partially Met score because their practitioner availability analysis report reflected incorrect standards for PCPs, and there were inconsistencies between two policies. An area of concern regarding member access involved both health plans' members being able to contact their primary care physician (PCP). For United, provider access was identified as an issue in an access study conducted by the plan, in the member satisfaction survey results, and identified as a barrier for not meeting some of the HEDIS measures. No improvement was shown in the number of PCPs that could be reached by telephone in the access and availability study conducted by CCME, so both plans received Not Met scores. 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 section below.

New provider orientation is conducted. In addition, the plans have provider educational materials available, resource information is included on their websites, and call centers provide telephonic support.

In the area of provider education, United received Partially Met and Not Met scores because their Provider Administrative Guide had inconsistent/incorrect information or lacked information required by the *DOM Contract*. In addition, United's Provider Directory (paper and electronic) did not include the providers' hours of operation as required. Magnolia received a Partially Met score for one standard; but overall, their Provider Manual was detailed and complied with contract requirements.

Both Magnolia and United performed provider satisfaction surveys that were administered by survey vendors; however, both plans received Not Met scores because the survey did not meet the CMS protocol requirements. The low number of responses and low response rates could bias results and provide unreliable information on the underlying population. Both plans were advised to implement interventions to increase the response rate and to improve survey documentation. Magnolia also received a Not Met score because they did not report the results of the provider satisfaction survey to an appropriate committee. Details of the survey validation can be found in the *Quality Improvement* section of this report.

An overview of the scores for the Provider Services section is illustrated in Table 2 – Provider Services.

TABLE 2: PROVIDER SERVICES

SECTION	STANDARD	UNITED	MAGNOLIA
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met ↑	Partially 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	Not Met ↓	Partially Met ↑
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met ↑	Met ↑
	Current valid license to practice in each state where the practitioner will treat Members	Met ↑	Met
	Valid DEA certificate and/or CDS certificate	Met ↑	Met
	Professional education and training, or board certification if claimed by the applicant	Met ↑	Met
	Work history	Met	Met
	Malpractice claims history	Met ↑	Met ↑

SECTION	STANDARD	UNITED	MAGNOLIA
Credentialing and Recredentialing	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	Met ↑	Met
	Query of the National Practitioner Data Bank (NPDB)	Met	Met
	Query of the 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)	Met ↑	Met
	Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	Met ↑	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	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	Met ↑	Met ↑
	Ownership Disclosure Form	Met	Met
	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	Partially Met ↑	Partially 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	Met ↑	Met ↑

SECTION	STANDARD	UNITED	MAGNOLIA
Credentialing and Recredentialing	Recredentialing every three years	Met	Met
	Current valid license to practice in each state where the practitioner will treat Members	Met ↑	Met ↑
	Valid DEA certificate and/or CDS certificate	Met ↑	Met ↑
	Board certification if claimed by the applicant	Met ↑	Met
	Malpractice claims since the previous credentialing event	Met ↑	Met
	Practitioner attestation statement	Met ↑	Met
	Requery the National Practitioner Data Bank (NPDB)	Met	Met
	Requery the System for Award Management (SAM)	Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Met ↑	Met
	Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE))	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	Met ↑	Met ↑
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met
	Ownership Disclosure form	Met	Not 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

SECTION	STANDARD	UNITED	MAGNOLIA
Credentialing and Recredentialing	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	Met ↑
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	Met	Not Met ↓
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the Members assigned	Met	Met ↑
	The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	Met	Met
	The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	Met	Met
	Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties	Met	Partially Met
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the Member may utilize an out-of-network specialist with no benefit penalty	Met	Met
	The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	Met	Met
	Providers are available who can serve Members 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 membership demand	Met	Met
	The CCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met ↑	Partially Met

SECTION	STANDARD	UNITED	MAGNOLIA
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Not Met
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers	Met	Met
	A description of the Care Management system and protocols	Met	Met
	Billing and reimbursement practices	Met	Met
	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM	Partially Met ↓	Met
	Procedure for referral to a specialist including standing referrals and specialists as PCPs	Met	Met
	Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	Met	Met
	Recommended standards of care including EPSDT screening requirements and services	Partially Met	Met
	Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services	Not Met	Met
	Medical record handling, availability, retention and confidentiality	Met	Met
	Provider and Member complaint, grievance, and appeal procedures including provider disputes	Met	Met
	Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Partially Met ↓	Met
	Prior authorization requirements including the definition of medically necessary	Met	Met
	A description of the role of a PCP and the reassignment of a Member to another PCP	Partially Met	Partially Met

SECTION	STANDARD	UNITED	MAGNOLIA
Provider Education	The process for communicating the provider's limitations on panel size to the CCO	Not Met	Met
	Medical record documentation requirements	Met	Met
	Information regarding available translation services and how to access those services	Not Met	Met
	Provider performance expectations including quality and utilization management criteria and processes	Met	Met
	A description of the provider web portal	Met	Met
	A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Not Met	Met
	The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements	Partially Met	Met
	The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, Member benefits, standards, policies, and procedures	Met	Met
Primary and Secondary Preventive Health Guidelines	The CCO develops preventive health guidelines for the care of its Members 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 Members 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

