



The State of Mississippi
Division of Medicaid

Magnolia Health Plan

2015 External Quality Review

NOVEMBER 23, 2015



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Executive Summary

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The following report contains a description of the process and the results of the 2015 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the Mississippi Division of Medicaid. The purpose of this review was to determine the level of performance demonstrated by Magnolia Health Plan and to provide feedback for potential areas of further improvement.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review included a desk review of documents and files, a two-day onsite visit to the Magnolia Health Plan office, validation of performance improvement projects, validation of performance measures, validation of consumer and provider surveys, and a review of the health plan's Information System Capabilities Assessment.

Findings

The findings of the 2015 EQR indicate that Magnolia Health Plan improved their percentage of met scores in the areas of Provider Services, Utilization Management and State-Mandated. A few areas of concern included the annual Quality Improvement Program description and evaluation contained numerous errors, and both the Non-HEDIS performance measures and the performance improvement projects failed to meet validation requirements. The access study showed no improvement so it appears that Magnolia members may not be receiving correct provider information which could impact access to care. The goal for HIPAA desk audits is set at 90 percent, which allows for the potential unauthorized disclosure of PHI. Overall, Magnolia received a Met Score for 85.59 percent of the standards for the 2015 External Quality Review.

STRENGTHS

Strengths of Magnolia Health Plan's performance at the time of this review include the following:

- Magnolia did an excellent job of laying out the disaster recovery test parameters and documenting the results.
- The Provider Manual and educational/reference materials on the website provider portal equips providers with good resource information for navigating the plan.
- The Credentialing Committee includes four Mississippi network providers with various specialties that have good attendance at committee meetings.
- Magnolia has a well-developed member education program and uses a multitude of methods to ensure and enhance member education.
- The Start Smart for Your Baby program's dedicated website contains a wealth of information for pregnant members.
- The Magnolia Health Plan website is a valuable resource of UM information for providers, including forms, clinical guidelines, practice improvement resources, etc.
- New case management requirements have been thoroughly incorporated into Magnolia's case management policies, procedures, and processes.

WEAKNESSES

Weaknesses identified included the following:

- Magnolia's compliance goal for their HIPAA desk audit is set at only 90 percent which allows for the potential unauthorized disclosure of PHI.
- Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, has the disclosure of ownership form listed as exceptions in cases of recredentialing, and the Unique Requirements for Credentialing (Attachment B) document does not specify for MS that the disclosure of ownership form is required at recredentialing.
- It was difficult to determine from the Credentialing Committee minutes who had voting privileges. The committee charter does not specify who has voting privileges and there was inconsistent information between the list of committee members and what the charter specifies as the committee membership. Several meetings appeared to not have met the quorum requirement.
- The Magnolia Site Review Tool showed incorrect appointment timeframes.
- Recredentialing files reviewed did not contain evidence of the ownership disclosure forms.
- The Practitioner Availability Analysis report did not comply with current contract requirements of two PCPs within 15 miles for urban and 30 miles for rural.
- Inconsistencies were noted in some policies regarding PCP-to-member ratios.
- Policies MS.PRVR.10, Evaluation of the Accessibility of Services, and MS.QI.05, Evaluation of the Accessibility of Services, address appointment criteria. However, the policies do not address all appointment criteria that are defined in the *DOM Contract, Section 7 (B)*.
- The documentation of dental and behavioral health appointment access standards are inconsistent.
- Results of the telephonic Provider Access and Availability Study performed by CCME did not show improvement from the previous study. It appears that Magnolia members may not be receiving correct provider information, so this could indicate an access problem.
- The reassignment of a member to another PCP could not be found as being addressed in the Provider Manual.
- Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines, states that Magnolia, on an annual basis, shall measure provider performance against at least two of the clinical guidelines. Then on the same page, it states that at least annually, Magnolia measures practitioner compliance with at least four CPGs.
- The provider satisfaction survey did not meet the CMS protocol requirements. The low response rate could bias the results.
- There were several member rights and responsibilities missing in the 2015 Member Handbook and policy MS-MBRS-25, Member Rights and Responsibilities.
- The Member Handbook does not inform members that they will be notified in writing of changes to services and benefits. It should also contain the timeframe for the written notification.
- The disenrollment requirements listed in the Member Handbook did not comply with the *DOM Contract, Section 4 (G)*. Magnolia's policy MS.ELIG.05, Disenrollment contained confusing statements regarding the disenrollment process.
- Policy MS.ELIG.08, PCP Notification, defines Magnolia's processes and timeframes for PCP auto-assignment. Inconsistencies in the timeframes for PCP auto-assignment were noted in policy MS.ELIG.01, Primary Care Provider (PCP) Auto-Assignment, as follows:

- Page one states that if the member does not request an available PCP within 30 days of enrollment, Magnolia will assign the new member to a network PCP within 60 days of enrollment.
- Page two states members who do not have a PCP on the Enrollment report are outreached during the New Member Welcome Call in order to inform the member of the PCP to whom he/she has been assigned. However, NurseWise conducts new member welcome calls within 30 days of enrollment. Because auto-assignment occurs after day 30 but before day 45, this statement is incorrect.
- Page two states that members will be informed of their PCP auto-assignment through the New Member Packet mailing. However, the new member packet is sent within 14 calendar days after the Plan receives notice of the member's enrollment. Because auto-assignment occurs after day 30 but before day 45, this is incorrect.
- The results of the Member Satisfaction Survey fell below the response rate targets set by AHRQ or NCQA (50 and 45 percent respectively). The Medicaid Child population exhibited the lowest response rate; therefore, response bias may be a large issue with that survey.
- When searching for grievance information on the Magnolia website, all results were found under the pages for the MississippiCHIP population and not in the website sections for MississippiCAN members.
- Regarding who is able to file a grievance, the 2015 Member Handbook and the revised Member Handbook state that a provider acting for the member can file a grievance. There is no indication that the provider needs written consent to file a grievance on a member's behalf.
- Information pertaining to the expedited grievance process and resolution timeframe is not found in the 2015 Member Handbook or the revised Member Handbook.
- Regarding extensions of the timeframes for grievance resolution, the following issues were noted:
 - The 2015 Member Handbook and the revised Member Handbook do not address that members can request an extension.
 - The Provider Manual does not provide information on grievance resolution extensions.
- The review of grievance files revealed the following issues:
 - Several files reflected the need for additional information to process the grievance, but staff were unable to obtain the missing information due to invalid phone numbers. These grievances were closed and the members were sent an "Unable to Process" (UTP) letter. No evidence was noted that staff attempted to obtain the information in other ways, such as use of Magnolia's "Unable to Contact Letter" for grievances, rather than simply closing the grievances as unable to process. In addition, the UTP letters for both files did not indicate the reason for the plan's inability to process the grievance (there was no check mark indicating the basis for the inability to process the grievances).
 - Several files contained no acknowledgement or resolution letters.
 - For a grievance related to multiple issues, there was no evidence that all the issues were addressed in the investigation. Additionally, the notice of resolution letter did not address all issues included in the grievance filing.
- Several errors were identified in the 2014 Annual Quality Improvement Program Evaluation and in the 2015 Quality Assessment and Performance Improvement Program Description.
- In reviewing the 2014 Annual QI Work Plan, under the Quality/Performance Improvement Activities & Interventions tab, there were several activities related to Cultural Competence that are conducted annually. According to the Outcome(s)/Status Notes, these activities were

presented to the Quality Improvement Committee on 1/17/14. However, there was no evidence found in the committee minutes that these activities were reported.

- The Committee Charter dated June 2015 indicates the Quality Improvement Committee membership will include two nurse practitioners. However, there are currently no nurse practitioners included on this committee. Also, page four of the charter contains a table listing the external committee membership. This table was incomplete.
- The non-HEDIS® measures did not meet the validation requirements. Two of the measures were scored as *Substantially Compliant* and two measures were found to be *Not Valid*. Issues with the way the numerators and denominators were calculated were of concern.
- Results of the validation of the performance improvement projects found numerous errors and failed to meet the validation protocol requirements. Three projects scored within the *Confidence* range and two in the *Low Confidence* range.
- Policy MS.UM.05, Timeliness of UM Decisions and Notifications does not address the requirement that for termination, suspension, or reduction of a previously authorized service, notice must be given at least 10 days before the date of the action.
- The Member Handbook does not provide the timeframe for urgent authorization determinations.
- The Utilization Management (UM) Program Description states the benchmark for a passing inter-rater reliability (IRR) score is 80 percent. However, policy CC.UM.02.05, Interrater Reliability, states the benchmark is 90 percent.
- The UM Program Description incorrectly states the pharmacy benefit manager (PBM) does not make denial decisions based on lack of medical necessity.
- The definitions of an appeal and an action are incorrect in the Member Handbook.
- The *DOM Contract, Exhibit D, Section D*, defines the timeframe for requesting an appeal as within 30 calendar days of receiving the Notice of Action. Issues identified include:
 - The Provider Manual does not document the timeframe for requesting an appeal.
 - The Member Handbook and denial letter templates incorrectly document the timeframe as within 30 days of the date on the Notice of Action.
- Policy MS.UM.08, Appeal of UM Decisions, does not include that the review of an appeal must be made by a practitioner with the appropriate clinical expertise in treating the member's condition or disease.
- The Provider Manual does not indicate that an oral request for an expedited appeal does not require a written follow-up and does not include information regarding extensions of expedited appeal resolution timeframes.
- Policy MS.UM.08, Appeal of UM Decisions, incorrectly states that appeals are acknowledged within five calendar days. Onsite discussion confirmed the timeframe is five business days.
- The appeal acknowledgement letter provides some information on continuation of benefits, but the information is incomplete.
- The Centene Corporate Standardized Credentialing Audit Tool 2015/2016 references conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. There is no addendum or notation that the Mississippi requirement for these site visits is within 45 calendar days.
- The 2015 Cenpatico Tracking Grid for Magnolia Health Plan includes a standard that for member/provider complaints and appeals, 98% or 100% are to be resolved within state required timeframes. Also, the timeframes for resolution of complaints/grievances are not specified.
- The 2015 Cenpatico Performance Summary Report does not address turn-around time requirements for member and provider complaints/grievances and appeals.

- The 2015 Cenpatico Tracking Grid does not specify timeliness requirements for standard and expedited authorization determinations.
- The 2015 Cenpatico Performance Summary Report does not have an area for monitoring expedited authorization turn-around times.
- The 2015 NIA Tracking Grid states, “Medical Necessity appeals are not delegated to Vendor (with the exception of 1st level Medical Necessity appeals).” However, onsite discussion confirmed that NIA does not process appeals for Magnolia Health Plan members.
- The corrections made for two of the deficiencies identified during the previous EQR were not implemented and found to be deficient during this review.

Comparative Data

A comparison review of the scored standards by review category for the previous EQR conducted by CCME in 2013 with the current review results is shown in the table that follows.

TABLE 1

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Administration					
2013	25	0	0	0	25
2015	28	1	0	0	29
Provider Services					
2013	54	7	8	0	69
2015	75	7	5	0	87
Member Services					
2013	33	4	0	0	37
2015	24	6	1	0	31
Quality Improvement					
2013	12	2	1	0	15
2015	11	3	1	0	15
Utilization Management					
2013	33	4	2	0	39
2015	47	6	0	0	53
Delegation					
2013	1	1	0	0	2
2015	1	1	0	0	2
State-Mandated Services					

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
2013	3	0	1	0	4
2015	4	0	1	0	5

Please note: the review tool used for the 2015 external quality review was updated based on changes in Magnolia’s contract with the Division of Medicaid. The total number of standards for each category may have changed as a result of the updates.

Recommendations for Improvement

CCME made the following recommendations that Magnolia Health Plan should implement to improve their processes and comply with state and federal requirements.

- The compliance goal for the HIPAA desk audits for potential unauthorized disclosure of PHI should be 100 percent.
- Update policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to reflect that ownership disclosure forms are required to be collected at credentialing and recredentialing for MS.
- Update the Credentialing Committee Charter and the list of committee members to be consistent for committee membership and to define who has voting privileges; include in the Credentialing Committee minutes the voting members present/absent and if a quorum has been met for the meeting.
- Update the Magnolia Site Review Tool to reflect the correct appointment criteria.
- Ownership disclosure forms should be collected at recredentialing. In addition, Magnolia needs to implement a process to collect ownership disclosure forms for providers that have already been recredentialled.
- Ensure the correct access standard parameters are used for the Practitioner Availability Analysis report. Address inconsistencies between policies MS.CONT.01, Provider Network, and MS.QI.04, Evaluation of Practitioner Availability.
- Update policies MS.PRVR.10, Evaluation of the Accessibility of Services, and MS.QI.05, Evaluation of the Accessibility of Services, to address all appointment criteria required by the *DOM Contract*.
- Update the Provider Manual and the Appointment & Access Requirements website document to contain consistent appointment criteria requirements.
- Implement interventions to address the member access issues identified in the Provider Access and Availability Study conducted by CCME.
- Update the Provider Manual to include instructions for the reassignment of a member to another PCP.
- Correct policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines, to reflect the correct number of clinical practice guidelines that Magnolia measures on an annual basis.
- Implement interventions to increase the response rate in the provider satisfaction survey and improve survey documentation.
- Update policy MS.MBRS.25 to include the following:
 - The right to receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.

- The right to voice complaints/grievances about the CCO or about the medical care and/or services received.
- The right to appeal decisions adversely affecting coverage, benefits, services, or the relationship with the CCO.
- Update the Member Handbook to indicate that members have the right to exercise their rights freely with no fear of adverse treatment by Magnolia or their providers.
- Update policy MS.MBRS.25 to include the member's responsibility to inform Magnolia of changes in family size, address changes, or other health care coverage.
- Update the Member Handbook to include the timeframe for, and method of, member notification of changes to services and benefits.
- Correct the Member Handbook to indicate that member requests for disenrollment may be made orally or in writing.
- Clarify the information on page two of policy MS.ELIG.05 to clearly indicate Magnolia will not request disenrollment of a member for uncooperative or disruptive behavior resulting from his or her special needs except when member's continued enrollment seriously impairs the ability to furnish services to either the member or other members.
- Correct pages one and two of policy MS.ELIG.01 to reflect the timeframes and processes used by Magnolia to notify members of their auto-assigned PCP.
- Develop strategies to increase the Member Satisfaction Survey response rates for the Medicaid Child population. Solicit the help of the survey vendor.
- Update the Magnolia website to include grievance information in the section of the website for MississippiCAN members.
- Revise the Member Handbook to clearly indicate that providers need written consent to file a grievance on behalf of a member.
- Information on the expedited grievance process and timeframe for resolution should be included in the Member Handbook.
- Revise the Member Handbook to include that members may request extensions of grievance resolution timeframes.
- Update the Provider Manual to include all information on extensions of grievance resolution timeframes.
- When additional information is needed for grievance processing, and member phone numbers are invalid, ensure that attempts are made to obtain information in alternate ways, including sending Magnolia's "Unable to Contact" letter prior to closing a grievance as unable to process. Ensure that written acknowledgement and resolution letters are sent for all grievances, as stated in policy MS.MBRS.07. Ensure that all issues included in the grievance are investigated and included in the grievance resolution letter.
- Correct the issues identified in the 2015 Quality Assessment and Performance Improvement Program Description.
- Ensure the Outcome(s) Status or Notes section of the Quality Improvement Work Plan accurately reflects the status for each activity.
- Continue to recruit nurse practitioners to serve on the Quality Improvement Committee. Also, update the table on page four of the committee charter and include the external committee member.
- Correct the source codes for the non-HEDIS measures to comply with the State specifications and re-run the results.
- Correct the errors identified with the performance improvement projects.

- The quality improvement program evaluation should be based on current HEDIS results and not interim results. Issues identified in the 2014 Annual Quality Improvement Program Evaluation should be addressed or corrected.
- Update policy MS.UM.05, page nine, to include that notice must be given at least 10 days before the date of the action when there is termination, suspension or reduction of a previously authorized service.
- Revise the Member Handbook, page 31, to include the timeframe for urgent authorization determinations.
- Ensure the IRR benchmark requirement is updated from 80 percent to 90 percent in the UM Program Description during its next revision.
- Update the Provider Manual, UM Program Description, and Member Handbook to indicate that Magnolia uses the Medicaid Program PDL.
- Update the UM Program Description to accurately document the pharmacy authorization process when medical necessity criteria are not met.
- Revise the Member Handbook definitions of an action and an appeal to be compliant with the definitions found in *Federal Regulation § 438.400 (b)*.
- Update the Provider Manual to include the timeframe to request an appeal.
- Revise the Member Handbook and the denial letters to reflect the correct timeframe to file an appeal.
- Revise policy MS.UM.08 to include that the review of an appeal must be made by a practitioner with the appropriate clinical expertise in treating the member's condition or disease.
- Update the Provider Manual to indicate that an oral request for an expedited appeal does not require a written follow-up.
- Update the Provider Manual to include information on extensions of expedited appeal resolution timeframes.
- Correct the timeframe for appeal acknowledgement in policy MS.UM.08.
- Revise the appeal acknowledgement letter to include complete information on continuation of benefits.
- Revise the Centene Corporate Standardized Credentialing Audit Tool to be consistent with the *DOM Contract* requirement.
- Update the 2015 Cenpatico Tracking Grid to specify the timeframes for resolution of complaints/grievances.
- Update the percentage of member/provider complaints and appeals that are to be resolved within timeliness requirements on the 2015 Cenpatico Tracking Grid.
- Revise the 2015 Cenpatico Tracking Grid to specify timeliness requirements for authorization determinations.
- The 2015 Cenpatico Performance Summary Report should be updated to include monitoring for expedited authorization turn-around times in addition to standard authorization turn-around times.
- The 2015 NIA Tracking Grid should be revised to remove the statement that "Medical Necessity appeals are not delegated to Vendor (with the exception of 1st level Medical Necessity appeals)."
- Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which may include validation of encounter data, administration and validation of member and provider surveys, calculation of additional performance measures, and conduct performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes 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 contains the plan's strengths and weaknesses; comparative information from previous reviews; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

Introduction

On January 1, 2011, the Mississippi Division of Medicaid (DOM) established the Mississippi Coordinated Access Network (MississippiCAN), a coordinated care program for Mississippi Medicaid beneficiaries. The goals of the program are to improve access to needed medical services, improve quality of care, and improve program efficiencies and cost effectiveness. The Mississippi Division of Medicaid has contracted with Magnolia Health Plan to provide services to individuals enrolled in the MississippiCAN Program.

DOM has 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 Program. The purpose of this review was to determine the level of performance demonstrated by Magnolia Health Plan since the EQR was completed in 2013.

Goals of the review were:

1. To determine Magnolia Health Plan's compliance with service delivery as mandated in the contract with DOM.
2. To evaluate the status of deficiencies identified during the 2013 annual review and any ongoing corrective action taken to remedy those deficiencies.
3. To provide feedback on potential areas for further improvement.

The overriding goal of the annual EQR process is to ensure that contracted health care services are actually being delivered and are of good quality.

Process

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On July 3, 2015, CCME sent notification to Magnolia Health Plan (Magnolia) that the annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Magnolia to ask questions regarding the EQR process and the desk materials being requested.

The review consisted of two segments. The first was a desk review of materials and documents received from Magnolia on August 3, 2015 and reviewed in the offices of CCME (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization decisions, and appeal files.

The second segment was an onsite review conducted on October 14th and 15th at the Magnolia Health Plan office located in Jackson, Mississippi. The onsite visit focused on areas not covered in the desk review or areas needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Magnolia's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

Findings

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Magnolia Health Plan and DOM. Strengths and weaknesses are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), or the standard was not evaluated (Not Evaluated) and are recorded on the tabular spreadsheet. (*Attachment 4*)

I. ADMINISTRATION

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance, and confidentiality. Christopher Bowers is the Senior Vice President of Health Plan Operations and Dr. Jason Dees serves as the Plan President and Chief Executive Officer (CEO). Dr. Dees is located in Mississippi and is responsible for the day-to-day administration of the health plan. The Chief Medical Director is Dr. Rebecca Waterer, who reports directly to the CEO and is responsible for pharmacy services, oversight of clinical operations, and development of medical policies. She chairs multiple committees including the Pharmacy and Therapeutics (P&T), Quality Improvement (QI), Credentialing (CC), and Utilization Management (UM). She is supported by Dr.

Jeremy Erwin serving as Medical Director. The organizational chart, job profiles, and onsite discussion confirm that key personnel and overall staffing appear to meet contract requirements.

Magnolia Health Plan has a comprehensive set of policies which are organized and for the most part appear to appropriately address state requirements. Some policies address Mississippi (MS) specific requirements through policy attachments. Policies are reviewed annually and accessible to all employees.

CCME performed an evaluation of the Information System Capabilities Assessment (ISCA) and other associated documentation provided by Magnolia. The evaluation included a review of 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 as required by DOM. Findings of the review showed Magnolia has a comprehensive system and processes in place and fully meets the requirements.