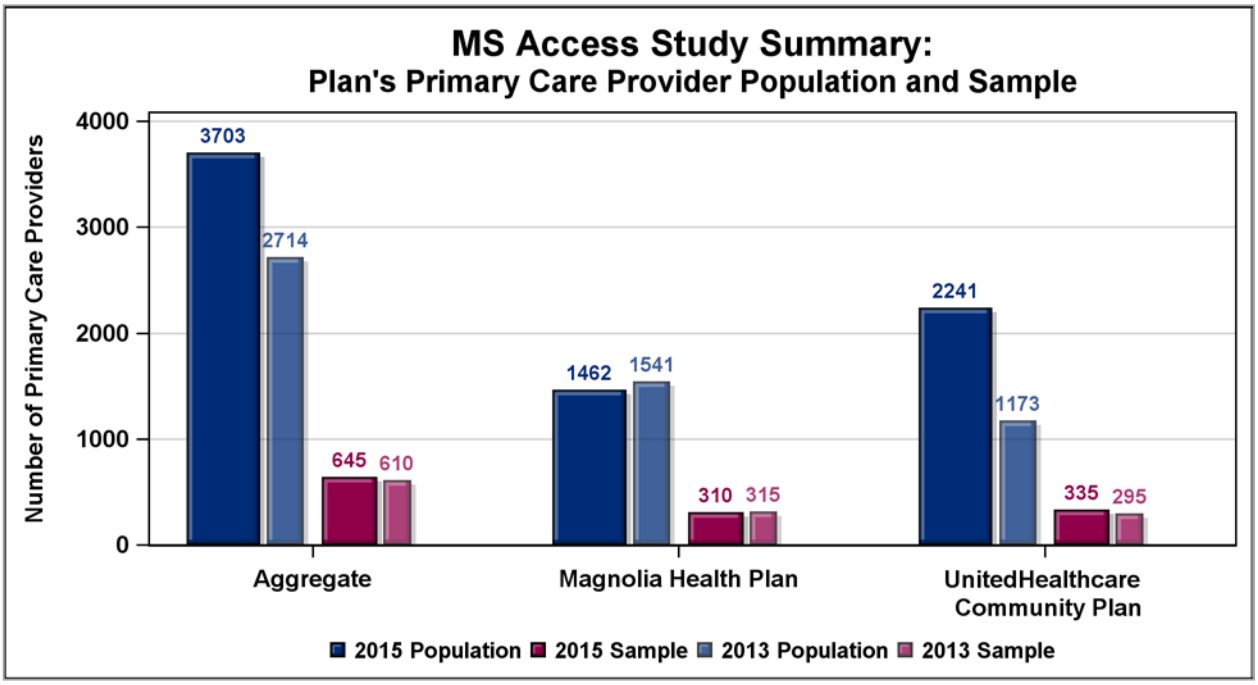
SECTION	STANDARD	UNITED	MAGNOLIA
Primary and Secondary Preventive Health Guidelines	Elderly screening recommendations at specified intervals	Met	Met
	Recommendations specific to Member high-risk groups	Met	Met
	Behavioral Health	Met	Met
	The CCO assesses practitioner compliance with preventive health 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 Members 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
	The CCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for CCO Members 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	Partially Met ↓
Continuity of Care	The CCO monitors continuity and coordination of care between the PCPs and other providers	Met	Met
Practitioner Medical Reports	The CCO formulates policies and procedures outlining standards for acceptable documentation in the Member 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	Met ↑
	The CCO ensures that the Members' medical records or copies thereof are available within 14 calendar days from receipt of a request to change providers	Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Provider Satisfaction Survey	A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol	Not Met	Not Met
	The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met
	The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Not Met

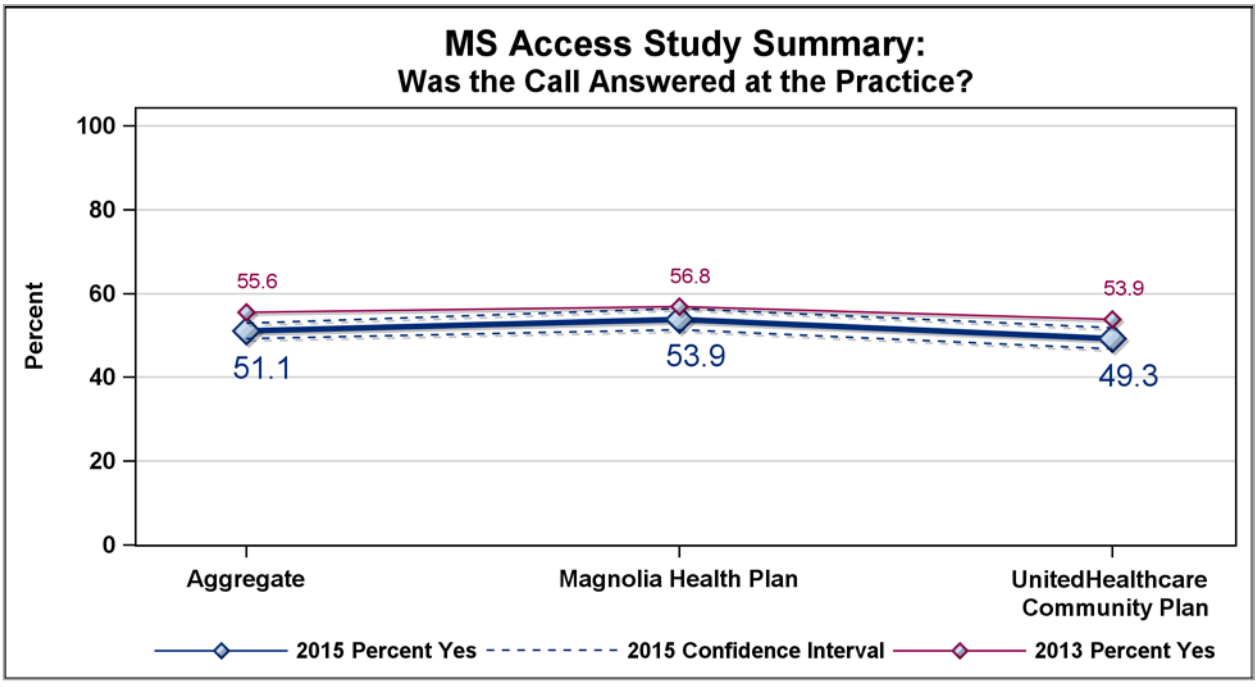
Provider Access and Availability Study

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 coordinated care organizations (CCOs). To help determine if improvements had been made, CCME followed the same project plan used in the previous study. This allowed the results received to be compared to the results received with the previous review.

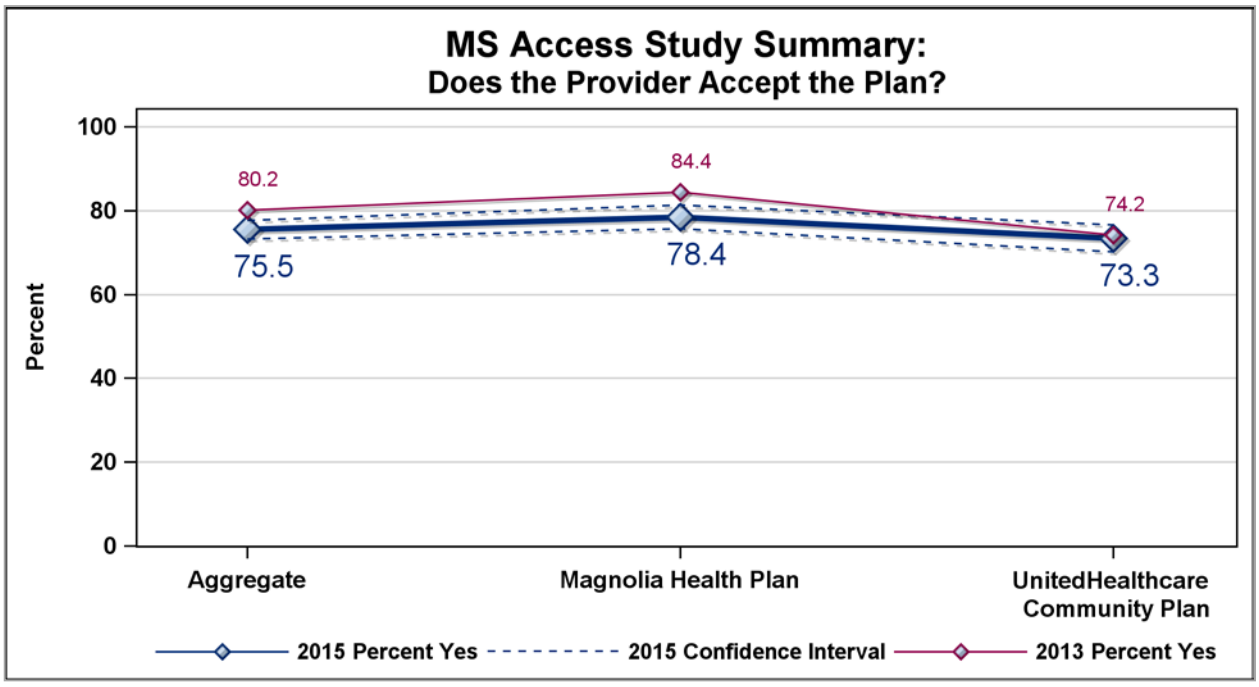
The study was conducted during the desk review for each plan. A list of network providers and contact information was requested and received with the desk materials for each of the health plans. From this list, a population of primary care providers was determined for each plan. CCME randomly selected 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 table summarizes these findings and compares the two Mississippi plans to each other and their last review.