Results of the Administration section of the EQR showed Magnolia met 96.55 percent of the standards as shown in the chart below. The Partially Met score was due to having a compliance goal of 90 percent for the HIPAA desk audits when the goal should be 100 percent compliance.

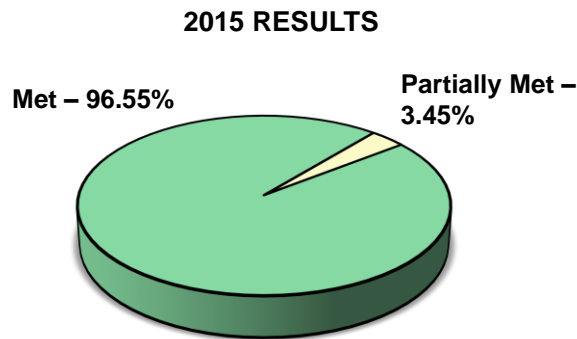


TABLE 1: ADMINISTRATION

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
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

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- Magnolia did an excellent job of laying out the disaster recovery test parameters and documenting the results.

WEAKNESSES

- The 2014 Annual Quality Improvement Program Evaluation (page 88) states the Compliance Officer performs HIPAA desk audits to determine compliance with Magnolia's policies for protecting PHI. The compliance goal is listed as 90 percent and onsite discussion revealed this is a corporate goal. However, unauthorized disclosure of Protected Health Information (PHI) is strictly prohibited under HIPAA laws and in Magnolia's policies. Setting the goal at only 90 percent allows for the potential of unauthorized disclosure of PHI. This goal should be set at 100 percent.

II. PROVIDER SERVICES

A review of all policies and procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, practice guidelines, and the provider satisfaction survey was conducted for Provider Services. The Credentialing Committee is chaired by Dr. Becky Waterer, Chief Medical Director. Voting members of the committee include the Chief Executive Officer, Medical Director (Dr. Erwin), Director of QI, Manager of QI, credentialing designee, and four network providers with the specialties of pediatrics, family medicine, and nurse practitioner. A committee charter and policy CC.CRED.03 (Credentialing Committee) states the committee meets monthly (no less than 10 times per year) and a quorum is met with 50 percent of voting members present.

It was difficult to determine from the Credentialing Committee minutes who had voting privileges. The committee charter does not specify who has voting privileges and there was inconsistent information between the list of committee members and what the charter specifies as the committee membership. For example, the list of committee members showed the Director QI, Manager QI, and a credentialing position as committee members with voting privileges; however, these positions were not mentioned in the charter as positions for the committee composition. Several meetings appeared to not have met the quorum requirement.

The Centene Corporate Credentialing Program adopted by Magnolia is defined in policy CC.CRED.01, Practitioner Credentialing & Recredentialing, as well as other policies. Attachments to the policies include MS specific requirements. It was noted in policy CC.CRED.01 that for recredentialing, the disclosure of ownership requirement was listed as an exception, and the Unique Requirements for Credentialing (Attachment B) document does not specify for MS that the disclosure of ownership form is required at recredentialing. Onsite discussion confirmed that Magnolia has not been collecting the disclosure of ownership form at recredentialing. CCME suggested that Magnolia put a process in place to collect ownership disclosure forms for providers that had already been recredentialed.

PROVIDER ACCESS AND AVAILABILITY STUDY

As a part of the annual EQR process for Magnolia Health Plan, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by the Magnolia, from which a population of 1,462 unique PCPs was found. A sample of 310 providers was randomly selected from this population for the access study. Attempts were made to contact these

providers to ask a series of questions regarding the access that members have with the contracted providers.

Calls were successfully answered 54 percent of the time by personnel at the correct practice which estimates to between 51 and 56 percent for the entire population. When compared to last year's results of 57 percent, this year's study proportion did fall from the previous measure, but statistically it was unchanged. So in both actual terms and statistically, no improvement was seen.

For those not answered successfully, 17 percent of the time (estimates to 16 to 20 percent for the entire population) the caller was informed that provider was not at that office or phone number. Of the successful calls, 78 percent (76, 81) of the providers indicated they specifically accept Magnolia Health Plan. Of those that indicated they accept the plan, 84 percent (81, 87) of the providers responded they are accepting new Medicaid patients.

When asked about any screening process for new patients, 25 percent (22, 29) indicated that an application or prescreen was necessary. Thirty-nine percent (31, 47) of those with a prescreening process require an application before accepting the patient, while 32 percent (25, 40) require a review of the medical record before accepting the patient. When the office was asked about the next available routine appointment, 76 percent (72, 79) of the appointment answers met within contract requirements.

PROVIDER SATISFACTION SURVEY VALIDATION

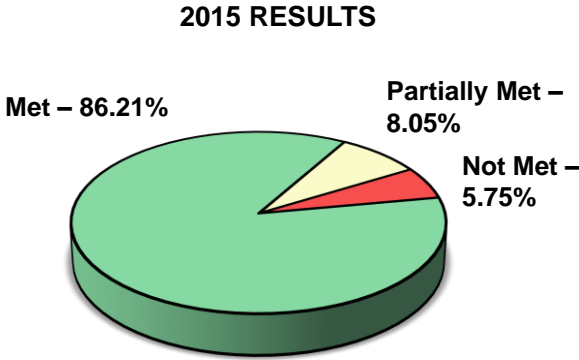
Magnolia Health Plan performed a provider satisfaction survey administered by The Myers Group (TMG), a survey vendor. As a part of this EQR, this survey was validated using the EQR Protocol 5, Validation and Implementation of Surveys (*version 2.0, September 2012*). The survey did not meet the CMS protocol requirements. In the table that follows we have identified areas that should be corrected to improve the survey documents and process.

Section	Reasoning	Recommendation
3.3 Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	Sampling strategy and process was not included in the documentation.	Include in the survey documentation the sampling strategy used to create the sample for this survey. The documentation should include the type of sample drawn and the steps used to create the sample.
3.4 Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	Detailed information regarding the selection of the sample size was not in the documentation.	Clearly document how the sample size was determined. Be sure to include the acceptable margin of error and the level of certainty that was used in the sample size calculation.
3.5 Review that the procedures used to select the sample were appropriate and protected	Sampling strategy and process was not included in the documentation.	Clearly document the sampling strategy used to create the sample for this survey. The

Section	Reasoning	Recommendation
against bias.		documentation should include the type of sample drawn and the steps used to create the sample.
4.2 Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	With the original sample having a low response rate, there is a strong possibility that a response bias exists in the results.	Focus on strategies that would help increase response rates for the entire population. Solicit the help of your survey vendor.
7.2 Identify the technical weaknesses of the survey and its documentation.	Survey documentation was missing pieces of important documentation regarding sample size calculation and creation.	Include these items in the survey summary document to complete the documentation.
7.3 Do the survey findings have any limitations or problems with generalization of the results?	The response rate for the original provider sample suffered from a low response rate. Response rate bias should be a concern.	Focus on strategies that promote higher response rates for the provider population.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report.

The chart below shows 86.21 percent of the standards in the Provider Services section were scored as Met. The Partially Met and Not Met scores were in the areas of Credentialing and Recredentialing, Adequacy of the Provider Network, Provider Education, Clinical Practice Guidelines, and the Provider Satisfaction Survey.



Percents may not total 100% due to rounding

TABLE 2: PROVIDER SERVICES

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Credentiaing 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	Not 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	Not Met	Met
	Malpractice claims history	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.	Partially 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.	Not Met	Partially Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	Not Met	Met
	Current valid license to practice in each state where the practitioner will treat Members;	Partially Met	Met
	Valid DEA certificate and/or CDS certificate;	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.	Partially 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.	Not Met	Met

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Credentialing and Recredentialing	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.	Not Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management	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
Practitioner Medical Reports	The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- The Provider Manual and educational/reference materials on the website provider portal equip providers with good resource information for navigating the plan.
- The Credentialing Committee includes four Mississippi network providers with various specialties that have good attendance at committee meetings.

WEAKNESSES

- Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, has the disclosure of ownership form listed as exceptions in cases of recredentialing and the Unique Requirements for Credentialing (Attachment B) document does not specify for MS that the disclosure of ownership form is required at recredentialing.
- It was difficult to determine from the Credentialing Committee minutes who had voting privileges. The committee charter does not specify who has voting privileges and there was inconsistent information between the list of committee members and what the charter specifies as the committee membership. For example, the list of committee members showed the Director QI, Manager QI, and a credentialing position as committee members with voting privileges; however, these positions were not mentioned in the charter as positions for the committee composition. Several meetings appeared to not have met the quorum requirement.
- The Magnolia Site Review Tool received in the onsite materials showed the following incorrect appointment timeframes:
 - For complete physical/preventive health exam or a routine, non-symptomatic visit it states within 45 calendar days when appointment criteria should be 30 calendar days.
 - For a routine, non-urgent symptomatic visit, it states within 10 calendar days when appointment criteria for a routine sick visit should be seven calendar days.
- Recredentialing files reviewed did not contain evidence of the ownership disclosure forms. Onsite discussion revealed that Magnolia was not collecting the information at recredentialing. This was an issue in the previous EQR.

- The Practitioner Availability Analysis report (July 1, 2014 to June 30, 2015) received after the onsite utilized access standards of one PCP within 30 miles urban/one PCP within 60 miles for rural areas. These standards do not comply with current contract requirements of two PCPs within 15 miles for urban and 30 miles for rural.
- The following inconsistencies were noted:
 - Policy MS.CONT.01, Provider Network, states that Magnolia maintains a PCP-to-member ratio of 1:2500 but policy MS.QI.04, Evaluation of Practitioner Availability, states all PCP types combined is two per 2500.
 - Policy MS.CONT.01 mentions network adequacy standards for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) and the information is not mentioned in policy MS.QI.04.
- Policies MS.PRVR.10, Evaluation of the Accessibility of Services, and MS.QI.05, Evaluation of the Accessibility of Services, address appointment criteria. However, the policies do not address all appointment criteria that are defined in the *DOM Contract, Section 7 (B)*. Information regarding behavioral health and dental providers appears to not be addressed.
- The dental and behavioral health appointment access standards are addressed in the Provider Manual (page 20) and in a document on the website called, “Appointment & Access Requirements”; however, inconsistencies were identified as follows:
 - The website states within 21 calendar days for behavioral health routine care. The Provider Manual states within 10 working days (14 calendar days).
 - The Provider Manual states behavioral health non-life-threatening emergencies within six hours, and this is not mentioned in the website document.
- Results of the telephonic Provider Access and Availability Study performed by CCME did not show improvement from the previous study. It appears that Magnolia members may not be receiving correct provider information so this could indicate an access problem.
- The reassignment of a member to another PCP could not be found as being addressed in the Provider Manual.
- Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines, states that Magnolia, on an annual basis, shall measure provider performance against at least two of the clinical guidelines. Then on the same page, it states that at least annually, Magnolia measures practitioner compliance with at least four CPGs.
- The provider satisfaction survey did not meet the CMS protocol requirements.
- For the provider satisfaction survey, low response rates could bias results.

III. MEMBER SERVICES

The review of Member Services included all policies and procedures, member rights, member training and educational materials, and Magnolia’s processes for handling grievances, member satisfaction, and practitioner changes.

Magnolia has policies and procedures, as well as call center scripts and training manuals, to guide staff in meeting requirements for member services functions. A few errors, discrepancies, and omissions of necessary information were noted in policies and procedures, the Member Handbook, and the Provider Manual, particularly related to member rights and responsibilities and grievances.

Magnolia has a well-developed member education program that includes the new member welcome packet, welcome calls, newsletters, and reminders to participate in preventive health services. In

addition, the MemberConnections program provides member and community education on topics such as Medicaid, the Plan’s services, and community resources.

Most of the grievance files reviewed revealed that the grievances were appropriately handled. However, issues were noted in several files which included failure to both investigate all the issues and address all the issues in the grievance resolution letters; missing acknowledgement and resolution letters; and closing grievances without sending the grievant the “unable to contact” letter that Magnolia has at its disposal to try to obtain needed information.

MEMBER SATISFACTION SURVEY VALIDATION

A member satisfaction survey was performed on behalf of Magnolia by The Myers Group, an NCQA-certified vendor, using the CAHPS® 5.0H instrument. As a part of this EQR, the survey was validated using the CMS protocol for Administering or Validating Surveys (*Final Protocol Version 2.0, September 2012*).

The survey did not meet the CMS protocol requirements. In the table that follows, areas are identified that should be corrected to improve the survey documents and process.

Section	Reasoning	Recommendation
Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	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.	Focus on strategies that would help increase response rates for the Medicaid Child population. Solicit the help of the survey vendor.
Do the survey findings have any limitations or problems with generalization of the results?	The response rate for the Medicaid Child population suffered from very low response rate. Response rate bias should be a concern.	Focus on strategies that promote higher response rates for the Medicaid Child population.

The full validation results are documented on the *CCME EQR Survey Validation Worksheets* located in *Attachment 3* of this report.

The chart below shows 77.42 percent of the standards in the Member Services section were scored as Met. Scores of Partially Met were related to errors in documentation found in policies, procedures, the Member Handbook, and the Provider Manual. One standard related to the member satisfaction survey was scored as Not Met due to the low response rate for the Medicaid Child population. All issues are addressed in the Weaknesses section below.

2015 RESULTS

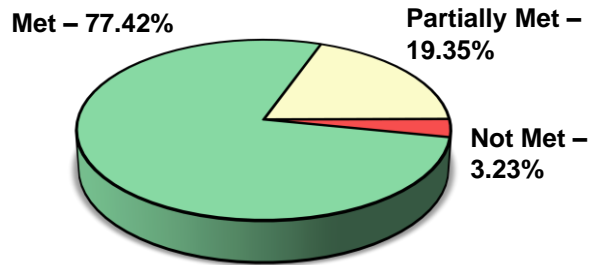


TABLE 3: MEMBER SERVICES

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Member Rights and Responsibilities	All Member Responsibilities are included	Met	Partially 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
Member Satisfaction Survey	The CCO conducts a formal annual assessment of Member satisfaction that meets all the requirements of the CMS Survey Validation Protocol	Met	Not Met
Complaints/ Grievances	Definition of a complaint/grievance and who may file a complaint/grievance	Met	Partially Met
	The procedure for filing and handling a complaint/grievance	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- Magnolia uses an NCQA certified vendor for CAHPS surveys.
- Magnolia has a well-developed member education program and uses a multitude of methods to ensure and enhance member education. In addition, the MemberConnections program provides additional member and community education on various topics pertinent to the population served.
- The Start Smart for Your Baby program’s dedicated website contains a wealth of information for pregnant members, including books, health sheets, podcasts and other audio files, and videos.

WEAKNESSES

- The following are not addressed in policy MS-MBRS-25, Member Rights and Responsibilities:
 - The right to receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
 - The right to voice complaints/grievances about the CCO or about the medical care and/or services received.
 - The right to appeal decisions adversely affecting coverage, benefits, services, or the member's relationship with the CCO.
- The 2015 Member Handbook contains no statement that members may exercise their rights without fear of adverse treatment or retaliation. This issue was also identified in the revised Member Handbook.
- Policy MS-MBRS-25, Member Rights and Responsibilities, does not address the member responsibility to inform Magnolia of changes in family size, address changes, or other health care coverage.
- The Member Handbook does not inform members that they will be notified in writing of changes to services and benefits. It should also contain the timeframe for the written notification.
- Per the *DOM Contract, Section 4 (G)*, requests for disenrollment may be made orally or in writing. The 2015 Member Handbook, page 13 (and the revised Member Handbook) states, "Members' requests for disenrollment must be directed to DOM in writing."
- Policy MS.ELIG.05, Disenrollment, page two, contains a bulleted list of reasons for which Magnolia will not disenroll members, including a statement that Magnolia will not disenroll a member for uncooperative or disruptive behavior resulting from his or her special needs (except when member's continued enrollment in the Plan seriously impairs the Plan's ability to furnish services to either the member or other members). However, the next paragraph states, "It is not the Plan's practice to disenroll a member if their disenrollment is not indicated on the 834 file. However, if a member is identified as having uncooperative or disruptive behavior, Plan will file a request in writing to DOM requesting to disenroll the member."
- Policy MS.ELIG.08, PCP Notification, as well as onsite discussion, confirmed that if a member does not have a PCP selection on the enrollment report from DOM, Magnolia allows 30 days for the member to select a PCP. If the member does not select a PCP by day 30, the Plan will assign a PCP within 45 days of enrollment. Inconsistencies in timeframes for PCP auto-assignment were noted in policy MS.ELIG.01, Primary Care Provider (PCP) Auto-Assignment, as follows:
 - Page one states that if the member does not request an available PCP within 30 days of enrollment, Magnolia will assign the new member to a network PCP within 60 days of enrollment.
 - Page two states members who do not have a PCP on the Enrollment report are outreached during the New Member Welcome Call in order to inform the member of the PCP to whom he/she has been assigned. However, NurseWise conducts new member welcome calls within 30 days of enrollment. Because auto-assignment occurs after day 30 but before day 45, this statement is incorrect.
 - Page two states that members will be informed of their PCP auto-assignment through the New Member Packet mailing. However, the new member packet is sent within 14 calendar days after the Plan receives notice of the member's enrollment. Because auto-assignment occurs after day 30 but before day 45, this is incorrect.

- The results of the Member Satisfaction Survey 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). The Medicaid Child population exhibited the lowest response rate; therefore, response bias may be a large issue with that survey.
- When searching for grievance information on the Magnolia website, all results were found under the pages for the MississippiCHIP population and not in the website sections for MississippiCAN members.
- Regarding who is able to file a grievance, the 2015 Member Handbook, page 51, and the Revised Member Handbook state that a provider acting for the member can file a grievance. There is no indication that the provider needs written consent to file a grievance on a member's behalf.
- Policy MS.MBRS.07, Member Grievance and Complaints Process, and the Provider Manual address an expedited grievance resolution timeframe of within 72 hours of receipt. During onsite discussion, Magnolia staff confirmed the use of an expedited grievance resolution process for clinically urgent or potential quality of care grievances. Information pertaining to the expedited grievance process and resolution timeframe is not found in the 2015 Member Handbook or the revised Member Handbook.
- Regarding extensions of the timeframes for grievance resolution, the following issues were noted:
 - The 2015 Member Handbook and the revised Member Handbook do not address that the member can request an extension.
 - The Provider Manual does not provide information on grievance resolution extensions.
- The review of grievance files revealed the following issues:
 - Several files reflected the need for additional information to process the grievance, but staff were unable to obtain the missing information due to invalid phone numbers. These grievances were closed and the members were sent an "Unable to Process" (UTP) letter. No evidence was noted that staff attempted to obtain the information in other ways, such as use of Magnolia's "Unable to Contact Letter" for grievances, rather than simply closing the grievances as unable to process. In addition, the UTP letters for both files did not indicate the reason for the plan's inability to process the grievance (there was no check mark indicating the basis for the inability to process the grievances).
 - Several files contained no acknowledgement or resolution letters.
 - For a grievance related to multiple issues, there was no evidence that all the issues were addressed in the investigation. Additionally, the notice of resolution letter did not address all issues included in the grievance filing.

IV. QUALITY IMPROVEMENT

Magnolia continues to operate a Quality Improvement (QI) program which encompasses the quality of both clinical care and services to Magnolia's members. The program actively involves the entire organization in the responsibility of improving the quality of care and services the health plan delivers to its providers and members. Magnolia has a quality improvement program description that outlines the quality management structure and activities throughout the organization. There were several deficiencies identified in the program description, such as an incomplete scope of work and inaccurate committee structure and descriptions. Quality improvement activities are managed through a work

plan which includes the activity or task, goal, responsible party, target date and status. In reviewing the 2014 Annual QI Work Plan, under the Quality/Performance Improvement Activities & Interventions tab, there were several activities related to Cultural Competence that are conducted annually. According to the Outcome(s)/Status Notes, these activities were presented to the Quality Improvement Committee on 1/17/14. However, there was no evidence found in the committee minutes that these activities were reported. Magnolia addressed this issue and explained the line item was satisfied in the December 2014 Quality Improvement Committee meeting by reviewing the annual NCQA Availability of Practitioners report that reviews CAHPS data, network availability and language line data. The development of Cultural Competency Plan training materials, identifying and prioritizing staff training needs, and conducting and evaluating the effectiveness of the training was listed as the planned activity on the work plan. However, this was not discussed during the committee meeting. It was recommended that the status notes section of the work plan accurately reflect the activities' status or outcome.

The Quality Improvement Committee performs oversight of all QI activities. Membership includes senior staff, department managers, and network providers. The network provider specialties include pediatrics, family medicine, and cardiology. The Committee Charter, dated June 2015, indicates the Quality Improvement Committee will also include two nurse practitioners. However, there are currently no nurse practitioners included on this committee.

Magnolia evaluates the effectiveness of their quality improvement program annually and produces a report that discusses the results of that evaluation. Their 2014 Annual Quality Improvement Program Evaluation was submitted with the desk materials. The program evaluation contained several errors; however, most concerning was that the evaluation appeared to be based on interim HEDIS results instead of current rates.

PERFORMANCE MEASURE VALIDATION

As part of the EQR for Magnolia, CCME conducted a validation review of the HEDIS® and non-HEDIS® performance measures following the protocols developed by CMS. Magnolia was 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 the Plan to ensure that what is submitted to the Division of Medicaid (DOM) complies with the measure specifications, as defined by DOM. The table that follows gives an overview of the validation score for each measure.

PERFORMANCE MEASURE VALIDATION SCORES

Measures	Current Review Decision
ASTHMA RELATED ER VISITS	40 / 55 = 73% SUBSTANTIALLY COMPLIANT
ASTHMA RELATED RE-ADMISSIONS	35 / 55 = 64% NOT VALID
CONGESTIVE HEART FAILURE RE-HOSPITALIZATION	35 / 55 = 64% NOT VALID
PRE AND POST NATAL COMPLICATIONS	40 / 55 = 73% SUBSTANTIALLY COMPLIANT

The non-HEDIS® measures did not meet the validation requirements. Two of the measures were *Substantially Compliant* and two measures were *Not Valid*. Issues with the way the numerators and denominators were calculated were of concern. The table that follows lists the specific issues identified by measure.

ASTHMA RELATED ER VISITS		
Section	Reasoning	Recommendation
N2. Numerator	The code is using any diagnosis that starts with 493. The State's specification document requires 493.0-2 and 493.9 be used. This could cause codes to be included that should not be counted in the numerator. The CPT codes listed in the specifications are only 99282, 99283, and 99285. The code provided is looking at codes 99281-99285, and so including additional codes into the calculation.	Correct source code to align with the State's specifications.
R1. Reporting	The codes included in the numerator are incorrect which causes the incorrect results reported.	Correct the issues with the numerator and recalculate the measure.
ASTHMA RELATED RE-ADMISSIONS		
Section	Reasoning	Recommendation
D2. Denominator	The member month code is using the wrong CPT codes. CPT codes 99281-99285 are being used, instead of 99221-99223 and 99231-99233 as required by the specifications.	Check these issues and correct as necessary to comply with the measure specifications.
N2. Numerator	The code includes all diagnoses starting with 493 instead of the 493.0-493.2 and 493.9 required by the specifications. Diagnoses may be included in the results that should not have been included.	Correct the codes to comply with the measure specifications.
R1. Reporting	The reported results could be incorrect due to issues with the numerator and denominator.	Correct the issues with the denominator and the numerator and recalculate the measure.
CONGESTIVE HEART FAILURE RE-HOSPITALIZATION		
Section	Reasoning	Recommendation
D2. Denominator	The member month code is using the wrong set of CPT codes. CPT codes 99281-99285 are being used, instead of 99221-99223 and 99231-99233 as required by the specifications.	Check these issues and correct as necessary to comply with the measure specifications.

N2. Numerator	The code is including all diagnoses starting with 428 instead of 428.0, 428.9, 428.1, and 428.40-428.42 as required by the specifications. It also excludes 440.9 and 402.91.	Correct the codes to comply with the measure specifications.
R1. Reporting	The reported results could be incorrect due to the issues identified with the numerator and denominator.	Correct the issues with the denominator and the numerator and recalculate the measure.
PRE AND POST NATAL COMPLICATIONS		
Section	Reasoning	Recommendation
N2. Numerator	<p>There are missing and extraneous codes being pulled in the source code reviewed that are outside the state required specifications.</p> <p>The birth weight codes should only include : Very Low – 765.14, 765.15 Low – 765.16, 765.17, 765.18 Exceptionally Large – 766.0 (not found in source code at all) Large for gestational age – 766.1</p> <p>Prenatal complications should only be in the range of 640-649 BUT ONLY the .01 and .03 sub codes. (For example 640.01, 640.03, 640.81, 640.83, 640.91, 640.93, 641.01, 641.03 etc....).</p>	Remove extraneous codes that are outside the specifications and make sure specified codes are included in the source code. Correct issues where more specific ranges of codes are required by the source code (i.e. not just the first three digits of the code).
R1. Reporting	Major deviations from the specifications were found which calls into question the accuracy of the reported rates.	Correct the issues so that the measure complies with the state specifications and recalculate measures.

Details of the validation process and the complete results are detailed in the *CCME EQR Validation Worksheets, Attachment 3*, of this report.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

The validation of the performance improvement projects submitted by Magnolia was done in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Topics for the projects included asthma, congestive heart failure, diabetes, hypertension, and obesity. The results of the validation are summarized in the table that follows.

PERFORMANCE IMPROVEMENT PROJECTS

PROJECT	VALIDATION SCORE
Asthma	84/100 = 89% CONFIDENCE
Congestive Heart Failure	69/100 = 69% LOW CONFIDENCE
Diabetes	104/131 = 79% CONFIDENCE
Hypertension	83/125 = 66% LOW CONFIDENCE
Obesity	99/131 = 76% CONFIDENCE

The results of the validation of Magnolia’s performance improvement projects found the projects failed to meet the validation requirements. Three projects scored within the *Confidence* range and two in the *Low Confidence* range. A review of the project documents found the following:

- The project documents submitted are noted as draft when in fact these projects have been underway since 2012.
- It is documented that HEDIS Specifications are used to define the Study Population, but the definition is general, not related to the topic. For example, in the Asthma project the population is defined as members 15-64 years old. There is no mention of the members having asthma.
- The majority of interventions are not related to the project topic or they focus on something other than the point of the study. For example, in the Diabetes project, most of the interventions documented are either not related to diabetes (COPD and asthma are mentioned) or are directed at controlling diabetes. This project is designed to increase rates of certain screening tests.
- Improvement has not been demonstrated in three projects. In one, improvement has been seen, but the goals are not being met. This is probably due to the interventions not focusing on the project.
- Results are not always accurately and clearly documented.
- For the projects using the hybrid method, there is no documentation of the staff being used to collect the data.
- An interpretation of the results should be documented for each data point/time period. This interpretation is missing for remeasurement one for multiple projects (Diabetes, Hypertension, and Obesity).
- The Diabetes and Obesity projects use a sample, but there is no documentation of statistical testing of the results.
- For Hypertension and Obesity, the sample information is not documented. For Hypertension, the sample size is documented as 100 percent and the population as 453. The sample size is actually 453.

In the table that follows we have listed the specific errors by project and included our recommendations to correct the errors.

Asthma		
Section	Reasoning	Recommendation
Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	Although it is documented that the HEDIS® Specifications for people with asthma are used to define the population, the population is identified as members 5-64 years old. There is no mention of them having asthma.	Clearly define the relevant study population.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Most of the interventions documented are either not related to asthma (CHF is mentioned) or are directed at the member. This project is designed to increase rates of appropriately prescribed medication. Interventions focused on the member are most likely not going to increase appropriately prescribed medication.	Implement interventions that will have an impact on the study question and the indicator for the project.
Was there any documented, quantitative improvement in processes or outcomes of care?	Improvement has not been seen in the measure.	Consider revising the interventions to help boost rates.
Congestive Heart Failure		
Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	There does not appear to be a HEDIS® measure as described in the documentation. In the 2015 HEDIS specs, there is not a numerator or denominator that matches the documentation.	Review the HEDIS Technical Specification and clearly define the indicator being used.
Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	The study population is defined as members 18 years old and older, but there is no mention of them having congestive heart failure.	Clearly define the relevant study population.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Most of the interventions documented are either not related to congestive heart failure (diabetes and high blood pressure are mentioned) or are directed at the member. This project is designed to increase rates of appropriately prescribed medication. Interventions focused on the member are most likely not going to increase appropriately prescribed medication.	Implement interventions that will have an impact on the study question and the indicator for the project.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The numerator and denominator do not give the rate documented for Remeasurement 2. Also, the wording for the remeasurements includes “at least 6 months of the appropriate medication.” This is not how the indicator is defined.	Be sure all data points are calculated correctly and measures are documented consistently.
Was there any documented, quantitative improvement in processes or outcomes of care?	Improvement has not been seen in the measure.	Interventions should be reevaluated and revised to help boost rates.

Diabetes		
Section	Reasoning	Recommendation
Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	The study population is defined as members 18-75 years old, but there is no mention of them having diabetes.	Clearly define the relevant study population.
Were qualified staff and personnel used to collect the data?	There is no documentation of the staff used by the plan for the record abstraction piece of the hybrid method.	Clearly document the qualified staff and personnel used for the abstraction piece of data collection.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Most of the interventions documented are either not related to diabetes (COPD and asthma are mentioned) or are directed at controlling diabetes. This project is designed to increase rates of certain screening tests. Interventions focused on the controlling diabetes are most likely not going to increase screening tests.	Implement interventions that will have an impact on the study question and the indicator for the project.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The numerator and denominator do not give the rate documented for Measure 2, and Remeasurement 2. Also, for Remeasurement 2, the numerator and denominator for this measure are much larger than the other measures.	Be sure all data points are calculated and documented correctly.
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Although there is documentation of an interpretation for Remeasurement 2, there is no information on Remeasurement 1.	Include an interpretation of the successfulness and follow-up activities for each time period analyzed.
Is there any statistical evidence that any observed performance improvement is true improvement?	No statistical testing is reported in the results.	Add statistical testing to the results to indicate if any improvement has statistical significance.
Hypertension		
Section	Reasoning	Recommendation
Was/were the study question(s) stated clearly in writing?	While a study question is present in the documentation, it appears to not address the actual focus of the study. The way the study question is stated as decreasing ER visits and inpatient stays and increasing primary care visits, the study appears to be measuring adequately controlled blood pressure. It is unclear whether looking solely at blood pressure alone would correlate with the study question.	Revise study question to reflect the focus of the measurement.
Did the study use objective, clearly defined, measurable indicators?	Study used a HEDIS® measure for its indicator. However, there is documentation regarding the denominator of different age groups (18-85 years and 18-84 years).	Clearly and consistently document the indicators being used.
Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	The study population is defined as members 18-75 years old, but there is no mention of them having hypertension.	Clearly define the relevant study population.
Did the sample contain a sufficient number of enrollees?	In the sampling techniques table. The sample size is documented as 100% with the	Clearly define the sample size and population being used for

	population being 453, but in the sampling method column, the sample size is noted as being 453. The actual population is unclear.	this project.
Were qualified staff and personnel used to collect the data?	There is no documentation of the staff used by the plan for the record abstraction piece of the hybrid method.	Clearly document the qualified staff and personnel used for the abstraction piece of data collection.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Most of the interventions documented are not related to hypertension (CHF, COPD, and asthma are mentioned). A baby shower was documented for pregnant mothers, but they are excluded from this project per HEDIS Specifications. The indicator for this project is controlled blood pressure. Interventions not focused on this are most likely not going to increase rates.	Implement interventions that will have an impact on the indicator for the project.
Was an analysis of the findings performed according to the data analysis plan?	The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented.	Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Although there is documentation of an interpretation for Remeasurement 2, there is no information on Remeasurement 1.	Include an interpretation of the successfulness and follow-up activities for each time period analyzed.
Was there any documented, quantitative improvement in processes or outcomes of care?	Improvement has not been seen in the measure.	Reevaluate interventions and revise as needed to help boost rates.
Obesity		
Section	Reasoning	Recommendation
Did the study use objective, clearly defined, measurable indicators?	For Study Indicator 2, the measure is defined as those with a visit, but the denominator is number of members.	Clearly define the indicators being used for this project.
Did the sample contain a sufficient number of enrollees?	In the sampling techniques table, the sample size is documented as 100% with the population being 419. It is unclear whether or not sampling is being used.	If sampling is being used, clearly define the sample size and population being used for this project.
Were qualified staff and personnel used to collect the data?	There is no documentation of the staff used by the plan for the record abstraction piece of the hybrid method.	Clearly document the qualified staff and personnel used for the abstraction piece of data collection.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Most of the interventions documented are either not related to obesity, focused on the member, or are directed at controlling obesity. This project is designed to increase rates of BMI and nutrition and physical activity documentation. Interventions focused on the member or controlling obesity are most likely not going to increase documentation. A baby shower was also documented for pregnant mothers, but they are excluded from this project per HEDIS Specifications.	Implement interventions that will have an impact on the study question and the indicator for the project.

Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The numerator and denominator do not give the rate documented for Measure 1 (Physical Activity), Remeasurement 2.	Be sure all data points are calculated correctly.
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Although there is documentation of an interpretation for Remeasurement 2, there is no information on Remeasurement 1.	Include an interpretation of the successfulness and follow-up activities for each time period analyzed.
Is there any statistical evidence that any observed performance improvement is true improvement?	No statistical testing is reported in the results.	Add statistical testing to the results to indicate if any improvement has statistical significance.

Complete details of the validation of the performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

The chart below shows that 73.33 percent of the scored standards for the Quality Improvement section of this EQR received a Met score. The non-HEDIS performance measures and the performance improvement projects failed to meet the validation requirements, which represent the Partially Met and Not Met scores. Deficiencies were also identified with the program description and program evaluation, and received a Partially Met score.

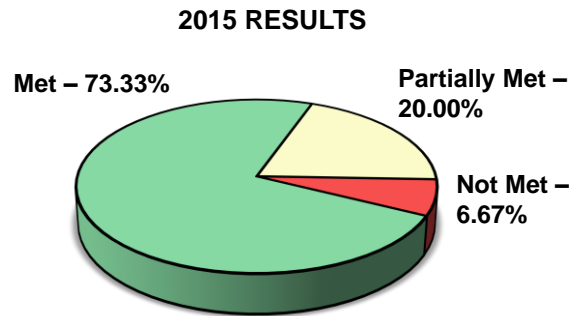


TABLE 4: QUALITY IMPROVEMENT

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Partially Met
Provider Participation in Quality Improvement Activities	Providers receive interpretation of their QI performance data and feedback regarding QI activities	Partially Met	Met

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
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 standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

WEAKNESSES

- The following issues were identified in the 2015 Quality Assessment and Performance Improvement Program Description:
 - The scope of the program listed on pages one and two do not include monitoring member or provider appeals, even though reviewing grievances and appeals is listed a responsibility of the Performance Improvement Team.
 - The committee organizational chart on page five does not include the Joint Oversight Committee.
 - Page nine refers to HEDIS as a “Data Information System”.
 - The committee responsible for monitoring the performance of Magnolia’s vendors is referred to as the Delegated Vendor Oversight /Joint Operative Committee on page 11. However, this committee is referred to as the Joint Oversight Committee in other documents.
 - Clinical and preventive guidelines are discussed on page 19 and 20. Page 20 states Magnolia measures practitioner compliance with at least two of its adopted clinical and preventive guidelines. However, policy MS.QI.08.01 states Magnolia will monitor at least two in one paragraph and four in another paragraph.
 - Page 23 indicates that annually Magnolia provides information to members and providers including a description of the QI program and a report on progress in meeting program goals. However, the QI program description found on Magnolia’s website was dated 2013 and the program evaluation was dated 2012.
 - The Delegation Services section of the program description, page 25, incorrectly lists DentaQuest as the vendor for dental services.
- In reviewing the 2014 Annual QI Work Plan, under the Quality/Performance Improvement Activities & Interventions tab, there were several activities related to Cultural Competence that are conducted annually. According to the Outcome(s)/Status Notes these activities were presented to the Quality Improvement Committee on 1/17/14. However, there was no evidence found in the committee minutes that these activities were reported.
- The Committee Charter dated June 2015 indicates the Quality Improvement Committee membership will include two nurse practitioners. However, there are currently no nurse practitioners included in this committee. Also, page four of the charter contains a table listing the external committee membership. This table was incomplete.
- The non-HEDIS® measures did not meet the validation requirements. Two of the measures were scored as *Substantially Compliant* and two measures were found to be *Not Valid*. Issues with the way the numerators and denominators were calculated were of concern.
- Results of the validation of the performance improvement projects found numerous errors and failed to meet the validation protocol requirements. Three projects scored within the *Confidence* range and two in the *Low Confidence* range.

- The following issues were identified in the 2014 Annual Quality Improvement Program Evaluation:
 - HEDIS is incorrectly listed as “The Health Effectiveness Data Information Systems” on page six.
 - The description on page six of the meeting frequency for the HEDIS Steering committee indicates the committee meets monthly and met 10 times in 2014. However, there was no documentation included to explain why the committee only met 10 times and not monthly.
 - It was noted on page 10 that the HEDIS rates were interim rates. However, the evaluation (interventions, barriers, etc.) should be based on final HEDIS rates.
 - Table 5 on page 33 does not include the Comparisons/Percentile Rank.
 - Preliminary results instead of final results are listed on page 47 for the C-Section Rate Reduction.
 - The section on page 57 discusses the monthly denial percentages; however, the table appears incomplete and does not include the percentages for each denial reason. There was no analysis presented and the last sentence is discussing appeals. This section is related to utilization denials.
 - Inter-rater reliability is included on page 62; however, the information is incomplete. It is missing details such as how many took the test, whether there were any new hires or physicians, and if there were, did any reviewers not meet the 80 percent score.
 - Opportunities for improvement listed on page 70 include publishing articles about asthma. However, the opportunities for improvement in this section should be related to diabetes and not asthma.
 - The table on page 74 does not list the delegated services for NurseWise.
 - In the annual audit table for Cenpatico (page 74) the overall audit score for credentialing is listed as 100 percent. However, it appears Cenpatico was placed on a corrective action plan for non-compliance with credentialing and recredentialing. The overall audit results for DentaQuest (page 75) in the area of Quality Improvement lists the score as 87.86 percent. However, there were no barriers identified for Quality Improvement.
 - Page 90 states “the Program Evaluation for 2013 has been reviewed and approved as follows.” This should read the 2014 Program Evaluation.

V. UTILIZATION MANAGEMENT

The Utilization Management review included a review of policies, the program description, and approval, denial, appeal, and case management files.

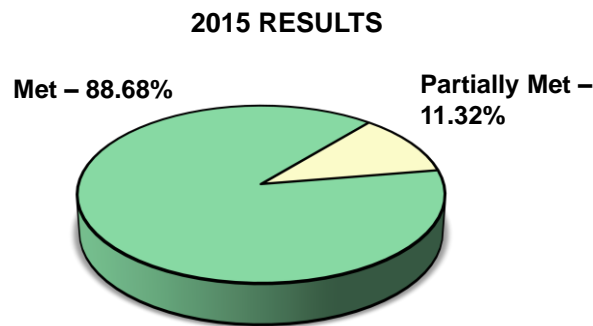
Magnolia has policies and procedures, as well as the Utilization Management Program Description, to guide staff in meeting requirements for utilization management (UM) functions. Related to UM processes and requirements, a few errors, discrepancies, and/or omissions of information were noted in policies and procedures, the Member Handbook, and the Provider Manual. The issues were particularly related to timeliness of utilization management decision timeframes and appeals processes and information.

Although there were several issues noted in policies, procedures, manuals, etc., reviews of UM approval and denial files confirmed appropriate processes are followed. Determinations were issued

in a timely fashion, appropriate criteria were used, and appropriate Level I and Level II reviewers issued the determinations. Review of appeal files also confirmed appropriate processes and timeframes are followed for appeal resolutions and notifications.

Magnolia has thoroughly incorporated the *DOM Contract's* new requirements for case management into policies, procedures, and processes. Case management files demonstrated thorough documentation and assessments, pertinent care plans, and appropriate follow-up activities; and reflect that Magnolia has incorporated all the new requirements.

Magnolia achieved a Met score of 88.68 percent of the standards for UM. Scores of Partially Met were related to documentation of UM determination timeliness requirements and information on appeals processes.



Percents may not total 100% due to rounding

TABLE 5: UTILIZATION MANAGEMENT

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
The Utilization Management (UM) Program	Timeliness of UM decisions, initial notification, and written (or electronic) verification;	Not Met	Partially Met
Appeals	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
	Other requirements as specified in the contract.	Not Met	Partially Met

SECTION	STANDARD	2013 REVIEW	2015 REVIEW
Appeals	The CCO applies the appeal policies and procedures as formulated.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2013 to 2015.

STRENGTHS

- The Magnolia Health Plan website is a valuable resource of UM information for providers, including forms, clinical guidelines, practice improvement resources, etc.
- New case management requirements have been thoroughly incorporated into Magnolia’s case management policies, procedures, and processes.