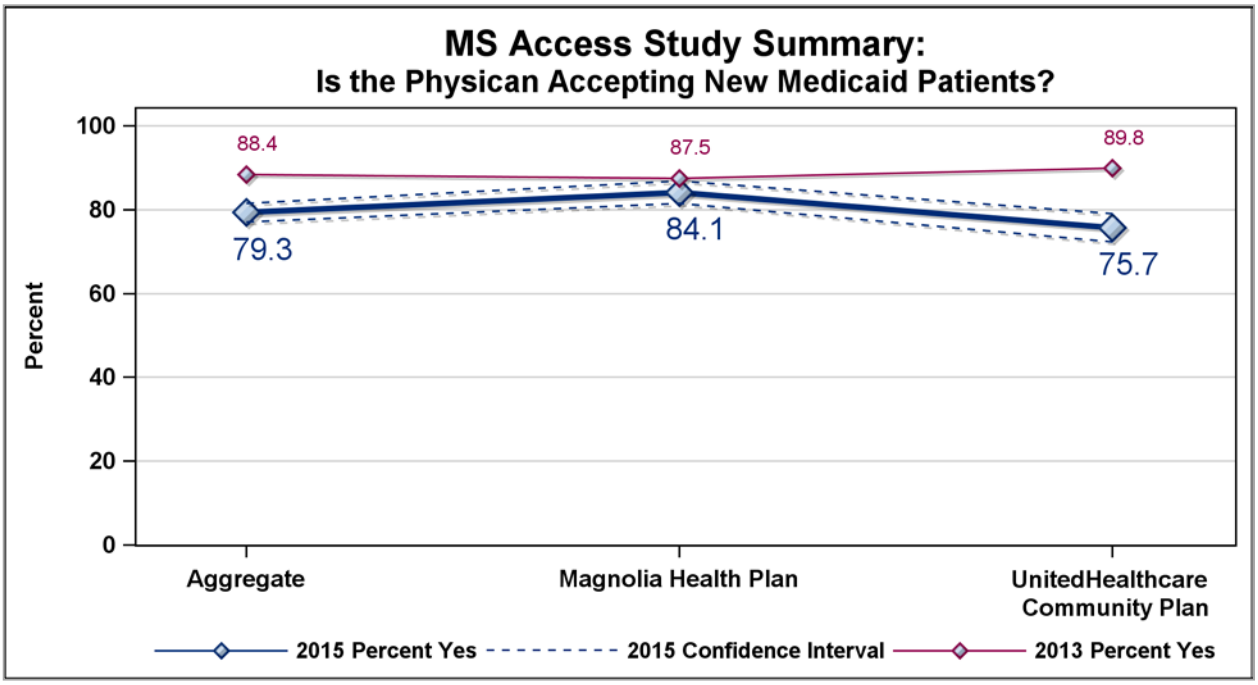
From the CCOs reviewed this contract year; a total population of 3,703 plan unique primary care providers was identified. From each plans' population, a sample was randomly drawn, and in total, 645 providers were selected to be included in the sample. In aggregate, these numbers were higher than the previous review. United had the largest identified population and sample selected from the two plans. This is reversed from the last review, where Magnolia had the largest population and sample.



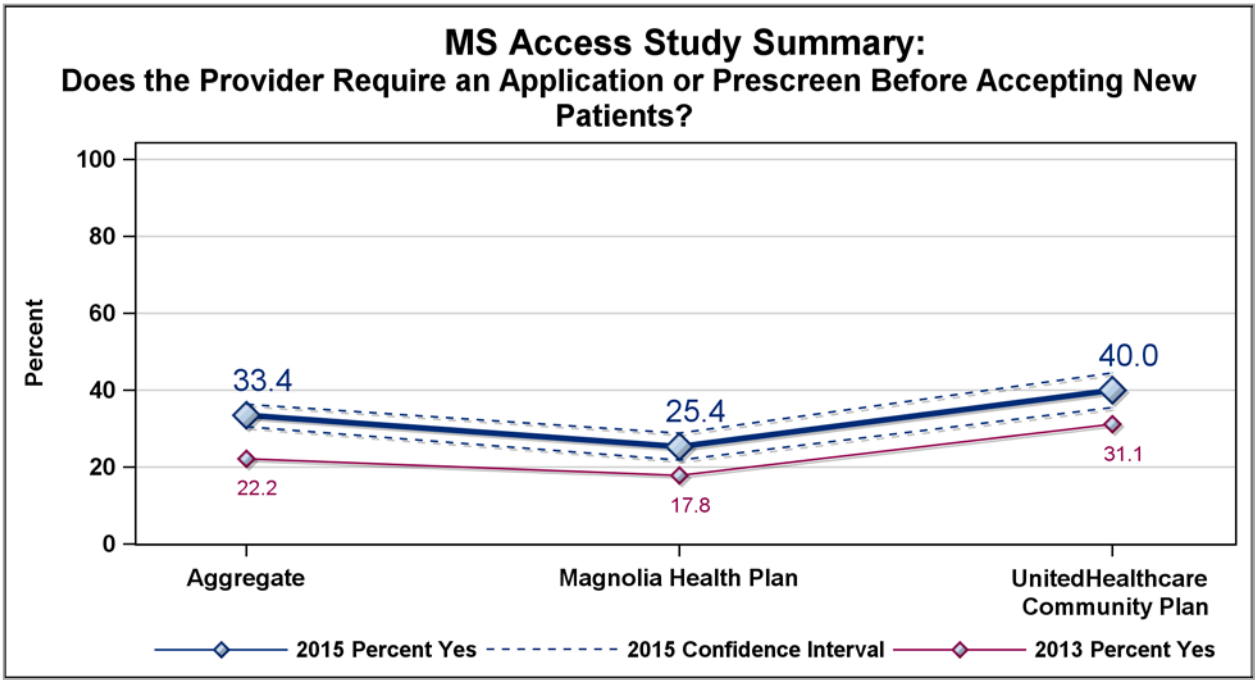
Using the telephone contact information provided by the plans, attempts to call each provider were performed and a series of questions was asked. In aggregate, 51 percent of these calls were successfully answered by the provider. United, again this year, had the lowest answer rate of the two plans. Both 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 19 percent of the calls).



Of the calls that were successfully answered, when asked if the provider accepted the respective plan, 76 percent reported that the plan was accepted; a four percentage point decrease from the previous review. Both plans saw this percentage decrease from their previous access study.

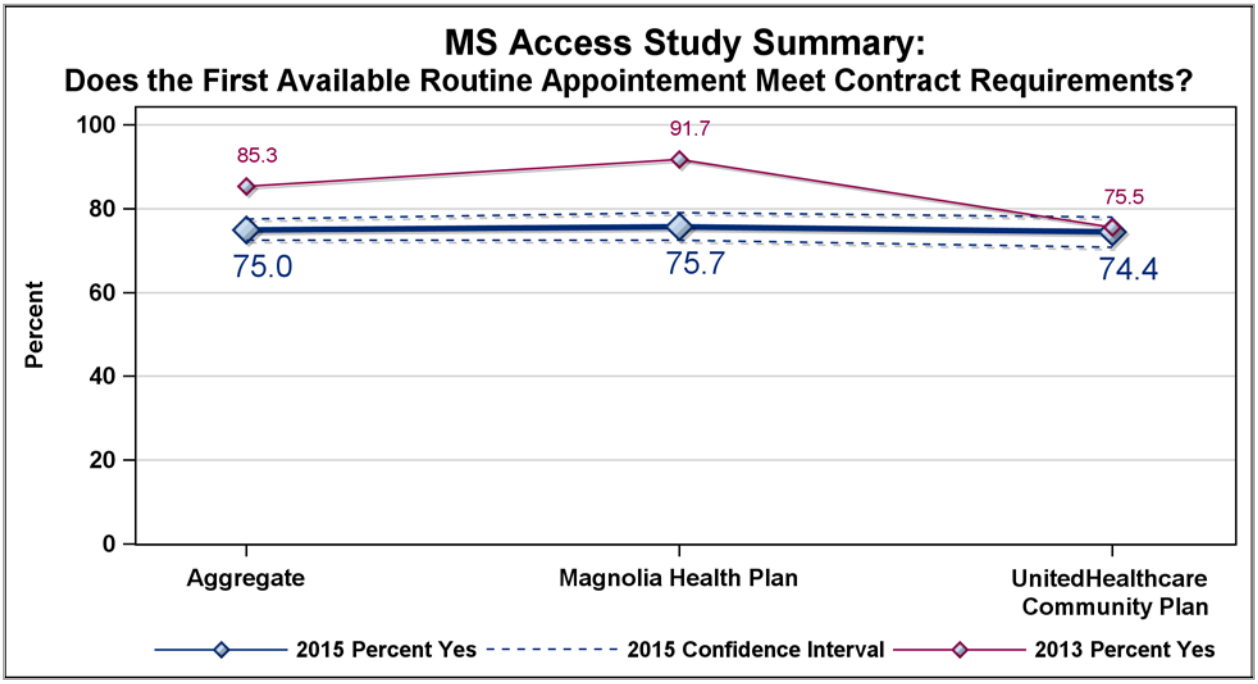


Of those who accepted the plan, approximately 79 percent responded that they were accepting new Medicaid patients, a decrease from the previous study of approximately nine percentage points. United declined over 10 percentage points from their last review.



Of those accepting new Medicaid patients, about 33 percent of the calls indicated they require an application or some form of screening before the patient is accepted into the practice. This was over a

10 percentage point increase in aggregate, while both plans had increases of over five percentage points from the previous review.



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 75 percent gave an appointment time that met the State's timeframe requirements for routine (well care) appointments. This was a 10 percentage point decrease over the last study, with Magnolia decreasing over 15 percentage points from the previous results.

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, both plans did not meet the standard of showing improvement in the proportion of successfully answered calls. Statistically, there was no evidence of any movement, improvement or otherwise, in either plan's proportion of successfully answered calls to provider offices. The estimated proportion did fall from the previous measure, but not enough to be considered statistically relevant. So both in actual terms and statistically, no improvement was seen.

III. MEMBER SERVICES

The review of Member Services included policies and procedures, member rights, member orientation and educational materials, member satisfaction, and the processes for handling grievances and practitioner changes. Magnolia and United have developed comprehensive member education programs that include welcome calls to new enrollees, newsletters, and preventive health reminders. The Member Handbook and other written resources are available in alternate formats, such as audio and large print, and both plans are cognizant of reading level requirements when developing member education materials. Welcome calls are intended to provide enrollees with guidance on the plans'

programs and processes, and how to receive services. Websites are very detailed and offer members access to their personal health information via secure portals.

United and Magnolia have developed Member Handbooks that are valuable resources for members; however, discrepancies were found between the Member Handbooks, the Provider Manuals, and plan policies regarding member rights and responsibilities. Magnolia and United did not include all member rights in their policies specific to member rights and responsibilities. United failed to include in policy or member and provider handbooks that oral interpretation services are provided without cost to the member or that members will be notified when there is a change to benefits/services. Magnolia's policy on primary care provider assignments did not clearly define when auto-assignment occurs for new members who have not chosen a primary care provider.

Grievance files were reviewed for both plans. Files for United were in very good order and demonstrated timely responses, investigations, and resolution. Information provided by United to both members and providers regarding grievances was inconsistent and lacked detail about extensions. Magnolia's grievance files contained evidence that grievances were not investigated thoroughly; some were missing acknowledgement and resolution letters, and files did not indicate that Magnolia offered the member sufficient opportunities to submit additional information.

Both plans used an NCQA-certified vendor to conduct their member satisfaction surveys. The surveys did not meet the validation requirements due to low response rates. This could indicate response bias. CCME recommended that both plans solicit the help of the survey vendors to increase the response rates for next year's survey. Details of the survey validation can be found in the *Quality Improvement* section of this report.