WEAKNESSES

- Policy MS.UM.05, Timeliness of UM Decisions and Notifications, page nine, does not address the requirement that for termination, suspension, or reduction of a previously authorized service, notice must be given at least 10 days before the date of the action. Refer to *Federal Regulation § 431.211*.
- The Member Handbook, page 31, does not provide the timeframe for urgent authorization determinations.
- The UM Program Description states the benchmark for a passing inter-rater reliability (IRR) score is 80 percent. However, policy CC.UM.02.05, Interrater Reliability, states the benchmark is 90 percent. Onsite discussion confirmed the benchmark was increased to 90 percent in August 2015.
- The *DOM Contract, Section 5 (F)*, requires the use of the most current version of the Medicaid Program Preferred Drug List (PDL). Onsite discussion confirmed this change was effective 1/1/2015. The following documents have not been updated to reflect this change:
 - The Provider Manual, page 40, contains a reference to the Magnolia PDL.
 - The UM Program Description, page 29, states, “The PDL is developed and maintained by the corporate P&T Committee, as well as the local Magnolia Health P&T Committee. The P&T Committee determines which drugs from the corporate PDL will be incorporated into the Plan PDL, and approves plan implementation of a Division of Medicaid PDL, if applicable.”
 - The Member Handbook, page 40, does not clearly indicate that Magnolia uses the Medicaid Program PDL.
- The UM Program Description, page 29, states the pharmacy benefit manager (PBM) does not make denial decisions based on lack of medical necessity. Onsite discussion confirmed this information is incorrect and that, as stated in policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, when a request does not meet criteria it is forwarded to a PBM licensed clinical pharmacist for a determination.
- The Member Handbook, page 52, defines an appeal as “a request for Magnolia to review a Magnolia Notice of Adverse Action”. Refer to *Federal Regulation § 438.400 (b)*, which defines an appeal as “a request for review of an action”.
- The Member Handbook, page 52, defines an action but fails to include the failure to act within timeframes and the denial of a member to obtain services outside the network. Refer to *Federal Regulation § 438.400 (b)*.

- The *DOM Contract, Exhibit D, Section D*, defines the timeframe for requesting an appeal as within 30 calendar days of receiving the Notice of Action. Issues identified include:
 - The Provider Manual does not document the timeframe for requesting an appeal.
 - The Member Handbook and denial letter templates incorrectly document the timeframe as within 30 days of the date on the Notice of Action.
- Policy MS.UM.08, Appeal of UM Decisions, does not include that the review of an appeal must be made by a practitioner with the appropriate clinical expertise in treating the member's condition or disease.
- The Provider Manual does not indicate that an oral request for an expedited appeal does not require a written follow-up.
- The Provider Manual does not include information on extensions of expedited appeal resolution timeframes.
- Policy MS.UM.08, Appeal of UM Decisions, incorrectly states that appeals are acknowledged within five calendar days. Onsite discussion confirmed the timeframe is five business days.
- The appeal acknowledgement letter provides some information on continuation of benefits, but the information is incomplete.

VI. DELEGATION

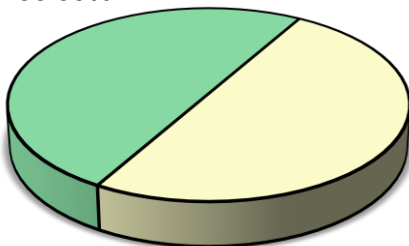
Magnolia Health Plan has delegation contracts with Cenpatico; Dental Health and Wellness; National Imaging Associates; Medical Transportation Management, Inc.; NurseWise; Nurtur; Opticare; and US Script. In addition, credentialing delegation agreements are in place with Mississippi Physicians Care Network; University of Mississippi Medical Center; Hattiesburg Clinic; RUSH Health Systems; LeBonheur; and St. Jude's Children's Research Center.

The Master Services Agreement, and its Attachment B, Delegated Services Agreement, specify the delegated activities and information on requirements for corrective action plans for substandard or non-performance, up to and including termination of the contract. In addition, Exhibit X of the Delegated Services Agreement details credentialing and recredentialing responsibilities for delegated credentialing entities, and appropriately addresses credentialing requirements specific to Mississippi. Documentation of annual oversight activities was reviewed and revealed several issues. These are discussed in the Weaknesses section below.

Fifty percent of the standards for the Delegation review were scored as Met. One standard received a score of Partially Met due to documentation of requirements on various delegation oversight tools.

2015 RESULTS

Met – 50.00%



Partially Met – 50.00%

WEAKNESSES

- The Centene Corporate Standardized Credentialing Audit Tool 2015/2016, page nine, references conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. There is no addendum or notation that the Mississippi requirement for these site visits is within 45 calendar days.
- The 2015 Cenpatico Tracking Grid for Magnolia Health Plan includes a standard that for member/provider complaints and appeals, 98% or 100% are to be resolved within state required timeframes. Also, the timeframes for resolution of complaints/grievances are not specified.
- The 2015 Cenpatico Performance Summary Report does not address turn-around time requirements for member and provider complaints/grievances and appeals.
- The 2015 Cenpatico Tracking Grid does not specify timeliness requirements for standard and expedited authorization determinations.
- The 2015 Cenpatico Performance Summary Report does not have an area for monitoring expedited authorization turn-around times.
- The 2015 NIA Tracking Grid states, “Medical Necessity appeals are not delegated to Vendor (with the exception of 1st level Medical Necessity appeals).” However, onsite discussion confirmed that NIA does not process appeals for Magnolia Health Plan members.

VII. STATE-MANDATED

Magnolia Health Plan provides all of the benefits specified in the in the DOM Contract.

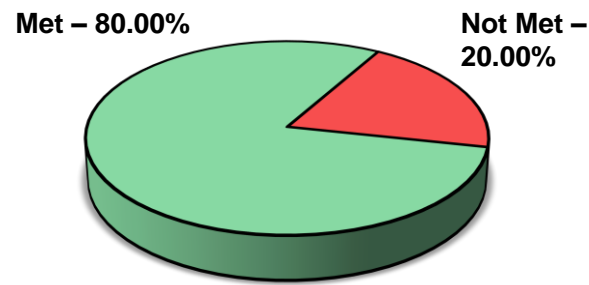
Magnolia monitors for provider compliance with preventive health and clinical practice guidelines, including those for well-care for newborns and children via claims and encounter data and medical record reviews. Physicians receive an annual profile report for each individual measure, including an individual provider score and a weighted composite score.

Magnolia has processes for monitoring compliance with EPSDT program requirements. QI and/or Provider Relations staff intervene to educate providers on timely provision of services and to promote sustained improvement over time. Magnolia reports to practitioners on assigned members in need of EPSDT services.

The findings of this EQR indicate that several deficiencies listed on the previous EQR have not been corrected. Details of the uncorrected deficiencies are provided in the Weaknesses section below.

Magnolia received Met scores for 80 percent of the standards in the State-Mandated section of the review. One standard was scored as Not Met due to uncorrected deficiencies from the previous EQR.

2015 RESULTS

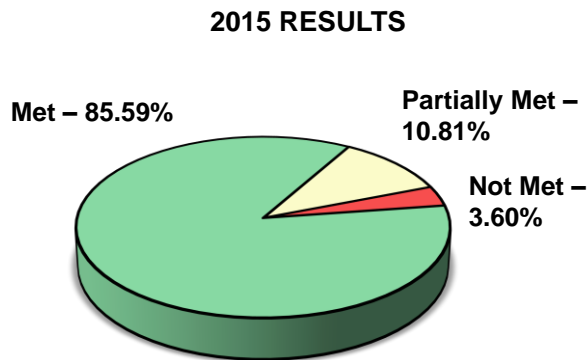


WEAKNESSES

- The following issues were noted in the previous EQR and have not been corrected:
 - Errors in the performance improvement projects were not corrected and failed to meet the validation requirements.
 - Recredentialing files did not contain ownership disclosure forms and the previous EQR CAP response indicated that ownership disclosure forms would be collected at recredentialing.

Summary and Recommendations

The findings of the 2015 EQR indicate that Magnolia Health Plan received Met scores for 85.59 percent of the standards for this External Quality Review. Areas that showed improvement in met scores over the prior EQR were Provider Services, Utilization Management and State-Mandated. The annual Quality Improvement Program description and program evaluation contained numerous errors and both the non-HEDIS performance measures and the performance improvement projects failed to meet validation requirements. The access study showed no improvement so it appears that Magnolia members may not be receiving correct provider information which could impact access to care. The goal for HIPAA desk audits is set at 90 percent, which allows for the potential unauthorized disclosure of PHI.



CCME recommends that Magnolia Health Plan implement the following recommendations to improve their processes and comply with all Federal Regulations and DOM Contract requirements.

1. The compliance goal for the HIPAA desk audits for potential unauthorized disclosure of PHI should be 100 percent.
2. Update policy CC.CRED.01, Practitioner Credentialing & Recredentialing, to reflect that ownership disclosure forms are required to be collected at credentialing and recredentialing for MS.
3. Update the Credentialing Committee Charter and the list of committee members to be consistent for committee membership and to define who has voting privileges; include in the Credentialing Committee minutes the voting members present/absent and if a quorum has been met for the meeting.
4. Update the Magnolia Site Review Tool to reflect the correct appointment criteria.
5. Ownership disclosure forms should be collected at recredentialing. In addition, Magnolia needs to implement a process to collect ownership disclosure forms for providers that have already been recredentialled.
6. Ensure the correct access standard parameters are used for the Practitioner Availability Analysis report and address inconsistencies between policies MS.CONT.01, Provider Network, and MS.QI.04, Evaluation of Practitioner Availability.

7. Update policies MS.PRVR.10, Evaluation of the Accessibility of Services, and MS.QI.05, Evaluation of the Accessibility of Services, to address all appointment criteria required by the *DOM Contract*.
8. Update the Provider Manual and the Appointment & Access Requirements website document to contain consistent appointment criteria requirements.
9. Implement interventions to address the member access issues identified in the Provider Access and Availability Study conducted by CCME.
10. Update the Provider Manual to include instructions for the reassignment of a member to another PCP.
11. Correct policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines, to reflect the correct number of clinical practice guidelines that Magnolia measures on an annual basis.
12. Implement interventions to increase the response rate in the provider satisfaction survey and improve survey documentation.
13. Update policy MS.MBRS.25 to include the following:
 - a. The right to receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
 - b. The right to voice complaints/grievances about the CCO or about the medical care and/or services received.
 - c. The right to appeal decisions adversely affecting coverage, benefits, services, or the relationship with the CCO.
14. Update the Member Handbook to indicate that members have the right to exercise their rights freely with no fear of adverse treatment by Magnolia or their providers.
15. Update policy MS.MBRS.25 to include the member's responsibility to inform Magnolia of changes in family size, address changes, or other health care coverage.
16. Update the Member Handbook to include the timeframe for, and method of, member notification of changes to services and benefits.
17. Correct the Member Handbook to indicate that member requests for disenrollment may be made orally or in writing.
18. Clarify the information on page two of policy MS.ELIG.05 to clearly indicate Magnolia will not request disenrollment of a member for uncooperative or disruptive behavior resulting from his or her special needs except when member's continued enrollment seriously impairs the ability to furnish services to either the member or other members.
19. Correct pages one and two of policy MS.ELIG.01 to reflect the timeframes and processes used by Magnolia to notify members of their auto-assigned PCP.
20. Develop strategies to increase the Member Satisfaction Survey response rates for the Medicaid Child population. Solicit the help of the survey vendor.
21. Update the Magnolia website to include grievance information in the section of the website for MississippiCAN members.
22. Revise the Member Handbook to clearly indicate that providers need written consent to file a grievance on behalf of a member.
23. Information on the expedited grievance process and timeframe for resolution should be included in the Member Handbook.
24. Revise the Member Handbook to include that members may request extensions of grievance resolution timeframes.
25. Update the Provider Manual to include all information on extensions of grievance resolution timeframes.
26. When additional information is needed for grievance processing, and member phone numbers are invalid, ensure that attempts are made to obtain information in alternate ways, including

- sending Magnolia's "Unable to Contact" letter prior to closing a grievance as unable to process. Ensure that written acknowledgement and resolution letters are sent for all grievances, as stated in policy MS.MBRS.07. Ensure that all issues included in the grievance are investigated and included in the grievance resolution letter.
27. Correct the issues identified in the 2015 Quality Assessment and Performance Improvement Program Description.
 28. Ensure the Outcome(s) Status or Notes section of the Quality Improvement Work Plan accurately reflects the status for each activity.
 29. Continue to recruit nurse practitioners to serve on the Quality Improvement Committee. Also, update the table on page four of the committee charter and include the external committee member.
 30. Correct the source codes for the non-HEDIS measures to comply with the State specifications and re-run the results.
 31. Correct the errors identified with the performance improvement projects.
 32. The quality improvement program evaluation should be based on current HEDIS results and not interim results. Issues identified in the 2014 Annual Quality Improvement Program Evaluation should be addressed or corrected.
 33. Update policy MS.UM.05, page nine, to include that notice must be given at least 10 days before the date of the action when there is termination, suspension or reduction of a previously authorized service.
 34. Revise the Member Handbook, page 31, to include the timeframe for urgent authorization determinations.
 35. Ensure the IRR benchmark requirement is updated from 80 percent to 90 percent in the UM Program Description during its next revision.
 36. Update the Provider Manual, UM Program Description, and Member Handbook to indicate that Magnolia uses the Medicaid Program PDL.
 37. Update the UM Program Description to accurately document the pharmacy authorization process when medical necessity criteria are not met.
 38. Revise the Member Handbook definitions of an action and an appeal to be compliant with the definitions found in *Federal Regulation § 438.400 (b)*.
 39. Update the Provider Manual to include the timeframe to request an appeal.
 40. Revise the Member Handbook and the denial letters to reflect the correct timeframe to file an appeal.
 41. Revise policy MS.UM.08 to include that the review of an appeal must be made by a practitioner with the appropriate clinical expertise in treating the member's condition or disease.
 42. Update the Provider Manual to indicate that an oral request for an expedited appeal does not require a written follow-up.
 43. Update the Provider Manual to include information on extensions of expedited appeal resolution timeframes.
 44. Correct the timeframe for appeal acknowledgement in policy MS.UM.08.
 45. Revise the appeal acknowledgement letter to include complete information on continuation of benefits.
 46. Revise the Centene Corporate Standardized Credentialing Audit Tool 2015/2016, page nine, to be consistent with the DOM Contract requirement that provider office site visits must be conducted within 45 calendar days when a complaint, grievance, or appeal threshold has been met against a specific provider related to the provider's office. Alternatively, the Mississippi

requirement of 45 calendar days could be included as an addendum or notation in the tool. Refer to the *DOM Contract, Exhibit D, Item (A) (12)*.

47. Update the 2015 Cenpatico Tracking Grid to specify the timeframes for resolution of complaints/grievances.
48. Update the percentage of member/provider complaints and appeals that are to be resolved within timeliness requirements on the 2015 Cenpatico Tracking Grid.
49. Revise the 2015 Cenpatico Tracking Grid to specify timeliness requirements for authorization determinations.
50. The 2015 Cenpatico Performance Summary Report should be updated to include monitoring for expedited authorization turn-around times in addition to standard authorization turn-around times.
51. Because onsite discussion confirmed that NIA does not process appeals, the 2015 NIA Tracking Grid should be revised to remove the statement that “Medical Necessity appeals are not delegated to Vendor (with the exception of 1st level Medical Necessity appeals).”
52. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

Magnolia Health Plan

2015 External Quality Review

Attachment 1

Initial Notice



July 2, 2015

Dr. Jason Dees
Plan President Magnolia Health Plan
Magnolia Health Plan
111 East Capitol Street, Suite 500
Jackson, MS 39201

Dear Dr. Dees:

This letter serves as your notification that the 2015 external quality review of Magnolia Health Plan is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with the Mississippi Division of Medicaid (DOM). The annual EQR is being initiated at this time at the request of DOM. It will include both a desk review at CCME and a multi-day onsite review at Magnolia Health Plan's office in Jackson, and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Please note that CCME's review methodology will include the protocols required by the Centers for Medicare and Medicaid Services for the external quality review of Medicaid Managed Care Organizations.

In preparation for the desk review, the items on the enclosed list are due at CCME no later than **August 3, 2015**. To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME through the website. The file transfer site can be found at:

<https://www.thecarolinascenter.org/EQRFileTransfer/Default.aspx>

This site allows you to create an account and download a container file that you will use while gathering your materials. When all the materials have been saved to the container file, log back in and upload your materials. We will be happy to provide you with additional information or help in using the file transfer website.

The CCME EQR team plans to conduct the onsite visit at Magnolia Health Plan on **October 14th** through **October 15th**. To prepare your organization for the upcoming review, we would like to offer to schedule a conference call with your management staff, in conjunction with DOM, to describe our process and answer any questions you may have. If you would like to have a conference call, please contact me at 800-682-2650, ext. 5588 or 919-461-5588 with dates your staff will be available for the call.

Sincerely,

Karen Smith
Project Manager

Enclosure
cc: DOM

Magnolia Health Plan

2015 External Quality Review

Attachment 1

Materials Requested for Desk Review

Magnolia Health Plan

External Quality Review 2015

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number, and department owner. The date of the addition/review/revision should be identifiable on each policy.
2. Organizational chart of all staff members including names of individuals in each position and any current vacancies.
3. Current membership demographics including total enrollment and distribution by age ranges, gender, and county of residence.
4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, member demographic studies, population needs assessments) that support the adequacy of the provider base. Please include any provider identified limitations on panel size considered in the network assessment.
5. A complete list of network providers for the MississippiCAN members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used; however, please provide an explanation of the codes used by your organization.
6. The total number of unique specialty providers as well as the total number of unique primary care providers, broken down by specialty, currently in the network.
7. A current provider list/directory as supplied to members.
8. A copy of the current Compliance plan.
9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.
10. The Quality Improvement work plans for 2014 and 2015.
11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Care Management programs.
12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc.).
 - a. For all projects with NON-HEDIS measures:
 - any outside audit of the plan's IT system used for processing member data from origination to calculation of measures used for the PIPs.

- b. For projects with measures derived from medical record abstraction:
 - full documentation of the abstraction process and tool used during abstraction, and
 - 15 sample records from those abstracted charts.
 - c. For projects with measures derived from administrative electronic systems:
 - full source code documentation of how the measure was processed and calculated for the PIP, and
 - any validity testing done from the programming of the measure to ensure the measure is capturing the populations of interest.
13. Minutes of all committee meetings in the past year for all committees reviewing or taking action on MississippiCAN-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory rather than sending duplicate materials.
 14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include committee charters if available.
 15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.
 16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.
 17. Results of the most recent medical office site reviews, medical record reviews, and a copy of the tools used to complete these reviews.
 18. A complete list of all members enrolled in the Care Management program from July 1, 2014 through June 30, 2015. Please include open and closed files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care management.
 19. A copy of staff handbooks/training manuals, orientation and educational materials, and scripts used by Member Services Representatives and Call Center personnel.
 20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.
 21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool, and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.
 22. A copy of any member and provider newsletters, educational materials, and/or other mailings.
 23. A copy of the Grievance, Complaint, and Appeal logs for the months of July 1, 2014 through June 30, 2015.
 24. Copies of all letter templates for documenting approvals, denials, appeals, grievances, and acknowledgements.
 25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal CCO compliance with these standards. Include copies of the most recent Network Geographic Access Assessment (GeoAccess) reports and provider appointment access monitoring.

26. Preventive health practice guidelines recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.
27. Clinical practice guidelines for disease and chronic illness management recommended by the CCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated, and how consistency with other CCO services and covered benefits is assessed.
28. A list of physicians currently available for utilization consultation/review and their specialty.
29. A copy of the provider handbook or manual.
30. Sample provider contracts.
31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
 - a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
 - b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in Mississippi, so if the health plan in Mississippi is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling Mississippi data.)*
 - c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
 - d. A copy of the IT Disaster Recovery Plan.
 - e. A copy of the most recent disaster recovery or business continuity plan test results.
 - f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
 - g. A description of the data security policy with respect to email and PHI.
32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the CCO, and any reports of activities submitted by the subcontractor to the CCO.
33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.
34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All performance measures calculated and required to be reported to the state. Required data and information include the following:
 - a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen, and how the data was input), including a full description of the procedures;
 - b. reporting frequency and format;
 - c. specifications for all components used to identify the eligible population (e.g., member ID, age, gender, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member

- months/years calculation, other specified parameters);
- d. if non HEDIS, programming specifications that include data sources such as files/databases and fields with definitions, programming logic, and computer source codes;
- e. denominator calculations methodology, including:
 - 1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
 - 2) specifications for all components used to identify the population for the denominator;
- f. numerator calculations methodology, including:
 - 1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
 - 2) specifications for all components used to identify the population for the numerator;
- g. calculated and reported rates.

36. Provide electronic copies of the following files:

- a. Credentialing files (including signed Ownership Disclosure Forms) for:
 - i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
 - ii. Two OB/GYNs;
 - iii. Two specialists;
 - iv. Two network hospitals; and
 - v. One file for each additional type of facility in the network.
- b. Recredentialing (including signed Ownership Disclosure Forms) files for:
 - i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
 - ii. Two OB/GYNs;
 - iii. Two specialists;
 - iv. Two network hospitals; and
 - v. One file for each additional type of facility in the network.
- c. Forty medical necessity denial files made in the months of July 1, 2014 through June 30, 2015. Include any medical information and physician review documentation used in making the denial determination. Please include four behavioral health files. Also, include 10 additional pharmacy medical necessity denial files with five being antipsychotic medication.
- d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of July 1, 2014 through June 30, 2015, including any medical information and approval criteria used in the decision.