Table 3 – Member Services provides an overview of the scores each health plan received by standard.

TABLE 3: MEMBER SERVICES

SECTION	STANDARD	UNITED	MAGNOLIA
Member Rights and Responsibilities	The CCO formulates and implements policies outlining Member rights and responsibilities and procedures for informing Members of these rights and responsibilities	Met	Met
	Member rights	Partially Met ↓	Partially Met
	Member responsibilities	Partially Met	Partially Met ↓
Member CCO Program Education	Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts of all benefits to which they are entitled	Partially Met ↑	Partially Met

SECTION	STANDARD	UNITED	MAGNOLIA
Member CCO Program Education	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met ↑	Met
	Member 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 Members of how to access a toll-free vehicle for 24-hour Member access to coverage information from the CCO, including the availability of free oral translation services for all languages	Met	Met
	Member complaints/grievances, denials, and appeals are reviewed to identify potential Member misunderstanding of the CCO program, with reeducation occurring as needed	Met	Met
	Materials used in marketing to potential Members are consistent with the state and federal requirements applicable to Members	Met	Met
Member Disenrollment	Member disenrollment is conducted in a manner consistent with contract requirements	Met ↑	Met
Preventive Health and Chronic Disease Management Education	The CCO enables each Member to choose a PCP upon enrollment and provides assistance as needed	Met	Partially Met ↓
	The CCO informs Members about the preventive health and chronic disease management services that are available to them and encourages Members to utilize these benefits	Met	Met
	The CCO identifies pregnant Members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant Members in their recommended care, including participation in the WIC program	Met	Met
	The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages Members to utilize these benefits	Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Preventive Health and Chronic Disease Management Education	The CCO provides educational opportunities to Members regarding health risk factors and wellness promotion	Met	Met
Member Satisfaction Survey	The CCO conducts a formal annual assessment of Member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Not Met ↓	Not Met ↓
	The CCO analyzes data obtained from the Member satisfaction survey to identify quality problems	Met	Met
	The CCO reports the results of the Member satisfaction survey to providers	Not Met ↓	Met
	The CCO reports to the appropriate committee on the results of the Member satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to Member complaints/grievances in a manner consistent with contract requirements	Met	Met
	Definition of a complaint/grievance and who may file a complaint/grievance	Met ↑	Partially Met ↓
	The procedure for filing and handling a complaint/grievance	Met	Met ↑
	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Partially Met	Partially Met
	Review of all complaints/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 Member of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated	Met ↑	Met
	Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Complaints/ Grievances	The CCO applies the complaint/grievance policy and procedure as formulated	Met	Met
	Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met
	Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures	Met	Met
Practitioner Changes	The CCO investigates all Member 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 complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee	Met	Met

IV. QUALITY IMPROVEMENT

Magnolia and United are required by contract and federal regulations to have an ongoing quality assessment and performance improvement program for the services it furnishes to its members. The reviews during this contract period found that both health plans have programs in place and have structured their programs to monitor and evaluate the clinical as well as non-clinical services being provided. Each plan is required to have a program description that includes the structure, scope, goals, and objectives for the program. Both plans presented a program description for review. Magnolia's program description contained several deficiencies including an incomplete scope of work, inaccurate committee structure, and description. United's program description contained the committee structure and a description for each committee. However, the committee chart did not contain all of the health plan's committees and some of the descriptions for the committees were not included in the program description.

Quality Improvement Committees are in place to oversee the plans' quality improvement activities. These committees met regularly and had adequate membership. Network providers were represented on Magnolia's Quality Improvement Committee and on United's Provider Advisory Committee. Documentation in committee minutes was generally detailed and thorough. Both plans evaluate the effectiveness of their quality improvement program annually and produce a report that discusses the results of their evaluation. Magnolia's program evaluation contained several errors; however, most concerning was the evaluation was based on interim HEDIS results instead of current rates.

Table 4, Quality Improvement, provides an overview of how each standard for quality was scored for each health plan. Both plans had deficiencies noted with their program descriptions, the non-HEDIS performance measures, and their performance improvement projects. Magnolia's written assessment of their quality improvement program was also deficient.

TABLE 4: QUALITY IMPROVEMENT

SECTION	STANDARD	UNITED	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 Members	Partially Met ↓	Partially Met
	The scope of the QI program includes monitoring of services furnished to Members with special health care needs and health care disparities	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 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"*	Partially Met ↓	Partially Met ↓
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the Member population or as directed by DOM	Met	Met
	The study design for QI projects meets the requirements of the CMS protocol *"Validating Performance Improvement Projects"*	Partially Met ↓	Not Met

SECTION	STANDARD	UNITED	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	Met ↑
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program is prepared annually	Met	Partially 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

The 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

The validation protocol used by CCME validates components of each project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

Component	Description
1	Review the Selected Study Topic(s)
2	Review the Study Question(s)
3	Review Selected Study Indicator(s)
4	Review the Identified Study Population

Component	Description
5	Review Sampling Methods
6	Review Data Collection Procedures
7	Assess Improvement Strategies
8	Review Data Analysis and Interpretation of Study Results
9	Assess Whether Improvement Is "Real" Improvement
10	Assess Sustained Improvement

During the review, each component is assessed as to what degree the project meets that component. A component that fully meets the criteria without issue is assigned a *Met* score and receives the full point value. A component that partially meets the criteria is assigned a *Partially Met* score and receives half the point value (rounded up)[1]. A component that fails to meet the criteria is assigned a *Not Met* score and receives none of the points for that component. Finally, a component that does not apply to a particular project is assigned an *NA* score, and those points are not counted against the project in the final audit calculation.

Once all components have been scored for a project, a final audit designation is assigned. To assign the audit designation for a project, a final "Validation Finding" is calculated by dividing the score the project actually received by the total possible points and then multiplying by 100. This percentage of points earned is used to assign the final "Audit Designation" as described in the following table.

Audit Designation Possibilities	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow its documented procedure in a way that data were misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results Not Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

Each health plan is required to submit to CCME their performance improvement projects (PIP) for review each year. As described above, the submitted projects are validated and scored using the CMS protocol that evaluates the validity and confidence in the results of each project. The results from this year's review are included in the table below.

[1] A score of *Partially Met* is not available for components with 1-point value assigned to them.