Note: Appeals, Grievances, and Care Management files will be selected from the logs received with the desk materials. The plan will then be requested to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at <https://www.thecarolinascenter.org/EQRFileTransfer/Default.aspx>**
- **should be submitted in the categories listed.**

Magnolia Health Plan

2015 External Quality Review

Attachment 2

Materials Requested for Onsite Review

Magnolia Health Plan

External Quality Review 2015

MATERIALS REQUESTED FOR ONSITE REVIEW

Items with an * should be provided as copies that can be retained by CCME. If possible, please provide these copies on a CD or flash drive.

1. *Copies of all committee minutes for committees that have met since the desk materials were copied.
2. *Please provide the following documents that were not received as part of the Credentialing Files:
 - a. Provider Office evaluations for all initial credentialing files as defined in policy MS.CONT.03, Site Assessments for New Provider Contracts
 - b. Liana Rodriguez, DO – Date approved by the credentialing committee
 - c. Jennifer Berger, MD – Date approved by the credentialing committee
 - d. Mary Watkins, NP – Work history (5 year) with justification for gaps
3. *Please provide the following document that was not received as part of the Organizational Credentialing Files:
 - a. Fresenius Medical Care – State license
4. *Please provide the following documents that were not received as part of the Recredentialing Files:
 - a. Date of approval by the Credentialing Committee for ALL recredentialing files
 - b. Kimberly Smash, MD – Hospital admitting privileges and/or attestation that another physician or group will admit members on PCP's behalf
 - c. Charles Haley, MD – proof of query for the Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)
 - d. Billy Parsons, MD – proof of query for the System for Award Management (SAM)
5. *Please provide the following documents that were not received as part of the Organizational Provider Recredentialing Files:
 - a. Baptist Memorial Women's Hospital – Ownership Disclosure form
 - b. Forest County General Hospital – Ownership Disclosure form
6. *Policy CC.UM.02.05, Interrater Reliability
7. *Letters/Notice of Action templates for denials of services and all letter templates related to appeals and grievances.
8. *Please include minutes from the UM Committee meetings for 3rd quarter of 2014, and 1st and 2nd quarters of 2015.

9. * Please provide copy of the Office Site Evaluation tool mentioned in policy MS.CONT.03, Site Assessments for New Provider Contracts.
10. * Provide a copy of the organizational chart for the credentialing department.
11. *Explanation for policies that were received in the previous EQR and not received in the desk materials for the current EQR. Examples are listed below. It also appears that some policies were renumbered:
 - a. CC.CRED.04 Initial Credentialing Process
 - b. CC.CRED.04.02 Provisional Credentialing
 - c. CC.CRED.03 Initial Credentialing Verification
 - d. CC.CRED.05 Initial Sanction Information
 - e. CC.CRED.07 Practitioner Recredentialing
12. *Copy of the Health Information Form sent to members.

Magnolia Health Plan

2015 External Quality Review

Attachment 3

EQR Validation Worksheets

Attachment 3

EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PIP/FS	ASTHMA
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	<i>Optional Activity 2 – Verify Study Findings was performed.</i>

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Study used a HEDIS® measure for its indicator.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measures processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	NOT MET	Although it is documented that the HEDIS Specifications for people with asthma are used to define the population, the population is identified as members 5-64 years old. There is no mention of them having asthma. RECOMMENDATION <i>Clearly define the relevant study population.</i>
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	The plan uses NCQA/HEDIS software to calculate their HEDIS measures. The relevant population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? (1)	MET	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was consistent and accurate.

6.5	Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was specified.
6.6	Were qualified staff and personnel used to collect the data? (5)	NA	Collection was through HEDIS software.
STEP 7: Assess Improvement Strategies			
Component / Standard (Total Score)		Score	Comments
7.1	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	NOT MET	<p>Most of the interventions documented are either not related to asthma (CHF is mentioned) or are directed at the member. This project is designed to increase rates of appropriately prescribed medication. Interventions focused on the member are most likely not going to increase appropriately prescribed medication.</p> <p>RECOMMENDATION <i>Implement interventions that will have an impact on the study question and the indicator for the project.</i></p>
STEP 8: Review Data Analysis and Interpretation of Study Results			
Component / Standard (Total Score)		Score	Comments
8.1	Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to the data analysis plan.
8.2	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Project results were presented clearly and accurately in the documentation.
8.3	Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	The plan is using initial and repeat measurements over time.
8.4	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Documentation includes interpretation of successes and barriers that continue.

STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	MET	The methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	Improvement has not been seen in the measure. RECOMMENDATION <i>Continue to improve interventions to help boost rates.</i>
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Not able to judge. No improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Not able to judge. No improvement.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Not able to judge. No improvement.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	MET	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	0	NA
Step 2			Step 7		
2.1	10	10	7.1	10	0
Step 3			Step 8		
3.1	10	10	8.1	5	5
3.2	1	1	8.2	10	10
Step 4			8.3	1	1
4.1	5	0	8.4	1	1
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	0	NA	9.2	1	0
5.2	0	NA	9.3	0	NA
5.3	0	NA	9.4	0	NA
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1	Activity 2		
6.3	1	1	Verify Findings	20	20

Project Score	84
Project Possible Score	100
Validation Findings	84%

CONFIDENCE

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. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PIP/FS	CONGESTIVE HEART FAILURE
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	<i>Optional Activity 2 – Verify Study Findings was performed.</i>

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	NOT MET	There does not appear to be a HEDIS measure as described in the documentation. In the 2015 HEDIS specs, there is not a numerator or denominator that matches the documentation. RECOMMENDATION <i>Clearly define the indicator being used.</i>
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicator measures processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	NOT MET	The study population is defined as members 18 years old and older, but there is no mention of them having congestive heart failure. RECOMMENDATION <i>Clearly define the relevant study population.</i>
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	The plan uses NCQA/HEDIS software to calculate their HEDIS measures. The relevant population was captured.

STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling was performed for this study.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	No sampling was performed for this study.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling was performed for this study.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? (1)	MET	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was consistent and accurate.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was specified.
6.6 Were qualified staff and personnel used to collect the data? (5)	NA	Collection was through HEDIS software.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	NOT MET	<p>Most of the interventions documented are either not related to congestive heart failure (diabetes and high blood pressure are mentioned) or are directed at the member. This project is designed to increase rates of appropriately prescribed medication. Interventions focused on the member are most likely not going to increase appropriately prescribed medication.</p> <p>RECOMMENDATION <i>Implement interventions that will have an impact on the study question and the indicator for the project.</i></p>
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	PARTIALLY MET	<p>The numerator and denominator do not give the rate documented for Remeasurement 2. Also, the wording for the remeasurements includes “at least 6 months of the appropriate medication.” This is not how the indicator is defined. It is not clear if a HEDIS measure is actually being used as identified.</p> <p>RECOMMENDATION <i>Be sure all data points are calculated correctly and measures are documented consistently.</i></p>
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	The plan is using initial and repeat measurements over time.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Documentation includes interpretation of successes and barriers that continue.

STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	MET	The methodology was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	Improvement has not been seen in the measure. RECOMMENDATION <i>Continue to improve interventions to help boost rates.</i>
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Not able to judge. No improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Not able to judge. No improvement.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Not able to judge. No improvement.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	MET	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	0	NA
Step 2			Step 7		
2.1	10	10	7.1	10	0
Step 3			Step 8		
3.1	10	0	8.1	5	5
3.2	1	1	8.2	10	5
Step 4			8.3	1	1
4.1	5	0	8.4	1	1
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	0	NA	9.2	1	0
5.2	0	NA	9.3	0	NA
5.3	0	NA	9.4	0	NA
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1	Activity 2		
6.3	1	1	Verify Findings	20	20

Project Score	69
Project Possible Score	100
Validation Findings	69%

LOW CONFIDENCE

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. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PIP/FS	DIABETES
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	<i>Optional Activity 2 – Verify Study Findings was performed.</i>

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	Study question was present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Study used HEDIS® measures for its indicators.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	NOT MET	The study population is defined as members 18-75 years old, but there is no mention of them having diabetes. RECOMMENDATION <i>Clearly define the relevant study population.</i>
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	MET	HEDIS hybrid methodology
5.3 Did the sample contain a sufficient number of enrollees? (5)	MET	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? (1)	MET	A data source was clearly specified in the documentation.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Study documentation specified a valid collection source for the project.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis was specified in the documentation.

<p>6.6 Were qualified staff and personnel used to collect the data? (5)</p>	<p>NOT MET</p>	<p>There is no documentation of the staff used by the plan for the record abstraction piece of the hybrid method.</p> <p>RECOMMENDATION <i>Clearly document the qualified staff and personnel used for the abstraction piece of data collection.</i></p>
<p>STEP 7: Assess Improvement Strategies</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)</p>	<p>NOT MET</p>	<p>Most of the interventions documented are either not related to diabetes (COPD and asthma are mentioned) or are directed at controlling diabetes. This project is designed to increase rates of certain screening tests. Interventions focused on the controlling diabetes are most likely not going to increase screening tests.</p> <p>RECOMMENDATION <i>Implement interventions that will have an impact on the study question and the indicator for the project.</i></p>
<p>STEP 8: Review Data Analysis and Interpretation of Study Results</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>8.1 Was an analysis of the findings performed according to the data analysis plan? (5)</p>	<p>MET</p>	<p>Analysis was performed according to the data analysis plan.</p>
<p>8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)</p>	<p>PARTIALLY MET</p>	<p>The numerator and denominator do not give the rate documented for Measure 2, Remeasurement 2. Also, for Remeasurement 2, the numerator and denominator for this measure are much larger than the other measures.</p> <p>RECOMMENDATION <i>Be sure all data points are calculated and documented correctly.</i></p>
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)</p>	<p>MET</p>	<p>The plan is using initial and repeat measurements over time.</p>

<p>8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)</p>	<p>NOT MET</p>	<p>Although there is documentation of an interpretation for Remeasurement 2, there is no information on Remeasurement 1.</p> <p>RECOMMENDATION <i>Include an interpretation of the successfulness and follow-up activities for each time period analyzed.</i></p>
<p>STEP 9: Assess Whether Improvement Is “Real” Improvement</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)</p>	<p>MET</p>	<p>The methodology was the same.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)</p>	<p>MET</p>	<p>Some improvement has been seen in the indicators.</p>
<p>9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)</p>	<p>MET</p>	<p>The reported improvement is deemed valid.</p>
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)</p>	<p>NOT MET</p>	<p>No statistical testing is reported in the results.</p> <p>RECOMMENDATION <i>Add statistical testing to the results to indicate if any improvement has statistical significance.</i></p>
<p>STEP 10: Assess Sustained Improvement</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)</p>	<p>NA</p>	<p>Not able to judge. Too early in project.</p>

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	MET	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	0
Step 2			Step 7		
2.1	10	10	7.1	10	0
Step 3			Step 8		
3.1	10	10	8.1	5	5
3.2	1	1	8.2	10	5
Step 4			8.3	1	1
4.1	5	0	8.4	1	0
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	5	5	9.2	1	1
5.2	10	10	9.3	5	5
5.3	5	5	9.4	1	0
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1	Activity 2		
6.3	1	1	Verify Findings	20	20
Project Score	104				
Project Possible Score	131				
Validation Findings	79%				

CONFIDENCE

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. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PIP/FS	HYPERTENSION
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	<i>Optional Activity 2 – Verify Study Findings was performed.</i>

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	PARTIALLY MET	<p>While a study question is present in the documentation, it appears to not address the actual focus of the study. Where the study question is stated as decreasing ER visits and inpatient stays and increasing primary care visits, the study appears to be measuring adequately controlled blood pressure. It is unclear whether looking solely at blood pressure alone would correlate with the study question.</p> <p>RECOMMENDATION <i>Revise study question to reflect the focus of the measurement.</i></p>
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	PARTIALLY MET	<p>Study used a HEDIS® measure for its indicator. However, there is documentation regarding the denominator of different age groups (18-85 years and 18-84 years).</p> <p>RECOMMENDATION <i>Clearly and consistently document the indicators being used.</i></p>
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure processes of care.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	NOT MET	The study population is defined as members 18-75 years old, but there is no mention of them having hypertension. RECOMMENDATION <i>Clearly define the relevant study population.</i>
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	MET	HEDIS Hybrid Methodology
5.3 Did the sample contain a sufficient number of enrollees? (5)	NOT MET	In the sampling techniques table, the sample size is documented as 100% with the population being 453, but in the sampling method column, the sample size is noted as being 453. The actual population is unclear. RECOMMENDATION <i>Clearly define the sample size and population being used for this project.</i>
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Data collected was specified clearly in the documentation.
6.2 Did the study design clearly specify the sources of data? (1)	MET	A data source was clearly specified in the documentation.

<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)</p>	<p>MET</p>	<p>Study documentation specified a valid collection source for the project.</p>
<p>6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)</p>	<p>MET</p>	<p>Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? (1)</p>	<p>MET</p>	<p>Data analysis was specified in the documentation.</p>
<p>6.6 Were qualified staff and personnel used to collect the data? (5)</p>	<p>NOT MET</p>	<p>There is no documentation of the staff used by the plan for the record abstraction piece of the hybrid method.</p> <p>RECOMMENDATION <i>Clearly document the qualified staff and personnel used for the abstraction piece of data collection.</i></p>

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)</p>	NOT MET	<p>Most of the interventions documented are not related to hypertension (CHF, COPD, and asthma are mentioned). A baby shower was documented for pregnant mothers, but they are excluded from this project per HEDIS Specifications. The indicator for this project is controlled blood pressure. Interventions not focused on this are most likely not going to increase rates.</p> <p>RECOMMENDATION <i>Implement interventions that will have an impact on the indicator for the project.</i></p>
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
<p>8.1 Was an analysis of the findings performed according to the data analysis plan? (5)</p>	NOT MET	<p>The analysis plan indicates that data will be analyzed monthly with a rolling 12-month report. There is no monthly analysis documented.</p> <p>RECOMMENDATION <i>Include monthly data points in analysis or remove this from the data analysis plan if it's not occurring.</i></p>
<p>8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)</p>	MET	The results are presented accurately.
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)</p>	MET	The plan is using initial and repeat measurements over time.

<p>8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)</p>	<p>NOT MET</p>	<p>Although there is documentation of an interpretation for Remeasurement 2, there is no information on Remeasurement 1.</p> <p>RECOMMENDATION <i>Include an interpretation of the successfulness and follow-up activities for each time period analyzed.</i></p>
<p>STEP 9: Assess Whether Improvement Is “Real” Improvement</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)</p>	<p>MET</p>	<p>The methodology was the same.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)</p>	<p>NOT MET</p>	<p>Improvement has not been seen in the measure.</p> <p>RECOMMENDATION <i>Continue to improve interventions to help boost rates.</i></p>
<p>9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)</p>	<p>NA</p>	<p>Not able to judge. No improvement.</p>
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)</p>	<p>NA</p>	<p>Not able to judge. No improvement.</p>
<p>STEP 10: Assess Sustained Improvement</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)</p>	<p>NA</p>	<p>Not able to judge. Too early in project.</p>

ACTIVITY 2

<p>VERIFYING STUDY FINDINGS</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>Were the initial study findings verified upon repeat measurement? (20)</p>	<p>MET</p>	<p>Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.</p>

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	0
Step 2			Step 7		
2.1	10	5	7.1	10	0
Step 3			Step 8		
3.1	10	5	8.1	5	0
3.2	1	1	8.2	10	10
Step 4			8.3	1	1
4.1	5	0	8.4	1	0
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	5	5	9.2	1	0
5.2	10	10	9.3	0	NA
5.3	5	0	9.4	0	NA
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1	Activity 2		
6.3	1	1	Verify Findings	20	20

Project Score	83
Project Possible Score	125
Validation Findings	66%

LOW CONFIDENCE

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. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PIP/FS	OBESITY
Validation Period	2015
Review Performed	9/2015
SPECIAL NOTE	<i>Optional Activity 2 – Verify Study Findings was performed.</i>

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on the health needs of the Mississippi community.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	Plan is addressing a broad spectrum of care through their PIPs.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	The plan is using approved HEDIS measures for tracking in this project. No relevant population was excluded.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	Study questions were present in the documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	PARTIALLY MET	For Study Indicator 2, the measure is defined as those with a visit, but the denominator is the number of members. RECOMMENDATION <i>Clearly define the indicators being used for this project.</i>
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure processes of care.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	The relevant HEDIS population is being used.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	The plan uses NCQA certified software to calculate their HEDIS measures. The relevant HEDIS population was captured.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	Plan used the hybrid HEDIS method for the measure calculation. Sampling was based on that methodology.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	MET	HEDIS Hybrid Methodology

<p>5.3 Did the sample contain a sufficient number of enrollees? (5)</p>	<p>NOT MET</p>	<p>In the sampling techniques table, the sample size is documented as 100% with the population being 419. It is unclear whether or not sampling is being used.</p> <p>RECOMMENDATION <i>If sampling is being used, clearly define the sample size and population being used for this project.</i></p>
<p>STEP 6: Review Data Collection Procedures</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>6.1 Did the study design clearly specify the data to be collected? (5)</p>	<p>MET</p>	<p>Data collected was specified clearly in the documentation.</p>
<p>6.2 Did the study design clearly specify the sources of data? (1)</p>	<p>MET</p>	<p>A data source was clearly specified in the documentation.</p>
<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)</p>	<p>MET</p>	<p>Study documentation specified a valid collection source for the project.</p>
<p>6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)</p>	<p>MET</p>	<p>Data collection was consistent and accurate. Plan used NCQA certified software for their hybrid data collection.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? (1)</p>	<p>MET</p>	<p>Data analysis was specified in the documentation.</p>
<p>6.6 Were qualified staff and personnel used to collect the data? (5)</p>	<p>NOT MET</p>	<p>There is no documentation of the staff used by the plan for the record abstraction piece of the hybrid method.</p> <p>RECOMMENDATION <i>Clearly document the qualified staff and personnel used for the abstraction piece of data collection.</i></p>

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)</p>	NOT MET	<p>Most of the interventions documented are either not related to obesity, focused on the member, or are directed at controlling obesity. This project is designed to increase rates of BMI and nutrition and physical activity documentation. Interventions focused on the member or controlling obesity are most likely not going to increase documentation. A baby shower was also documented for pregnant mothers, but they are excluded from this project per HEDIS Specifications.</p> <p>RECOMMENDATION <i>Implement interventions that will have an impact on the study question and the indicator for the project.</i></p>
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
<p>8.1 Was an analysis of the findings performed according to the data analysis plan? (5)</p>	MET	<p>Analysis was performed according to the data analysis plan.</p>
<p>8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)</p>	PARTIALLY MET	<p>The numerator and denominator do not give the rate documented for Measure 1 (Physical Activity), Remeasurement 2.</p> <p>RECOMMENDATION <i>Be sure all data points are calculated correctly.</i></p>
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)</p>	MET	<p>The plan is using initial and repeat measurements over time.</p>

<p>8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)</p>	<p>NOT MET</p>	<p>Although there is documentation of an interpretation for Remeasurement 2, there is no information on Remeasurement 1.</p> <p>RECOMMENDATION <i>Include an interpretation of the successfulness and follow-up activities for each time period analyzed.</i></p>
<p>STEP 9: Assess Whether Improvement Is “Real” Improvement</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)</p>	<p>MET</p>	<p>The methodology was the same.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)</p>	<p>MET</p>	<p>Some improvement has been seen in the indicators, although the goals are not being met.</p>
<p>9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)</p>	<p>MET</p>	<p>The reported improvement is deemed valid.</p>
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)</p>	<p>NOT MET</p>	<p>No statistical testing is reported in the results.</p> <p>RECOMMENDATION <i>Add statistical testing to the results to indicate if any improvement has statistical significance.</i></p>
<p>STEP 10: Assess Sustained Improvement</p>		
<p>Component / Standard (Total Score)</p>	<p>Score</p>	<p>Comments</p>
<p>10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)</p>	<p>NA</p>	<p>Not able to judge. No improvement.</p>

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	MET	Study uses HEDIS measures for the project and certified HEDIS software which ensures verified results for the measures.