Results of the Validation of CCO Performance Improvement Projects

Health Plan	Reviewed Projects and Protocol Scores with Confidence Level				
	Project 1	Project 2	Project 3	Project 4	Project 5
Magnolia	Obesity 99 / 131 = 76% CONFIDENCE	Asthma 84 / 100 = 89% CONFIDENCE	Congestive Heart Failure 69 / 100 = 69% LOW CONFIDENCE	Diabetes 104 / 131 = 79% CONFIDENCE	Hypertension 83 / 125 = 66% LOW CONFIDENCE
United	Reducing Adult, Adolescent and Childhood Obesity 126 / 136 = 93% HIGH CONFIDENCE	Use of Appropriate Medications for People with Asthma 105 /106 = 99% HIGH CONFIDENCE	Annual Monitoring for Patients on ACE/ARB Inhibitors 95 / 111 = 86% CONFIDENCE	Comprehensive Diabetes Care 111 / 116 = 96% HIGH CONFIDENCE	

For the nine projects validated for the plans this year, review classifications ranged from three projects scoring in the *High Confidence* determination to two projects scoring at the *Low Confidence* level, with the scores ranging from 66 percent to 99 percent across the nine projects.

Based on this year's review, neither plan met the EQR standard for the performance improvement projects. Magnolia failed the validation and received a *Not Met* score, and United received a *Partially Met* score. Both were required to complete a corrective action plan to demonstrate how the issues found during the review would be resolved.

Performance Measures

CCME conducted a validation review of the HEDIS® and non-HEDIS® performance measures for both health plans following the protocols developed by CMS. Magnolia and United were found to be fully compliant and met all the requirements for the HEDIS® measures.

The validation of the non-HEDIS® measures required a review of the following for each measure:

- General documentation for the performance measure.
- Denominator data quality.
- Validity of denominator calculation.
- Numerator data quality.
- Validity of numerator calculation.
- Data collection procedures (if applicable).
- Sampling methodology (if applicable).
- Measure reporting accuracy.

This process assesses the production of these measures by each plan to ensure that what is submitted to the DOM complies with the measure specifications, as defined by DOM. The table that follows gives an overview of the validation score for each measure.

Non-HEDIS Measures	Magnolia	United
Asthma Related ER Visits	40 / 55 = 73% SUBSTANTIALLY COMPLIANT	35 / 55 = 64% NOT VALID
Asthma Related Re-Admissions	35 / 55 = 64% NOT VALID	35 / 55 = 64% NOT VALID
Congestive Heart Failure Re-Hospitalization	35 / 55 = 64% NOT VALID	35 / 55 = 64% NOT VALID
Pre-Post Natal Complications	40 / 55 = 73% SUBSTANTIALLY COMPLIANT	40 / 55 = 73% SUBSTANTIALLY COMPLIANT

The non-HEDIS® measures did not meet the validation requirements for either plan. Scores across both plans ranged from 64 percent to 73 percent, resulting in three measures out of eight being designated as *Substantially Compliant,* and five of the eight were *Not Valid*. A common issue across both plans was the way numerators and the denominators for the measures were calculated.

Satisfaction Surveys

As required by contract, both health plans conducted member and provider satisfaction surveys. 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

Magnolia and United used an NCQA-certified vendor to conduct the member and provider satisfaction surveys. Results of the validation found that the surveys did not meet the CMS protocol requirements. The response rate for the member satisfaction survey was an issue for both plans. The response rate, sampling size, and how the survey was developed were some of the issues noted for the provider satisfaction survey. The table that follows provides an overview of the survey validation results.

Results of the Validation of CCO Satisfaction Surveys

ENROLLEE SATISFACTION SURVEY VALIDATION	
MAGNOLIA	**UNITED**
The results met the minimum number of responses considered by NCQA to be necessary for a valid survey (411 responses), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively). Alternative approaches may be needed to increase the response rates, especially for the Medicaid Child population which suffered the lowest response rate. Response bias may be a large issue with the Child survey.	The results met the minimum number of responses considered by NCQA to be necessary for a valid survey (411 responses), but fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively). Alternative approaches may be needed to increase the response rates, especially for the Medicaid Child population, which suffered the lowest response rate. Response bias may be a large issue with the survey.
The response rate for the Medicaid Child population suffered from very low response rate. Response rate bias should be a concern.	The response rate for the Medicaid Child population suffered from a very low response rate. Response rate bias should be a concern.
PROVIDER SATISFACTION SURVEY VALIDATION	
MAGNOLIA	**UNITED**
Sampling strategy and process was not included in the documentation.	Detailed information regarding the selection of the sample size was not in the documentation. The documents received during the onsite indicated a non-statistical rationale for sample size which is not consistent with the CMS protocol.
Detailed information regarding the selection of the sample size was not in the documentation.	A response rate was included in secondary documentation received at the onsite but no explanation of the calculation was provided. Only the number of complete surveys was documented in the main documentation.
With the original sample having a low response rate, there is a strong possibility that a response bias exists in the results.	A response rate was not calculated in the survey documentation. Only the number of complete surveys was documented. With only 95 completed surveys, the power of the results could be severely limited.
Survey documentation was missing pieces of important documentation regarding sample size calculation and creation.	While conclusions were made from the results of the survey, it is questionable how representative those results are of the provider population, given the small number of responses received.
The response rate for the original provider sample suffered from a low response rate. Response rate bias should be a concern.	Survey documentation was missing pieces of important documentation regarding survey development, sample size calculation and creation, and response rate calculation.

V. UTILIZATION MANAGEMENT

Magnolia and United have utilization management program descriptions as well as policies and procedures in place which provide requirements for, and guide staff in, the performance of utilization management (UM) functions and processes.

Both Magnolia and United were noted to have issues with their documentation related to timeliness of UM decisions and initial notification of those determinations. Magnolia's Timeliness of UM Decisions policy did not address the timeframe for notification of a termination, suspension, or reduction of a previously authorized service. Also, Magnolia's Member Handbook did not include the timeframe for urgent authorization determinations. United's Initial Review Timeframes policy contained information regarding the requirements for notifying the requestor of the proper process to request an authorization that would place the plan out of compliance with determination timeframes. United later responded that this process is not applicable to Mississippi. The Mississippi Addendum to United's UM Program Description addressed provider appeals, but did not clearly reflect that the appeals process is also available to members.

The plans ensure consistent application of criteria by use of routine inter-rater reliability (IRR) testing. Of note, Magnolia increased the scoring expectation for staff from 80 percent to 90 percent in August of 2015. During onsite discussion, United staff stated the IRR scoring expectation for staff is 100 percent; however, the Clinical Review Criteria policy documented a lower scoring expectation. Both plans have policies in place to address the IRR requirements, but United's policy did not clearly define the processes followed for IRR testing and did not address how scores below the established threshold are addressed.

Review of UM approval and denial files reflected that both plans follow appropriate processes, timeframes, and use of appropriate criteria. Additional information is requested when needed, and appropriate physician reviewers issue all denial determinations. United's Initial Adverse Determination Notices policy states that for urgent concurrent and retroactive requests resulting in an adverse determination, when the member is not at financial risk, only the provider must be notified of the determination. During onsite discussion, United staff stated the policy was correct; however, they later responded that this process does not apply in Mississippi.

For both Magnolia and United, the area of greatest concern in the UM review is appeals. Of 11 standards in the appeals area, both Magnolia and United received a Met score for only six standards. United received a score of Not Met for one standard due to an uncorrected deficiency from the previous external quality review. Issues related to appeals included:

- Incorrect or insufficient definitions of an action and appeal (Magnolia)
- Insufficient information regarding who may file an appeal (United)
- Missing and/or incorrect documentation of the timeframe or procedure to file an appeal (Magnolia, United)
- Missing and/or incorrect information regarding the timeframes for appeal resolutions and information on extensions of appeal timeframes (Magnolia, United)
- Incorrect information regarding requesting a State Fair Hearing (United)
- Insufficient or incorrect information regarding requesting continuation of benefits pending an appeal or State Fair Hearing (Magnolia, United)

Despite the issues related to appeals documentation in policies, procedures and other documents, both Magnolia's and United's appeals files were timely and reflected that appropriate processes were followed.

Both Plans have well-developed and well-implemented case management programs. Policies, procedures, program descriptions, and other documentation are thorough and detailed. Case management files reflected that the plans follow appropriate case management processes, document member case information thoroughly, develop appropriate care plans, and monitor members appropriately.

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

TABLE 5: UTILIZATION MANAGEMENT

SECTION	STANDARD	UNITED	MAGNOLIA
The Utilization Management (UM) Program	The CCO formulates and acts within policies and procedures that describe its utilization management program	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	Met ↑	Met
	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met ↑	Partially Met ↑
	Consideration of new technology	Met	Met
	The appeal process, including a mechanism for expedited appeal	Partially 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

SECTION	STANDARD	UNITED	MAGNOLIA
The Utilization Management (UM) Program	The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and complaints/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 Members across all reviewers	Partially Met ↓	Met
	The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Partially Met	Met
	The CCO has established policies and procedures for the prior authorization of medications	Partially 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	Met ↑	Met
	A reasonable effort that is not burdensome on the Member 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 Member and include the basis for the denial of service and the procedure for appeal	Partially Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to Member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements	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	Partially 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	Partially Met ↓
	A mechanism for expedited appeal where the life or health of the Member would be jeopardized by delay	Met ↑	Partially Met ↓
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met ↑	Met
	Written notice of the appeal resolution as required by the contract	Not Met ↓	Met
	Other requirements as specified in the contract	Partially Met	Partially Met ↑
	The CCO applies the appeal policies and procedures as formulated	Met	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
Care Management	The CCO assess the varying needs and different levels of care management needs of its Member population	Met	Met
	The CCO uses varying sources to identify and evaluate Members' needs for care management	Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
Care Management	A health risk assessment is completed within 30 calendar days for Members newly assigned to the high or medium risk level	Met	Met
	Identification of the severity of the Member's conditions/disease state	Met	Met
	Evaluation of co-morbidities or multiple complex health care conditions	Met	Met
	Demographic information	Met	Met
	Member's current treatment provider and treatment plan if available	Met	Met
	The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments	Met	Met
	The risk level assignment is periodically updated as the Member's health status or needs change	Met	Met
	The CCO utilizes care management techniques to insure comprehensive, coordinated care for all Members through the following minimum functions	Met	Met
	The CCO provides Members assigned to the medium risk level all services included in the low risk and the specific services required by the contract	Met	Met
	The CCO provides Members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met
	The CCO has policies and procedures that address continuity of care when the Member disenrolls from the health plan	Met	Met
	The CCO has disease 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, 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

SECTION	STANDARD	UNITED	MAGNOLIA
Evaluation of Over/ Underutilization	The CCO monitors and analyzes utilization data for under and over utilization	Met	Met
Annual Evaluation of the Utilization Management Program	A written summary and assessment of the effectiveness of the UM program is prepared annually	Met	Met
	The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met

VI. DELEGATION

Magnolia and United have delegation agreements with multiple vendors. The delegation agreements specify the delegated activities and include information on requirements for corrective action plans for substandard or non-performance, up to and including termination of the contract. For both plans, addendums to the agreements specify appropriate credentialing and recredentialing requirements for Mississippi.

Both plans have policies and procedures in place detailing requirements for oversight of their delegated vendors. Review of actual oversight activities and auditing tools revealed several issues.

For Magnolia, the following issues were noted:

- Magnolia follows the Centene Corporate Standardized Credentialing Audit Tool 2015/2016. The tool contained a timeframe for provider site visits when a complaint threshold has been met that was not compliant with the *DOM Contract.*
- The tracking grid for Cenpatico, the behavioral health vendor, listed two standards (98 percent and 100 percent) for the percentage of member/provider complaints and appeals were to be completed within state required timeframes. Also, the tracking grid did not specify timeliness requirements for authorization determinations.
- The Cenpatico Performance Summary Report did not address turn-around times for member and provider complaints, grievances and appeals or authorization turn-around times.
- The National Imaging Associates (NIA) tracking grid indicated that NIA processes first-level medical necessity appeals. Onsite discussion confirmed this is incorrect.

For UnitedHealthcare, the following issues were noted:

- The Dental Program Monthly Report Card 2015 contained an incorrect timeframe for standard authorization turn-around times and did not include the timeframe for expedited authorization turn-around times.
- The CareCore National Dashboard spreadsheet contained an incorrect timeframe for standard authorization turn-around times.
- The Optum Behavioral Health 2015 CR Audit Report tab titled “Audit Tool” did not address all Mississippi-specific credentialing requirements.

In addition, United was found to have an uncorrected deficiency from the previous external quality review regarding incomplete credentialing requirements. This resulted in one standard in the Delegation review being scored as Not Met.

An overview of the CCO scores for the Delegation section is illustrated in Table 6 – Delegation.

TABLE 6: DELEGATION

SECTION	STANDARD	UNITED	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	Not Met ↓	Partially Met

VII. STATE-MANDATED SERVICES

Both health plans provide enrollees with all the benefits required by their contract with DOM. They both have processes in place to monitor provider compliance with EPSDT/Well Child screenings and required immunization schedules that include data from performance measures, utilization and claims data, and medical record review. Providers are notified when individual enrollees are due for preventive and well child services.

Both plans failed to correct deficiencies found in the previous EQR which resulted in a Not Met score as noted in the table below. Magnolia failed to correct identified errors in Performance Improvement Projects and did not include ownership disclosure forms for recredentialing. United failed to correct the Appeal Upheld letter template and to include Mississippi requirements on their audit tool for Behavioral Health services.