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	0
Step 2			Step 7		
2.1	10	10	7.1	10	0
Step 3			Step 8		
3.1	10	5	8.1	5	5
3.2	1	1	8.2	10	5
Step 4			8.3	1	1
4.1	5	5	8.4	1	0
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	5	5	9.2	1	1
5.2	10	10	9.3	5	5
5.3	5	0	9.4	1	0
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1	Activity 2		
6.3	1	1	Verify Findings	20	20
Project Score	99				
Project Possible Score	131				
Validation Findings	76%				

CONFIDENCE

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. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

Attachment 3

EQR PM Validation Worksheets

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PM	HEDIS MEASURES
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2015

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Plan uses NCQA certified software, Quality Spectrum Insight, from Inovalon. Review requirements for documentation have been met.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Plan uses NCQA certified software, Quality Spectrum Insight, from Inovalon. Review requirements for documentation have been met.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software, Quality Spectrum Insight, from Inovalon. Review requirements for documentation have been met.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Plan uses NCQA certified software, Quality Spectrum Insight, from Inovalon. Review requirements for documentation have been met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software, Quality Spectrum Insight, from Inovalon. Review requirements for documentation have been met.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	No abstractions were performed.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	Not being done.
S2. Sampling	Sample treated all measures independently.	NA	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	Not being done.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	MET	Plan uses NCQA certified software, Quality Spectrum Insight, from Inovalon. Review requirements for documentation have been met.
R2. Reporting	Was the measure reported according to State specifications?	NA	State does not require any additional reporting requirements.

VALIDATION SUMMARY			
Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	50
Measure Weight Score	50
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PM	ASTHMA RELATED ER VISITS
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Denominator is adhering to the appropriate specifications dictated by the State.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	NOT MET	<p>The code is using any diagnosis that starts with 493. The State's specification document requires 493.0-2 and 493.9 be used. This could cause codes to be included that should not be counted in the numerator.</p> <p>The CPT codes listed in the specifications are only 99282, 99283, and 99285. The code provided is looking at codes 99281-99285, and so including additional codes into the calculation.</p> <p>RECOMMENDATION Fix source code to align with the State's specifications.</p>
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	Not being done.
S2. Sampling	Sample treated all measures independently.	NA	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	Not being done.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	NOT MET	The codes included in the numerator are incorrect which causes the incorrect results reported. RECOMMENDATION <i>Correct the issues with the numerator and recalculate measure.</i>
R2. Reporting	Was the measure reported according to State specifications?	MET	Measure was reported according to all State specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	40
Measure Weight Score	55
Validation Findings	73%

AUDIT DESIGNATION

Substantially Compliant

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PM	ASTHMA RELATED RE-ADMISSIONS
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	NOT MET	<p>The member month code is using the wrong CPT codes. CPT codes 99281-99285 are being used, instead of 99221-99223 and 99231-99233 as required by the specifications.</p> <p style="color: red;">RECOMMENDATION Check these issues and correct as necessary to comply with the measure specifications.</p>

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	NOT MET	The code includes all diagnoses starting with 493 instead of the 493.0-493.2 and 493.9 required by the specifications. Diagnoses may be included in the results that should not have been included. RECOMMENDATION <i>Correct the codes to comply with the measure specifications.</i>
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	No abstractions were performed.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	Not being done.
S2. Sampling	Sample treated all measures independently.	NA	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	Not being done.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	NOT MET	The reported results could be incorrect due to issues with the numerator and denominator. RECOMMENDATION <i>Correct the issues with the denominator and the numerator and recalculate the measure.</i>
R2. Reporting	Was the measure reported according to State specifications?	MET	Measure was reported according to all state specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	NOT MET	0
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	35
Measure Weight Score	55
Validation Findings	64%

AUDIT DESIGNATION

Not Valid

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PM	CONGESTIVE HEART FAILURE RE-HOSPITALIZATION
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	NOT MET	<p>The member month code is using the wrong set of CPT codes. CPT codes 99281-99285 are being used, instead of 99221-99223 and 99231-99233 as required by the specifications.</p> <p style="color: red;">RECOMMENDATION Check these issues and correct as necessary to comply with the measure specifications.</p>

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	NOT MET	The code is including all diagnoses starting with 428 instead of 428.0, 428.9, 428.1, and 428.40-428.42 as required by the specifications. It also excludes 440.9 and 402.91. RECOMMENDATION <i>Correct the codes to comply with the measure specifications.</i>
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	No abstractions were performed.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	Not being done.
S2. Sampling	Sample treated all measures independently.	NA	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	Not being done.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	NOT MET	The reported results could be incorrect due to the issues identified with the numerator and denominator. RECOMMENDATION <i>Correct the issues with the denominator and the numerator and recalculate the measure.</i>
R2. Reporting	Was the measure reported according to State specifications?	MET	Measure was reported according to all state specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	NOT MET	0
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	35
Measure Weight Score	55
Validation Findings	64%

AUDIT DESIGNATION

Not Valid

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Name of PM	PRE AND POST NATAL COMPLICATIONS
Reporting Year	2015
Review Performed	9/2015

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
MS Division of Medicaid

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Documentation is appropriate.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Denominator is adhering to the appropriate specifications dictated by the State.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Data sources, based on ISCA review, are complete and accurate.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	NOT MET	<p>There are missing and extraneous codes being pulled in the source code reviewed that are outside the state required specifications.</p> <p>The birth weight codes should only include : Very Low – 765.14, 765.15 Low – 765.16, 765.17, 765.18 Exceptionally Large – 766.0 (not found in source code at all) Large for gestational age – 766.1</p> <p>Prenatal complications should only be in the range of 640-649 BUT ONLY the .01 and .03 sub codes. (For example 640.01, 640.03, 640.81, 640.83, 640.91, 640.93, 641.01, 641.03 etc....).</p> <p>RECOMMENDATION <i>Remove extraneous codes outside the specifications and make sure specified codes are included in the source code. Correct issues where more specific ranges of codes are required by the source code (i.e. not just the first three digits of the code).</i></p>
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	No abstractions were performed.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	NA	Hybrid method not used.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	NA	Not being used.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	NA	Not being done.
S2. Sampling	Sample treated all measures independently.	NA	Not being done.
S3. Sampling	Sample size and replacement methodologies met specifications.	NA	Not being done.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	NOT MET	Major deviations from the specifications were found which call into question the accuracy of the reported rates. RECOMMENDATION <i>Correct the issues so that the measure complies with the State specifications and recalculate the measures.</i>
R2. Reporting	Was the measure reported according to State specifications?	MET	Measure was reported according to all State specifications.

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	NOT MET	0
N3	0	NA	NA
N4	0	NA	NA
N5	0	NA	NA
S1	0	NA	NA
S2	0	NA	NA
S3	0	NA	NA
R1	10	NOT MET	0
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	40
Measure Weight Score	55
Validation Findings	73%

AUDIT DESIGNATION

SUBSTANTIALLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES

Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Attachment 3

EQR Survey Validation Worksheets

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Survey Validated	CONSUMER SATISFACTION
Validation Period	2015
Review Performed	09/2015

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	-Uses CAHPS and its standardized purpose <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	-Uses CAHPS and its standardized objectives. <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	-Uses standard CAHPS for measurement and use <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT		
Survey Element	Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	MET -Uses standard CAHPS for measurement via a certified vendor <i>Documented:</i> -Survey version 5.0H for all surveys administrated -Vendor: The Myers Group
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	MET -Uses standard CAHPS for measurement via a certified vendor <i>Documented:</i> -Survey version 5.0H for all surveys administrated -Vendor: The Myers Group

ACTIVITY 3: REVIEW THE SAMPLING PLAN		
Survey Element	Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	MET -Uses standard CAHPS for measurement via a certified vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	MET -Uses standard CAHPS for measurement via a certified vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	MET -Uses standard CAHPS for measurement via a certified vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	MET -Uses standard CAHPS for measurement via a certified vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)

ACTIVITY 3: REVIEW THE SAMPLING PLAN		
Survey Element	Element Met / Not Met	Comments And Documentation
3.5	MET	<p>-Uses standard CAHPS for measurement via a certified vendor</p> <p><i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)</p>

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE		
Survey Element	Element Met / Not Met	Comments And Documentation
4.1	MET	<p>-Uses standard NCQA definition for response rate calculation by their certified vendor</p> <p><i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)</p>
4.2	NOT MET	<p>- The results met the minimum number of responses considered by NCQA 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.</p> <p>RECOMMENDATION <i>Focus on strategies that would help increase response rates for this population. Solicit the help of the survey vendor.</i></p> <p><i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)</p> <p>Response Rate (NCQA definition): Adult: $716 / 1724 = 41.5\%$ Child: 26.2% (total response rate numerator and denominator were not provided in results reports)</p>

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	-Uses standard CAHPS for measurement via a certified Vendor which uses the protocols established by NCQA in their <i>HEDIS 2014, Volume 3: Specifications for Survey Measures and Quality Assurance Plan for HEIDS 2014 Survey Measures</i> . <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
5.2	Did the implementation of the survey follow the planned approach?	MET	-Based on the timelines provided, the survey followed the planned approach. <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
5.3	Were confidentiality procedures followed?	MET	-Uses a NCQA certified CAHPS vendor who adheres to the approved confidentiality processes and procedures. <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	MET	-Uses standard CAHPS for measurement via a certified Vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)
6.2	Were appropriate statistical tests used and applied correctly?	MET	-Uses standard CAHPS for measurement via a certified Vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS			
Survey Element		Element Met / Not Met	Comments And Documentation
6.3	Were all survey conclusions supported by the data and analysis?	MET	-Uses standard CAHPS for measurement via a certified Vendor <i>Documented:</i> -CAHPS Executive Summary by Magnolia Health -2014 CAHPS Final Report by The Myers Group (adult and child versions)

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY		
Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	- The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - The Myers Group as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report. - Report includes trended results that allow analysis over time.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	- The response rate for the Medicaid Child population suffered from very low response rate. Response rate bias should be a concern. RECOMMENDATION <i>Focus on strategies that promote higher response rates for the Medicaid Child population.</i>

ACTIVITY 7: DOCUMENT THE EVALUTION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.4	<p>What conclusions are drawn from the survey data?</p>	<p>Based on the vendor and plan results summaries, the following areas scored the lowest ranking versus the 2013 Quality Compass® All Plan Comparisons.</p> <p>Medicaid Adult</p> <ul style="list-style-type: none"> - Getting Needed Care - Discussing Cessation Medications <p>- Statistical increases in performance over 2013 were noted in the following questions:</p> <ul style="list-style-type: none"> - Q14. Ease of getting care, tests, or treatment needed - Q17. Doctors explained things in an understandable way - Q18. Doctors listened carefully to you <p>Medicaid Child – General</p> <ul style="list-style-type: none"> - Getting Care Quickly - How Well Doctors Communicate - Ease of Filling Out Forms - Rating of Health Care - Rating of Health Plan <p>- Statistical increases in performance over 2013 were noted in the following questions:</p> <ul style="list-style-type: none"> - Q14. Rating of Health Care - Q54. Rating of Health Plan - Q20. Ease of getting special medical equipment or devices <p>Medicaid Child – CCC</p> <ul style="list-style-type: none"> - Getting Needed Care - How Well Doctors Communicate - Customer Service - Ease of Filling Out Forms - Rating of Health Care - Rating of Specialist - Rating of Health Plan - Access to Prescription Medicines - Access to Specialized Services - Getting Needed Information <p>- Statistical increases in performance over 2013 were noted in the following questions:</p> <ul style="list-style-type: none"> - Q4. Child obtained needed care right away <p>- Statistical decreases in performance over 2013 were noted in the following questions:</p> <ul style="list-style-type: none"> - Q12. Doctor/health provider talked about reasons you might not want your child to take a medicine
7.5	<p>Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).</p>	<p>This assessment is done in part by the survey vendor and summarized in the survey executive summary by Magnolia.</p>

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.6	Comparative information about all MCOs (as appropriate).	Not applicable.

CCME EQR SURVEY VALIDATION WORKSHEET

Plan Name	Magnolia Health Plan
Survey Validated	PROVIDER SATISFACTION
Validation Period	2015
Review Performed	09/2015
Review Instructions	
Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)	

ACTIVITY 1: REVIEW SURVEY PURPOSES(S), OBJECTIVE(S) AND INTENDED USE			
Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	- The survey purpose is clearly written in the report <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	- The survey objectives are clearly written in the report <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	- The survey intended use/audience is by the plan <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT			
Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	MET	- Survey instrument was administered by The Myers Group, an experienced survey company and approved/certified by CMS and NCQA to administer and analyze surveys. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group - The Myers Group website, 10/6/15

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT		
Survey Element	Element Met / Not Met	Comments And Documentation
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	MET - Survey instrument was administered by The Myers Group, an experienced survey company and approved/certified by CMS and NCQA to administer and analyze surveys. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group - The Myers Group website, 10/6/15

ACTIVITY 3: REVIEW THE SAMPLING PLAN		
Survey Element	Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	MET - Survey population was clearly identified in the survey results report. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	MET - Sample frame was clearly defined in the documentation. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group
3.3	Review that the sampling strategy (simple random, stratified random, non-probability) was appropriate.	NOT MET - Sampling strategy and process was not included in the documentation. RECOMMENDATION <i>Include in the survey documentation the sampling strategy used to create the sample for this survey. The documentation should include the type of sample drawn and the steps used to create the sample.</i>
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	NOT MET - Detailed information regarding the selection of the sample size was not in the documentation. RECOMMENDATION <i>Clearly document how the sample size was determined. Be sure to include the acceptable margin of error and the level of certainty that was used in the sample size calculation.</i>

ACTIVITY 3: REVIEW THE SAMPLING PLAN		
Survey Element	Element Met / Not Met	Comments And Documentation
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	<p>NOT MET</p> <p>- Sampling strategy and process was not included in the documentation.</p> <p>RECOMMENDATION <i>Clearly document in the survey documentation the sampling strategy used to create the sample for this survey. The documentation should include the type of sample drawn and the steps used to create the sample.</i></p>

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE		
Survey Element	Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	<p>MET</p> <p>- The response rate calculation was provided in the documentation and was appropriate.</p> <p><i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group</p>
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalize ability of survey findings.	<p>NOT MET</p> <p>- With the original sample having a low response rate, there is a strong possibility that a response bias exists in the results.</p> <p>RECOMMENDATION <i>Focus on strategies that would help increase response rates for the entire population. Solicit the help of your survey vendor.</i></p> <p><i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group</p> <p>Response Rate: Mail/Internet = 76 / 1372 = 5.5% Phone = 144 / 412 = 35.0%</p>

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION		
Survey Element	Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET - Survey instrument was administered by The Myers Group, an experienced survey company and approved/certified by CMS and NCQA to administer and analyze surveys. Their standard procedures were used for this survey. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group - The Myers Group website, 10/6/15
5.2	Did the implementation of the survey follow the planned approach?	MET - Based on the schedule provided, vendor met all timeline deliverables as planned. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group
5.3	Were confidentiality procedures followed?	MET - Survey instrument was administered by The Myers Group, an experienced survey company who is HIPAA compliant and has the URAC HIPAA Security Accreditation. Their standard procedures were used for this survey. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group - The Myers Group website, 10/6/15

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS		
Survey Element	Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	MET -Survey was analyzed by the vendor with those results summarized by the plan. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group
6.2	Were appropriate statistical tests used and applied correctly?	MET -Survey was analyzed by the vendor with those results summarized by the plan. <i>Documented:</i> - 2014 Provider Satisfaction Report by The Myers Group

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS		
Survey Element	Element Met / Not Met	Comments And Documentation
6.3	Were all survey conclusions supported by the data and analysis?	<p>MET</p> <p>- Survey conclusions were supported by the data and analysis presented.</p> <p><i>Documented:</i></p> <p>- 2014 Provider Satisfaction Report by The Myers Group</p>

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY		
Results Elements	Validation Comments And Conclusions	
7.1	Identify the technical strengths of the survey and its documentation.	- Survey was done by an experienced survey vendor that provided a complete analyze of the data collected through the survey.
7.2	Identify the technical weaknesses of the survey and its documentation.	<p>- Survey documentation was missing pieces of important documentation regarding sample size calculation and creation.</p> <p>RECOMMENDATION <i>Include these items in the survey summary document to complete the documentation.</i></p>
7.3	Do the survey findings have any limitations or problems with generalization of the results?	<p>- The response rate for the original provider sample suffered from a low response rate. Response rate bias should be a concern.</p> <p>RECOMMENDATION <i>Focus on strategies that promote higher response rates for the provider population.</i></p>
7.4	What conclusions are drawn from the survey data?	<p>-The following composite areas were identified as high priority area for Magnolia.</p> <ul style="list-style-type: none"> - Finance Issues - Pharmacy - Network/Coordination <p><i>Documented:</i></p> <p>- 2014 Provider Satisfaction Report by The Myers Group</p>
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	<p>- These assessment s are provided in the satisfaction report prepared by The Myers Group.</p> <p><i>Documented:</i></p> <p>- 2014 Provider Satisfaction Report by The Myers Group</p>
7.6	Comparative information about all MCOs (as appropriate).	Not applicable

Magnolia Health Plan

2015 External Quality Review

Attachment 4

Tabular Spreadsheet

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The CCO has in place policies and procedures that impact the quality of care provided to Members, both directly and indirectly.	X					Magnolia Health Plan has a comprehensive set of policies which are organized and for the most part appear to appropriately address state requirements. Some policies address Mississippi (MS) specific requirements through policy attachments. Policies are reviewed annually and accessible to all employees.
I B. Organizational Chart / Staffing						
1. The CCO's resources are sufficient to ensure that all health care products and services required by the State of Mississippi are provided to Members. At a minimum, this includes designated staff performing in the following roles:						
1.1 Full time Chief Executive Officer;	X					Christopher Bowers is the Senior Vice President of Health Plan Operations. Dr. Jason Dees serves as the Plan President and CEO. He is located in Mississippi and is responsible for the day-to-day administration of the Health Plan.
1.2 Chief Operations Officer;	X					Aaron Sisk is the VP of Operations.
1.3 Chief Financial Officer;	X					Trip Peebles is the VP of Finance.
1.4 Chief Information Officer: A professional who will oversee information technology and systems to support CCO operations, including submission of accurate and timely encounter data;	X					The Chief Information Officer, Keith Hibbard, is located at the Centene corporate office in St. Louis.
1.4.1 Information Systems personnel;	X					
1.5 Claims Administrator;	X					
1.6 Provider Services Manager;	X					The Provider Services department is now called Provider Engagement. Michael Ruffin was recently hired as the manager.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 Provider credentialing and education;	X					Provider credentialing is conducted through the Centene Corporate Credentialing department. Provider Relations is responsible for provider education.
1.7 Member Services Manager;	X					Lucretia Causey is the Member Services Manager.
1.7.1 Member services and education;	X					Several departments such as Medical Management, Call Center, and Marketing assist with member education.
1.8 Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals;	X					Grievance and Appeals coordinators housed in the Quality department assist with complaints, grievances, and appeals.
1.9 Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions;	X					Andrea Thomas serves as UM Coordinator and reports to Paula Whitfield, VP of Medical Management.
1.9.1 Medical/Care Management Staff	X					
1.10 Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities;	X					Carrie Mitchell is the Director of Quality Management.
1.11 Marketing and/or Public Relations;	X					
1.12 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;	X					The Chief Medical Director is Dr. Rebecca Waterer who reports directly to the CEO and is responsible for pharmacy services, oversight of clinical operations, and development of medical policy. She chairs multiple committees including P&T, QIC, Credentialing, and UM. She is supported by Dr. Jeremy Erwin serving as Medical Director.
1.13 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.	X					Terrica Miller is the Compliance Officer and chair of the Compliance Committee. The committee meets quarterly and a quorum is met with 50 percent of voting members present. Committee minutes reflect fair attendance by committee members. The Compliance Committee reports all actions to Centene's Compliance Officer. Magnolia has developed a Compliance Plan and policies to ensure processes are in place to implement

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and ensure compliance at every level.
2. Operational relationships of CCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions.	X					
4. A professionally staffed all service/ Helpline/ Nurse Line which operates 24 hours per day, 7 days per week.	X					Magnolia’s members have access to NurseWise, a free health hotline available 24 hours a day, every day, via a toll-free phone number. NurseWise is staffed with registered nurses.
5. The CCO maintains a toll-free dedicated Member Services and Provider Services call center to respond to inquiries, issues, or referrals.	X					
5.1 Call Center scripts are in-place and staff receives training as required by the contract.	X					Call center scripts were provided in the desk materials. According to the new hire training agenda, call script education occurs on day four of training.
5.2 Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee.	X					Call center statistics are monitored on a monthly basis. Ongoing training ensures contract standards are met or exceeded. The call center data located in the annual QI evaluation documents overall consistency in meeting the standards for average speed to answer, call abandonment rate, and service level.
I C. Management Information Systems						
1. The CCO processes provider claims in an accurate and timely fashion.	X					Magnolia has adequate systems and guidelines in place to ensure not only that the benchmarks are met, but also that the metrics are monitored to ensure compliance. Production standards are also monitored by Claims Operations Management on a daily and monthly basis to ensure compliance to the required standards.
2. The CCO tracks enrollment and demographic data and links it to the provider base.	X					Magnolia continues to do extensive analysis of the demographics and enrollment of their members. Membership is tracked and compared against their provider database to ensure that they are providing adequate coverage.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities.	X					
4. The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Magnolia has a comprehensive business continuity plan in place that seems to cover most disaster scenarios. The plan has been tested and updated. Magnolia tests regularly and does an excellent job of laying out the test parameters. The 2015 exercise was to demonstrate the proficiency in recovery capabilities using acquired technologies. Testing also included the corporate employee notification tool, Notifind, which is a cloud-based tool that provides communication using a variety of channels (phone, text, and email) to advise employees and stakeholders of a crisis or unplanned event. Magnolia also introduced a new component to their infrastructure recovery for Oracle Exadata.
I D. Confidentiality						
1. The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.		X				Magnolia Health Plan has a comprehensive Business Ethics and Conduct policy and several additional policies which address confidentiality and handling of protected health information. Members are provided the Notice Of Privacy Practices in the Member Handbook and on the website. The 2014 Annual Quality Improvement Program Evaluation (page 88) states the Compliance Officer performs HIPAA desk audits to determine compliance with Magnolia’s policies for protecting PHI. The compliance goal is listed as 90 percent and onsite discussion revealed this is a corporate goal. However, unauthorized disclosure of Protected Health Information (PHI) is strictly prohibited under HIPAA laws and in Magnolia’s policies. Setting the goal at only 90 percent allows for the potential of unauthorized disclosure of PHI. This goal should be

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						set at 100 percent. <i>Corrective Action: The compliance goal for the HIPAA desk audits for potential unauthorized disclosure of PHI should be 100 percent.</i>
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. 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.		X				Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, defines the Centene Corporate Credentialing Program adopted by Magnolia. Additional policies address credentialing/ recredentialing and attachments to the policies state MS specific requirements. Policy CC.CRED.01 has the disclosure of ownership form listed as exceptions in cases of recredentialing and the Unique Requirements for Credentialing (Attachment B) document does not specify for MS that the disclosure of ownership form is required at recredentialing. Onsite discussion confirmed that Magnolia has not been collecting the disclosure of ownership form at recredentialing. <i>Corrective Action: Update policy CC.CRED.01 to reflect that ownership disclosure forms are required to be collected at credentialing and recredentialing for MS.</i>
2. 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.		X				The Credentialing Committee is chaired by Dr. Becky Waterer, Chief Medical Director. Voting members of the committee include the Chief Executive Officer, Medical Director (Dr. Erwin), Director of QI, Manager of QI, credentialing designee, and four network providers with the specialties of pediatrics, family medicine, and nurse practitioner. A committee charter and policy CC.CRED.03 (Credentialing Committee) states the committee meets monthly (no less than 10

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>times per year) and a quorum is met with 50 percent of voting members.</p> <p>It was difficult to determine from the Credentialing Committee minutes who had voting privileges. The committee charter does not specify who has voting privileges and there was inconsistent information between the list of committee members and what the charter specified as the committee membership. For example, the list of committee members showed the Director QI, Manager QI, and a credentialing position as committee members with voting privileges; however, these positions were not mentioned in the charter as positions for the committee composition. Several meetings appeared to not have met the quorum requirement.</p> <p><i>Corrective Action: Update the Credentialing Committee Charter and the list of committee members to be consistent for committee membership and to define who has voting privileges. Include in the Credentialing Committee minutes the voting members present/absent and if a quorum has been met for the meeting.</i></p>
3. The credentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Credentialing files reviewed were organized and contained appropriate documentation.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat Members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.5 Malpractice claims history;	X					
3.1.6 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;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of the System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
3.1.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.12 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.	X					
3.1.13 Ownership Disclosure Form.	X					
3.2 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.		X				Policy MS.CONT.03, Site Assessment for New Provider Contracts, states that Magnolia conducts an initial visit to the office of all new potential primary care practitioners, obstetricians/gynecologists, and all high volume specialists prior to making the credentialing decision for that provider. High volume

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>specialists are defined as general surgeons, orthopedic surgeons, cardiologists, interventional cardiologists, neurologists, gastroenterologists, dermatologists, podiatrists, and newly designated Rural Health Centers (RHCs). The plan may also assess appointment availability and medical/treatment record keeping practices at each site to determine if they meet Plan, state, and accreditation standards. For sites that do not meet an overall minimum score of 80 percent, follow-up action plans are developed and revisits are scheduled at least every six months until performance standards have been met.</p> <p>The Magnolia Site Review Tool received in the onsite materials showed the following incorrect appointment timeframes:</p> <ul style="list-style-type: none"> •For a complete physical/preventive health exam or routine, non-symptomatic visit, it states within 45 calendar days when appointment criteria should be 30 calendar days. •For a routine, non-urgent symptomatic visit, it states within 10 calendar days when appointment criteria for a routine sick visit should be seven calendar days. <p><i>Corrective Action: Update the Magnolia Site Review Tool to reflect the correct appointment criteria.</i></p>
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the CCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat Members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery the System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event (Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE));	X					
4.2.10 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.	X					
4.2.11 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
4.2.12 Ownership Disclosure form.			X			<p>Recredentialing files reviewed did not contain evidence of the ownership disclosure forms. Onsite discussion revealed that Magnolia was not collecting the information at recredentialing. This was an issue in the previous EQR.</p> <p><i>Corrective Action: Ownership disclosure forms should be collected at recredentialing. In addition, Magnolia needs to put a process in place to collect ownership disclosure forms for providers that have already been recredentialled.</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 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.	X					Policy MS.CONT.03, Site Assessment for New Provider Contracts, states that Magnolia monitors deficiencies related to a practitioner’s office by monitoring member complaints/grievances and/or member survey information. Upon identification of complaints related to quality of a practitioner’s office site, Provider Relations performs an onsite visit within 45 days of identification that the complaint threshold has been met. Sites must receive a passing score of greater than 80 percent in any category. Otherwise, a CAP will be presented to the office and is to be fully implemented within six months of the initial visit. Plan staff revisits the site at least every six months until the performance standards have been met, or until the Credentialing Committee recommends terminating the provider, if applicable.
4.4 Review of practitioner profiling activities.	X					Policy MS.QI.23, Provider Profiling Program, states that Magnolia develops, implements, monitors, and distributes provider profiling reports to providers. The policy states that Magnolia has developed a provider profiling report which identifies member utilization of selected services by the provider. Annually, the Quality Improvement Committee (QIC) and Provider Advisory Committee (PAC) assist in establishing provider performance goals and improvement benchmarks for each HEDIS or non-HEDIS measure. The provider profiles may be distributed to providers electronically, by traditional mail, or in-person. Provider Relations (PR) Specialists schedule face-to-face meetings with providers when under-performance or outliers are discovered. A qualified clinical designee—such as the Medical Director or Quality Improvement Coordinator—will then meet with the provider to discuss the profile results, identify any barriers to performance, and determine what intervention is necessary for performance improvement. Onsite discussion revealed that Magnolia is in the

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process of finalizing a scorecard to send to PCP and OB/GYN providers. Magnolia had to restructure the profiling reports mentioned in the previous EQR and is now just finishing the process. An example was received onsite and the plan will be sending it out very soon.
5. 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.	X					<p>Policy MS.QI.18, Quality of Care Investigations, states that potential quality of care issues will be routed to the QI department for investigation. The policy describes the process for determining severity levels and review by the Medical Director and Peer Review Committee. If a practitioner's network participation is to be suspended or terminated for reasons relating to the practitioner's competence or professional conduct, appropriate authorities will be notified. The number and severity level of quality of care investigations may be used by the Credentialing Committee at the time of physician recredentialing.</p> <p>Policy CC.CRED.08, Practitioner Appeal Hearing Process, describes the appeal process for practitioners when the Credentialing Committee recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to the competence or professional conduct of the practitioner.</p>
6. Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities.			X			<p>Policy CC.CRED.09, Organizational Assessment and Reassessment, defines the credentialing/ recredentialing guidelines for organizational providers. Recredentialing files for organizational providers did not contain ownership disclosure forms. Onsite discussion confirmed that Magnolia was not collecting the ownership disclosure forms at recredentialing.</p> <p><i>Corrective Action: Ownership disclosure forms should be collected at recredentialing. In addition, Magnolia needs to put a process in place to collect ownership disclosure forms for providers that have already been recredentialed.</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II B. Adequacy of the Provider Network						
1. The CCO maintains a network of providers that is sufficient to meet the health care needs of Members and is consistent with contract requirements.						
1.1 The CCO has policies and procedures for notifying primary care providers of the Members assigned.	X					Policy MS.PRVR.09, Verification of Member Eligibility, states that within five business days of receipt of enrollment from DOM, Magnolia will ensure all updates to the PCP Panel/Patient List will be available for eligibility verification via the Secure Provider Portal located on the website.
1.2 The CCO has policies and procedures to ensure out-of-network providers can verify enrollment.	X					Policy MS.PRVR.09, Verification of Member Eligibility, states that providers can access the PCP Panel/Patient List for eligibility verification via the Secure Provider Portal located on the website. All providers may also call the toll-free telephone number printed on the member's ID card and utilize the interactive voice response (IVR) system 24 hours per day/seven days per week. Providers may also utilize the secure provider portal on the website.
1.3 The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients.	X					The online Provider Directory has a search option for selecting providers that are accepting new patients.
1.4 Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties.		X				Policies MS.CONT.01, Provider Network, and MS.QI.04, Evaluation of Practitioner Availability, define the geographic definitions that comply with contract requirements. GEO access reports received match defined parameters that comply with the <i>DOM Contract</i> . However, the Practitioner Availability Analysis report (July 1, 2014 to June 30, 2015) received after the onsite, utilized access standards of one PCP within 30 miles urban/one PCP within 60 miles for rural areas. These standards do not comply with current contract requirements of two PCPs within 15 miles for urban and 30 miles for rural. Inconsistencies were noted between the two aforementioned policies. Policy MS.CONT.01 states that Magnolia maintains a PCP-to-member ratio of

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>1:2500 but policy MS.QI.04 states all PCP types combined is two per 2500. Also, policy MS.CONT.01 mentions network adequacy standards for Federally Qualified Health Centers (FQHCs) and RHCs and the information is not mentioned in policy MS.QI.04.</p> <p><i>Corrective Action: Ensure the correct access standard parameters are used for the Practitioner Availability Analysis report and address inconsistencies between policies MS.CONT.01, Provider Network, and MS.QI.04, Evaluation of Practitioner Availability.</i></p>
1.5 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.	X					
1.6 The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly.	X					Policy MS.QI.04, Evaluation of Practitioner Availability, states practitioner type and availability is measured quarterly by the Magnolia Provider Relations and Network Development and Contracting Departments.
1.7 Providers are available who can serve Members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					<p>Policy MS.QI.04, Evaluation of Practitioner Availability, states that Magnolia assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts practitioner availability within its network. Activities include collecting cultural, ethnic, racial and linguistic data about practitioners on a voluntary basis during the credentialing process and ongoing during meetings with the practitioner; and facilitating connecting members with practitioners who can meet members' needs.</p> <p>Policy MS.QI.22, Cultural Competency, defines guidelines for how Magnolia meets the cultural competency needs of members. The Cultural Competency Plan, attached to the policy, is reviewed annually and Magnolia has adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards as developed by the Department of Health and Human</p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services, Office of Minority Health, as their official guidelines for providing culturally sensitive services. Policy MS.MBRS.03, Hearing-Impaired/Language-Specific Interpreter Services, defines the availability for free access to interpreter services for members.
1.8 The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 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.		X				<p>Policies MS.PRVR.10, Evaluation of the Accessibility of Services, and MS.QI.05, Evaluation of the Accessibility of Services, address appointment criteria. However, the policies do not address all appointment criteria that are defined in the <i>DOM Contract, Section 7 (B)</i>. Information regarding behavioral health and dental providers appears to not be addressed.</p> <p>The dental and behavioral health appointment access standards are addressed in the Provider Manual (page 20) and in a document on the website called, "Appointment & Access Requirements"; however, inconsistencies were identified as follows:</p> <ul style="list-style-type: none"> •The website states within 21 calendar days for behavioral health routine care. The Provider Manual states within 10 working days (14 calendar days). •The Provider Manual states behavioral health non-life-threatening emergencies within six hours and this is not mentioned in the website document. <p><i>Corrective Action: Update policies MS.PRVR.10, Evaluation of the Accessibility of Services, and MS.QI.05, Evaluation of the Accessibility of Services, to address all appointment criteria required by the DOM Contract. Update the Provider Manual and the Appointment & Access Requirements website document to contain consistent appointment criteria requirements.</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			<p>Results of the Provider Access and Availability Study conducted by CCME continued to be low in the areas of calls being answered successfully by personnel at the correct practice (54%). When compared to last year's results of 57%, this year's study proportion did fall from the previous measure, but statistically it was unchanged. So in both actual terms and statistically, no improvement was seen.</p> <p>For those not answered successfully, 17% of the time the physician was not at the practice or phone number listed.</p> <p>It appears that Magnolia members may not be receiving correct provider information so there could be an access problem.</p> <p><i>Corrective Action: Implement interventions to address the member access issues identified in the Provider Access and Availability Study conducted by CCME.</i></p>
II C. Provider Education						
1. The CCO formulates and acts within policies and procedures related to initial education of providers.	X					<p>Policy CC.PRVR.13, Provider Orientations, states that newly contracted providers receive an orientation within 30 days of execution of a new provider contract. The provider portal on the website has a provider training section that includes training videos for areas such as provider orientation 2015, web portal training, contracting and credentialing, EPSDT training, etc. Additional resource information is provided on the website such as adopted clinical practice guidelines, manuals & reference guides, information on pharmacy, claims, etc.</p> <p>Policy CC.PRVR.02, Provider Manual, states the</p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>Provider Manual serves as a source of information regarding health plan covered services, policies and procedures, statutes, regulations, telephone access, and special requirements to ensure all contract requirements are met. The Provider Manual is referenced during the orientation visits performed by the Provider Relations department. Providers are advised that the Provider Manual is posted on the health plan website or available hardcopy upon request by the provider.</p> <p>Policy MS.PRVR.03, Toll-free Provider Telephone Hotline, defines the provider services call center functions, including response standards, call tracking and inquiry resolution.</p>
2. Initial provider education includes:						The Provider Manual has detailed information and for the most part addresses contract requirements. One issue was identified that is explained below.
2.1 A description of the Care Management system and protocols;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM;	X					
2.4 Procedure for referral to a specialist including standing referrals and specialists as PCPs;	X					
2.5 Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments;	X					
2.6 Recommended standards of care including EPSDT screening requirements and services;	X					
2.7 Responsibility to follow-up with Members who are non-compliant with EPSDT screenings and services;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Medical record handling, availability, retention and confidentiality;	X					
2.9 Provider and Member complaint, grievance, and appeal procedures including provider disputes;	X					
2.10 Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete;	X					
2.11 Prior authorization requirements including the definition of medically necessary;	X					
2.12 A description of the role of a PCP and the reassignment of a Member to another PCP;		X				The role of the PCP is stated; however, the reassignment of a member to another PCP could not be found as being addressed in the Provider Manual. <i>Corrective Action: Update the Provider Manual to include instructions for the reassignment of a member to another PCP.</i>
2.13 The process for communicating the provider's limitations on panel size to the CCO;	X					
2.14 Medical record documentation requirements;	X					
2.15 Information regarding available translation services and how to access those services;	X					
2.16 Provider performance expectations including quality and utilization management criteria and processes;	X					
2.17 A description of the provider web portal;	X					
2.18 A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business.	X					
3. The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements.	X					Policy MS.PRVR.19, Provider Directory, states web-based data is refreshed nightly from the Enterprise Data Warehouse (EDW) system to keep all information current. Provider Directory data is sourced from the Plan credentialing system in a live feed

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providing immediate updates. Hard copy Provider Directories are updated annually or more often if there are significant network changes.
4. The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, Member benefits, standards, policies, and procedures.	X					Policy MS.PRVR.14 Provider Visit Schedule, states that Magnolia establishes regularly scheduled meetings with in-network providers based on assignment and Plan initiatives as needed. The meetings occur in the provider office and are conducted by the health plan representative. Monthly meetings are scheduled for VIP providers and other providers are scheduled as needed. The website provider portal contains an "Important Notification" section where announcements and notifications are available to providers.
II D. Primary and Secondary Preventive Health Guidelines						
1. 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.	X					Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, states that whenever possible, Magnolia will adopt preventive and clinical practice guidelines (CPG) from recognized sources for the provision of acute, preventive, and chronic care services relevant to the populations served. Guidelines are presented to the Quality Improvement Committee (QIC) for appropriate physician review and adoption. Guidelines will be updated upon significant new scientific evidence or change in national standards, or at a minimum reviewed at least every two years.
2. The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO Members to providers.	X					The new provider orientation presentation informs providers that they can find the preventive guidelines on the Magnolia website. The preventive guidelines are also listed in the Provider Manual.
3. The preventive health guidelines include, at a minimum, the following if relevant to Member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to Member high-risk groups.	X					
3.7 Behavioral Health	X					
4. The CCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. 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.	X					<p>Policy MS.QI.08, Preventive Health and Clinical Practice Guidelines, states that Magnolia adopts/develops and distributes preventive health and clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. Guidelines are presented to the QIC for appropriate physician review and adoption. The guidelines are reviewed at a minimum of every two years or upon significant new scientific evidence or change in national standards.</p> <p>Policy CQI.129, Clinical Practice Guidelines, states that Cenpatico adopts/develops and distributes evidence based practice guidelines to help providers make decisions about appropriate health care for specific clinical circumstances. All guidelines are reviewed and updated by the QIC upon significant new scientific evidence, change in national standards, or at a minimum of every two years.</p>
2. 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.	X					The new provider orientation presentation informs providers that they can find the clinical practice guidelines on the Magnolia website. The clinical practice guidelines are also listed in the Provider

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Manual. Cenpatico disseminates approved clinical practice guidelines to the practitioner network and enrollees through a variety of channels, including but not limited to, mail, FAX, Provider Manual/Newsletter, Cenpatico website, web-links, and by individual request.
3. 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.		X				Policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines, states that Magnolia, on an annual basis, shall measure provider performance against at least <u>two</u> of the clinical guidelines. On the same page, it also states that at least annually, Magnolia measures practitioner compliance with at least <u>four</u> CPGs; two of the selected CPGs must be in regard to behavioral health and may be done in conjunction with the delegated vendor as applicable. At least one of the CPGs selected for annual evaluation will be related to a DOM performance measure. Whenever possible, Magnolia will use applicable HEDIS measures to monitor practitioner compliance with an adopted CPG. For the analysis related to the DOM performance measure, non-HEDIS data will be used to monitor practitioner compliance with the adopted CPG. <i>Corrective Action: Correct policy MS.QI.08.01, Practitioner Adherence to Clinical Practice Guidelines, to reflect the correct number of clinical practice guidelines that Magnolia measures on an annual basis.</i>
II F. Continuity of Care						
1. The CCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy MS.QI.09, Continuity & Coordination of Medical Care, states that Magnolia has a systematic method for detecting problems in continuity and coordination of care between PCPs and other providers. This may include reviewing complaints/grievances; conducting PCP office record