TABLE 7: STATE-MANDATED SERVICES

SECTION	STANDARD	UNITED	MAGNOLIA
State-Mandated Services	Initial visits for newborns	Met	Met
	EPSDT screenings and results	Met	Met
	Diagnosis and/or treatment for children	Met	Met

SECTION	STANDARD	UNITED	MAGNOLIA
State-Mandated Services	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

Corrective Action

CCME's external quality review process includes requesting a corrective action plan (CAP) from the coordinated care organization for any standard that was scored as less than Met. CCME provides a CAP template to the CCO that includes all standards that were scored as Partially Met or Not Met. The CCO has 30 days to address each deficiency and provide the updated documentation to CCME. The CAP is reviewed and each deficiency is designated as Accepted or Not Accepted. CCME works with the CCO until all items have been sufficiently addressed and accepted. A final acceptance letter is sent to the CCO stating that the review process for the year has been completed.

For the 2015 – 2016 EQR, both United and Magnolia were required to submit CAPs. The following table provides an overview of the CAP process for each plan. CCME worked with the plans to address any questions they had throughout the process. Due to numerous issues with their performance improvement projects (PIPs), Magnolia decided to retire all of their PIPs and begin new projects. CCME reviewed the new project documentation and provided feedback to the plan to ensure their new projects are successfully implemented. The CAP for United was accepted by CCME on 2/18/16 and the CAP for Magnolia was accepted on 3/14/16.

CORRECTIVE ACTION PROCESS

CORRECTIVE ACTION PROCESS	UNITED	MAGNOLIA
Date EQR report sent to CCO	12-15-15	12-15-15
CAP due date / Date received from CCO	1-19-16 / 1-15-16	1-19-16 / 1-19-16
Total number of CAP items	54	73
Number of CAP items Accepted / Not Accepted	39 / 15	66 / 7
CAP response sent to CCO	2-1-16	2-5-16
2nd CAP due date / Date received from CCO	2-15-16 / 2/15/16	2-19-16 / 2-19-16
Total number of CAP items	54	73

CORRECTIVE ACTION PROCESS	UNITED	MAGNOLIA
Number of CAP items Accepted / Not Accepted	54 / 0	73 / 0
Final CAP response sent to CCO	2-18-16	3-14-16

Conclusions

The findings of the annual external quality reviews conducted for contract year 2015 – 2016 confirm that United and Magnolia achieved improvements in the overall Met scores for Provider Services, Utilization Management, and State-Mandated Services. Despite the progress in these sections, there is room for improvement in all areas of review for both plans.

The comparison table that follows reflects the total percentage of standards that were scored as Met for the 2015 review. The percentages highlighted in green indicate an improvement over the prior review's findings. Those highlighted in yellow represent a reduction in the prior review's findings.

Standard	UnitedHealthcare Community Plan		Magnolia Health Plan	
	2013	2015	2013	2015
Administration	100.00%	96.55%	100.00%	96.55%
Provider Services	66.67%	85.06%	78.26%	86.21%
Member Services	81.08%	80.65%	89.19%	77.42%
Quality Improvement	100.00%	80.00%	80.00%	73.33%
Utilization Management	71.79%	79.25%	84.62%	88.68%
Delegation	50.00%	50.00%	50.00%	50.00%
State-Mandated Services	75.00%	80.00%	75.00%	80.00%

Magnolia and United have seasoned leadership teams and well developed processes that facilitate meeting DOM's requirements and goals for claims processing, IT functions, and reporting capabilities. In addition, both plans have thoroughly implemented the new case management requirements into their case management programs, provide all required benefits, and have appropriate EPSDT programs. Deficiencies common to both plans were related to the Credentialing Committees;

communication of member rights and responsibilities; member access to their primary care providers; low response rates to member and provider satisfaction surveys; non-HEDIS® performance measure and quality improvement project errors; documentation of UM and appeals requirements; and delegation oversight. In addition, each plan was found to have two uncorrected deficiencies from the previous external quality reviews. All deficiencies from the previous and current reviews were addressed through the corrective action process.

Magnolia and United should continue to concentrate their quality improvement efforts on the areas that received Partially Met or Not Met scores and to ensure that all corrective actions are fully implemented. CCME looks forward to continued collaboration with both plans and DOM to achieve measurable improvement.

STRENGTHS

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

1. Member education and outreach programs are well-developed for both plans, particularly for women who are pregnant or have a high risk for premature birth.
2. Both plans utilize an NCQA certified vendor to conduct their member and provider satisfaction surveys.
3. Topics selected for the performance improvement projects are appropriate for each health plan's member population.
4. Although there were errors in policies and other documentation, review of UM approval, denial, and appeal files reflected that both plans follow appropriate processes, timeframes, and use of appropriate criteria.
5. Both CCOs have well-developed and well-implemented case management programs. Policies, procedures, program descriptions, and other documentation are thorough, detailed, and reflect that all new requirements for case management have been incorporated. Case management files were thoroughly documented and reflected staff meets all requirements for case management for their members.
6. The plans have adequate delegation agreements in place. The delegation agreements specify the delegated activities, requirements for corrective action plans for substandard or non-performance, up to and including termination of the contract, and contain appropriate Mississippi-specific credentialing and recredentialing requirements.

WEAKNESSES

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

1. The member and provider satisfaction surveys exhibited low response rates; therefore, response bias may be an issue for both health plans.
2. Issues were noted with the credentialing committees for both plans. Magnolia's documents had inconsistencies regarding committee membership and did not define voting members and United's Chief Medical officer did not chair or oversee the functions of the credentialing committee as required by the *DOM Contract*.
3. Member access to their PCPs was an area of concern for both health plans.
4. The quality improvement program descriptions were detailed but contained several errors.
5. The non-HEDIS® measures did not meet the validation requirements.
6. Results of the validation of the performance improvement projects revealed several errors, and Magnolia's projects failed to meet the validation protocol requirements.

7. Inconsistencies, and/or omissions were noted in documentation in policies, procedures, the Member Handbooks, the Provider Manuals, and in other documents.
8. Documentation of appeals requirements in policies and manuals continues to be problematic for both Magnolia and United.
9. Delegated credentialing and non-credentialing oversight documents and auditing tools contained incorrect requirements and/or did not address all Mississippi-specific requirements.

RECOMMENDATIONS

CCME recommends that DOM consider the following:

1. Both plans should work with their survey vendors to develop strategies to improve response rates to member and provider satisfaction surveys.
2. Processes to improve member access to their primary care providers need to be implemented by both plans.
3. The plans should ensure that documentation and calculations are correct so that non-HEDIS measures and performance improvement projects fully meet validation requirements.
4. Both plans should work to reinforce their understanding of appeals requirements and processes, and to ensure that documentation of those processes and requirements is correct.
5. The plans should revise their delegation oversight tools and documents to ensure they contain all measures that should be monitored and the requirements for those measures are correct.