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review; assessing the effectiveness of discharge planning via member survey and medical record review; assessing the quality of the information exchange between medical providers, including the protection of privacy through medical record review; and survey of PCPs to assess their satisfaction with feedback from referred providers, including behavioral health, medical/surgical specialists, and other organizational providers.
II G. Practitioner Medical Records						
1. The CCO formulates policies and procedures outlining standards for acceptable documentation in the Member medical records maintained by primary care physicians.	X					Policy MS.QI.13, Medical Record Review, outline the process by which Magnolia monitors its practitioners for maintenance of medical records in a current, detailed, and organized manner and which permits effective and confidential patient care and quality review. The policy defines minimum standards for practitioner medical record keeping practices which include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information and are outlined in the Provider Manual.
2. Medical Record Audit						
2.1 The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Policy MS.QI.13, Medical Record Review, states Magnolia will assess network medical record keeping practices against the established standards at least annually. Physicians sampled must meet 80% of the requirements for medical record keeping or be subject to corrective action. The Provider Manual states that Magnolia will conduct random medical record audits as part of its QI program to monitor compliance with the medical record documentation standards. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services, also may be assessed during a medical record audit.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. 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.	X					
II H. Provider Satisfaction Survey						
1. A provider satisfaction survey was performed and met all requirements of the CMS Survey Validation Protocol.			X			Magnolia Health Plan performed a provider satisfaction survey administered by The Myers Group (TMG), a survey vendor. As a part of this EQR, this survey was validated using the EQR Protocol 5, Validation and Implementation of Surveys (<i>version 2.0, September 2012</i>). The survey did not meet the CMS protocol requirements. For the provider satisfaction survey, low response rates could bias results. The full validation results are documented on the CCME EQR Survey Validation Worksheets located in <i>Attachment 3</i> of this report. <i>Corrective Action: Implement interventions to increase the response rate in the provider satisfaction survey and improve survey documentation.</i>
2. The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems.	X					
3. 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.			X			Committee minutes reflecting where the provider satisfaction survey results were discussed could not be found. <i>Corrective Action: Report provider satisfaction survey results to the appropriate committee.</i>
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The CCO formulates and implements policies outlining Member rights and responsibilities and procedures for informing Members of these rights and responsibilities.	X					Policy MS.MBRS.25, Member Rights and Responsibilities, defines rights afforded to members.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Member rights include, but are not limited to, the right:		X				Member rights are documented in policy MS.MBRS.25, Member Rights and Responsibilities, the Member Handbook, the Provider Manual, and on the Magnolia website; however, a few issues were noted and are addressed in the individual standards below.
2.1 To be treated with respect and dignity;						
2.2 To privacy and confidentiality, both in their person and in their medical information;						
2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;						
2.4 To participate in decisions regarding his or her health care, including the right to refuse treatment;						
2.5 To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;						Not addressed in policy MS.MBRS.25, Member Rights and Responsibilities. <i>Corrective Action: Include the right to receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition in policy MS.MBRS.25.</i>
2.6 To voice complaints/grievances about the CCO or about the medical care and/or services they receive;						Not addressed in policy MS.MBRS.25, Member Rights and Responsibilities. <i>Corrective Action: Include the right to voice complaints/grievances about the CCO or about the medical care and/or services they receive in policy MS.MBRS.25.</i>
2.7 To appeal decisions adversely affecting coverage, benefits, services, or their relationship with the CCO;						Not addressed in policy MS.MBRS.25, Member Rights and Responsibilities. <i>Corrective Action: Include the right to appeal decisions adversely affecting coverage, benefits,</i>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>services, or their relationship with the CCO in policy MS.MBRS.25.</i>
2.8 To formulate advance directives;						
2.9 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.10 To receive information in accordance with 42 CFR §438.10 which includes oral interpretation services free of charge and be notified that oral interpretation is available and how to access those services;						
2.11 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with federal regulations;						
2.12 To have free exercise of rights and that the exercise of those rights does not adversely affect the way the CCO and its providers treat the Member.						Page 50 of the 2015 Member Handbook and the revised Member Handbook states, “Magnolia will not hold it against you or treat you differently if you file a grievance.” However, there is no overall statement that members may exercise <u>their rights</u> with no fear of adverse treatment or retaliation. <i>Corrective Action: Update the Member Handbook to indicate the members have the right to exercise their rights freely with no fear of adverse treatment by Magnolia or their providers.</i>
2.13 To be furnished with health care services in accordance with 42 CFR § 438.206 – 438.210.						
3. Member Responsibilities include the responsibility;		X				Member responsibilities are documented in policy MS.MBRS.25, Member Rights and Responsibilities, the Member Handbook, the Provider Manual, and on the Magnolia website. Issues with documentation of member responsibilities are addressed in the individual standards below.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 To pay for unauthorized health care services obtained from outside providers and to know the procedures for obtaining authorization for such services;						
3.2 To cooperate with those providing health care services by supplying information essential to the rendition of optimal care;						
3.3 To follow instructions and guidelines for care the Member has agreed upon with those providing health care services;						
3.4 To show courtesy and respect to providers and staff.						
3.5 To inform the CCO of changes in family size, address changes, or other health care coverage.						Not addressed in policy MS.MBRS.25, Member Rights and Responsibilities. <i>Corrective Action: Update policy MS.MBRS.25 to include the member responsibility to inform Magnolia of changes in family size, address changes, or other health care coverage.</i>
III B. Member CCO Program Education						
1. 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, including:		X				Policy MS.MBRS.01, New Member Packet/Member ID Card, states that prior to the first day of the month in which enrollment starts, and no later than 14 days after receiving notice of the member's enrollment, a new member packet will be mailed. The packet contains contractually required components including an introduction letter, identification card, information about how to obtain a Provider Directory, and a Member Handbook. Issues identified with member education are addressed in the individual standards below.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include direct access for female Members to a women's health specialist in addition to a PCP;						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Benefits include access to 2 nd opinions at no cost including use of an out-of-network provider if necessary;						
1.2 Limits of coverage, maximum allowable benefits and claim submission procedures; including that no cost is passed on to the Member for out-of-network services;						
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.6 Policies and procedures for accessing specialty/referral care;						
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						
1.8 Policies and procedures for notifying Members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						<p>Page 28 of the 2015 Member Handbook states Magnolia will send a notice to members at least 15 days before their provider leaves the network.</p> <p>Page three of the 2015 Member Handbook states, “The practices, policies, and benefits described herein may be modified or discontinued from time to time. Every attempt will be made to inform you of any changes as they occur. Please visit www.MagnoliaHealthPlan.com, or call 1-866-912-6285, for the most up-to-date information.” An identical statement is found in the revised Member Handbook.</p> <p><i>Recommendation: Update the Member Handbook to include the timeframe for, and method of, member notification of changes to services and benefits.</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 A description of the Member's identification card and how to use the card;						
1.10 Primary care provider's role and responsibilities, procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedure for making appointments and information regarding provider access standards;						
1.12 A description of the functions of the CCO's Member Services department, the CCO's call center, the nurse advice line, and the Member portal;						
1.13 A description of the EPSDT services;						
1.14 Procedures for disenrolling from the CCO;						Per the <i>DOM Contract, Section 4 (G)</i> , requests for disenrollment may be made <u>orally or in writing</u> . The 2015 Member Handbook, page 13, and the revised Member Handbook, "Members' requests for disenrollment must be directed to DOM <u>in writing</u> ." <i>Corrective Action: Correct the Member Handbook to indicate that member requests for disenrollment may be made orally or in writing.</i>
1.15 Procedures for filing complaints/grievances and appeals, including the right to request a Fair Hearing through DOM;						
1.16 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care, and of alternate languages spoken by the provider's office;						
1.17 Instructions on reporting suspected cases of Fraud and Abuse;						The Member Handbook instructs to call Member Services, the Compliance department (phone number given), or the compliance hotline (phone number given).
1.18 Information regarding the Care Management Program and how to contact the Care Management Team;						
1.19 Information on advance directives;						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.20 Additional information as required by the contract and by federal regulation.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					<p>Policy MS.MBRS.12, Member Notification of Plan Changes, defines how and when members are notified of benefit changes. The policy confirms that members are notified of changes in benefits and services via the website, addendums to the Member Handbook, at new member orientations, and letters. The notification will be made at least 30 calendar days before the changes are effective.</p> <p>Policy MS.MBRS.27, Member Advisory of Provider Termination, states written notice of any provider terminations will be provided within 15 days of notice or issuance of termination of a provider and at least 30 days prior to the effective date; if the notice is received timely, to each member who received primary care from or was seen on a regular basis by the terminated provider.</p>
3. 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.	X					<p>Member materials are written to a total readability level not to exceed the sixth grade level of reading comprehension. Documents are available in the prevalent non-English languages spoken in the State of Mississippi, defined as five percent (5%) of the Plan's enrolled Members who speak a common non-English language. Documents are available in alternative formats that take into consideration the special needs of members. Magnolia makes verbal interpretation services available free of charge for all non-English languages and provides TTY/TDD services for the hearing impaired.</p>
4. 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.	X					<p>The Member Services department is available 8 am to 8 pm the first workday of each week; 8 am to 5 pm Tuesday through Friday; and 8 am to 5 pm the second weekend of each month.</p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The NurseWise line is available 24/7/365 and staffed by RNs and behavioral health professionals to provide general information, offer medical advice and answers to health questions, and to help with scheduling and PCP appointments.
5. Member complaints/grievances, denials, and appeals are reviewed to identify potential Member misunderstanding of the CCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential Members are consistent with the state and federal requirements applicable to Members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					<p>Policy MS.ELIG.05, Disenrollment, addresses disenrollment requirements for members. Page two contains a bulleted list of reasons for which Magnolia will not disenroll members. Included in this list is a statement that Magnolia shall not disenroll a member for uncooperative or disruptive behavior resulting from his or her special needs (except when member's continued enrollment in the Plan seriously impairs the Plan's ability to furnish services to either the member or other members).</p> <p>However, the next paragraph states, "It is not the Plan's practice to disenroll a member if their disenrollment is not indicated on the 834 file. However, <u>if a member is identified as having uncooperative or disruptive behavior, Plan will file a request in writing to DOM requesting to disenroll the member.</u>"</p> <p>Onsite discussion confirmed that the second statement applies only to those members whose behavior seriously impairs the ability to furnish services to either the member or other members.</p> <p><i>Recommendation: Clarify the information on page two</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>of policy MS.ELIG.05 to clearly indicate Magnolia will not request disenrollment of a member for uncooperative or disruptive behavior resulting from his or her special needs except when member's continued enrollment seriously impairs the ability to furnish services to either the member or other members.</i>
III D. Preventive Health and Chronic Disease Management Education						
1. The CCO enables each Member to choose a PCP upon enrollment and provides assistance as needed.		X				<p>Onsite discussion confirmed that if a member does not have a PCP selection on the enrollment report from DOM, Magnolia allows a 30-day period for the member to select a PCP. If the member does not select a PCP, <u>the Plan will assign a PCP within 45 days</u>. This is consistent with the process documentation found in policy MS.ELIG.08, PCP Notification.</p> <p>Inconsistencies were noted in policy MS.ELIG.01, Primary Care Provider (PCP) Auto-Assignment, as follows:</p> <ul style="list-style-type: none"> •Page one states that if the member does not request an available PCP within 30 days of enrollment, Magnolia will assign the new member to a network PCP <u>within 60 days of enrollment</u>. As noted above, staff confirmed the assignment occurs by the 45th day. •Page two states members who do not have a PCP on the Enrollment report are outreached <u>during the New Member Welcome Call in order to inform the member of the PCP to whom he/she has been assigned</u>. However, NurseWise conducts New Member Welcome Calls within 30 days of enrollment. Because auto-assignment occurs after day 30 but before day 45, this is incorrect. •Page two states that members will be informed of their PCP auto-assignment through the New Member Packet mailing. However, the new member packet is

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>sent within 14 calendar days after the Plan receives notice of the member's enrollment. Because auto-assignment occurs after day 30 but before day 45, this is incorrect.</p> <p><i>Corrective Action: Correct the errors noted above on pages one and two of policy MS.ELIG.01.</i></p>
<p>2. 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.</p>	X					<p>Policy MS.QI.24, Health, Wellness, and Preventive Education Programs, defines Magnolia’s process for educating members and promoting health, wellness, and preventive care programs. Magnolia maintains a written work plan for health education and prevention based on the needs of its membership. Member education related to preventive health and chronic disease management is achieved via:</p> <ul style="list-style-type: none"> •Printed materials •Audiovisual or face to face communications •Information on the Magnolia website •Mailed materials •Informational telephone on-hold messages •Quarterly member newsletters with health education information and reminders to obtain recommended services •Preventive health reminder postcards •Collaborative workshops <p>The CentAccount member incentive program promotes personal healthcare responsibility and ownership by offering financial incentives.</p>
<p>3. 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.</p>	X					<p>Pregnant members may be identified via claims or encounter administrative data, hospital discharge data, pharmacy data, UM data, ED utilization reports, laboratory data, State/CMS enrollment and other data, information provided by members/caregivers (such as data gathered from Health Risk Assessments), and information provided by practitioners (such as Notification of Pregnancy forms).</p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>The Start Smart for Your Baby program is Magnolia’s healthy pregnancy/healthy baby program that provides educational materials, support, and answers to questions throughout the member’s pregnancy. The program has a dedicated website that contains a wealth of information for pregnant members, including books, health sheets, podcasts and other audio files, and videos. The Start Smart program provides education on WIC services.</p> <p>High-risk pregnancies are managed through Magnolia’s Case Management program.</p>
4. The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages Members to utilize these benefits.	X					<p>Magnolia has processes for monitoring compliance with EPSDT requirements and interventions to educate members and providers on timely provision of services. Key aspects of the program include control monitoring reports, employee education, provider and member level interventions that include a periodic notification system. Plan screening and participation percentages are tracked over time to identify trends.</p> <p>The CentAccount program rewards members for healthy behaviors such as well child visits and immunizations. Providers are also incentivized to ensure members receive recommended services through Magnolia’s provider profiling and pay-for-performance programs.</p>
5. The CCO provides educational opportunities to Members regarding health risk factors and wellness promotion.	X					
III E. Member Satisfaction Survey						
1. The CCO conducts a formal annual assessment of Member satisfaction that meets all the requirements of the CMS Survey Validation Protocol.			X			<p>The survey 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 and NCQA (50 and</p>

STANDARD 2015	SCORE					COMMENTS
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						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. <i>Corrective Action: Focus on strategies that would help increase response rates for the Medicaid Child population. Solicit the help of UHC's survey vendor.</i>
2. The CCO analyzes data obtained from the Member satisfaction survey to identify quality problems.	X					
3. The CCO reports the results of the Member satisfaction survey to providers.	X					
4. 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.	X					Survey results were discussed in the QIC meeting on 10/22/14.
III F. Complaints/Grievances						
1. The CCO formulates reasonable policies and procedures for registering and responding to Member complaints/grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, addresses Magnolia's processes for receiving, processing, and responding to complaints and grievances.
1.1 Definition of a complaint/grievance and who may file a complaint/grievance;		X				When searching for grievance information on the Magnolia website, all results were found under the pages for the MississippiCHIP population and not in the website sections for MississippiCAN members. Regarding who is able to file a grievance, the 2015 Member Handbook, page 51, and the Revised Member Handbook (pending DOM approval) state that a provider acting for the member can file a grievance. <u>There is no indication that the provider needs written consent to file a grievance on a member's behalf.</u> <i>Corrective Action: Update the Magnolia website to include grievance information in the section of the</i>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>website for MississippiCAN members. Revise the Member Handbook to clearly indicate that providers need written consent to file a grievance on behalf of a member.</i>
1.2 The procedure for filing and handling a complaint/grievance;	X					
1.3 Timeliness guidelines for resolution of the complaint/grievance as specified in the contract;		X				<p>Timeframes for standard grievance resolutions are documented in policy MS.MBRS.07, Member Grievance and Complaints Process; the 2015 Member Handbook; the Revised Member Handbook; and the Provider Manual.</p> <p>During onsite discussion, Magnolia staff confirmed that Magnolia has an expedited grievance resolution process for clinically urgent or potential quality of care grievances. Policy MS.MBRS.07 and the Provider Manual address the expedited grievance resolution timeframe (within 72 hours of receipt). The 2015 Member Handbook and the revised Member Handbook do not include information regarding the expedited appeal process or timeframe for resolution.</p> <p>Regarding extensions of the timeframes for grievance resolution, the following issues were noted:</p> <ul style="list-style-type: none"> •The 2015 Member Handbook and the revised Member Handbook do not address that members can request an extension. •The Provider Manual does not provide information on grievance resolution extensions. <p><i>Corrective Action: Information on the expedited grievance process and timeframe for resolution should be included in the Member Handbook. Revise the Member Handbook to include that members may also request extensions of grievance resolution timeframes. Update the Provider Manual to include all information on extensions of grievance resolution timeframes.</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 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;	X					Policy MS.MBRS.07, Member Grievance and Complaints Process, states Magnolia will ensure that healthcare professionals with appropriate clinical expertise shall make decisions on grievances that involve clinical issues.
1.5 Notification to the Member of the right to request a Fair Hearing from DOM when a covered service is denied, reduced, and/or terminated;	X					
1.6 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.	X					
2. The CCO applies the complaint/grievance policy and procedure as formulated.	X					<p>The review of grievance files revealed the following issues:</p> <ul style="list-style-type: none"> •For two files, additional information was needed to process the grievance. Magnolia staff were subsequently unable to obtain the missing information due to invalid phone numbers; therefore, the grievances were closed and “Unable to Process” (UTP) letters were sent. Materials submitted for the desk review contained an “Unable to Contact Letter” for grievances that would have been more appropriate to use, rather than simply closing the grievances as unable to process. In addition, the UTP letters for both files did not indicate the reason for the plan’s inability to process the grievance (there was no check mark indicating the basis for the inability to process the grievances). •Two files contained no acknowledgement or resolution letters, although appropriate documentation of the investigation of each grievance was noted. •For a grievance related to multiple issues with a provider, not all issues were addressed in the investigation. Additionally, the notice of resolution letter did not address all issues included in the grievance filing. <p><i>Recommendation: When additional information is</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>needed for grievance processing and staff is unable to contact the grievant, ensure that attempts are made to obtain information in alternate ways, including sending Magnolia's "Unable to Contact" letter for grievances, prior to closing a grievance as unable to process. Ensure that written acknowledgement and resolution letters are sent for all grievances, as stated in policy S.MBRS.07, Member Grievance and Complaints Process. Ensure that all issues included in the grievance are investigated and included in the grievance resolution letter.</i>
3. Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Per policy MS.MBRS.07, Member Grievance and Complaints Process, Magnolia provides a monthly grievance report to DOM and utilizes the reported information for QI Program activities. Review of committee minutes confirms grievance data is reported to the QIC, UM Committee, etc.
4. Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The CCO investigates all Member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					
2. 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.	X					
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
<p>1. 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.</p>		X				<p>Magnolia has a Quality Improvement (QI) program in place that actively involves the entire organization in the responsibility of improving the quality of care and services the health plan delivers to its members. Their primary goal is to improve members' health status.</p> <p>The following issues were identified in the 2015 Quality Assessment and Performance Improvement Program Description:</p> <ul style="list-style-type: none"> •The scope of the program listed on pages one and two do not include monitoring member or provider appeals even though reviewing grievances and appeals is listed a responsibility of the Performance Improvement Team. •The committee organizational chart on page five does not include the Joint Oversight Committee. •Page nine refers to HEDIS as a "Data Information System". •The committee responsible for monitoring the performance of Magnolia's vendors is referred to as the Delegated Vendor Oversight /Joint Operative Committee on page11. However, this committee is referred to as the Joint Oversight Committee in other documents. •Clinical and preventive guidelines are discussed on page 19 and 20. Page 20 states Magnolia measures practitioner compliance with at least two of its adopted clinical and preventive guidelines. However, policy MS.QI.08.01 states Magnolia will monitor at least two in one paragraph and four in another paragraph. •Page 23 indicates that annually Magnolia provides information to members and providers including a description of the QI program and a report on progress in meeting program goals. However, the QI program description found on Magnolia's website was dated 2013 and the program evaluation was dated 2012. •The Delegation Services section of the program description, page 25, incorrectly lists DentaQuest as the vendor for dental services.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>Corrective Action: Correct the issues identified in the 2015 Quality Assessment and Performance Improvement Program Description.</i>
2. The scope of the QI program includes monitoring of services furnished to Members with special health care needs and health care disparities.	X					
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Utilization Management, including under and over utilization, is included in the scope of work for the QI program.
4. 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).	X					<p>Magnolia has developed a work plan that addresses all of the organization’s quality initiatives. The work plan included the goal, tasks needed to meet the goal, responsible party, target date, and the status. In reviewing the 2014 Annual QI Work Plan, under the Quality/Performance Improvement Activities & Interventions tab, there were several activities related to Cultural Competence that are conducted annually. According to the Outcome(s)/Status Notes, these activities were presented to the Quality Improvement Committee on 1/17/14. However, there was no evidence found in the committee minutes that these activities were reported. Magnolia addressed this issue and explained the line item was satisfied in the December 2014 Quality Improvement Committee meeting by reviewing the annual NCQA Availability of Practitioners report that reviews CAHPS data, network availability, and language line data. The development of the Cultural Competency Plan training materials, identifying and prioritizing staff training needs, conducting, and evaluating the effectiveness of the training was listed as the planned activity on the work plan. However, this was not discussed during the committee meeting.</p> <p><i>Recommendation: Ensure the Outcome(s) Status Notes section of the Quality Improvement Work plan</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>accurately reflect the status for each activity.</i>
IV B. Quality Improvement Committee						
1. The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Magnolia’s Board of Directors approves the QI Program and maintains the ultimate authority for overseeing its management and direction. Various committees and subcommittees have been established to monitor and support its QI Program. The Quality Improvement Committee is Magnolia’s senior level committee accountable to the Board of Directors. The Quality Improvement Committee performs oversight of all QI activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership includes senior staff, department managers, and network providers. The network provider specialties include pediatrics, family medicine, and cardiology. The Committee Charter dated June 2015 indicates the Quality Improvement Committee will also include two nurse practitioners. However, there are currently no nurse practitioners included in this committee. Magnolia indicated they continue to recruit nurse practitioners to serve on this committee. Also, page four of the charter contains a table listing the external committee membership. This table was incomplete. <i>Recommendation: Continue to recruit nurse practitioners to serve on the Quality Improvement Committee. Also, update the table on page four of the committee charter and include the external committee member.</i>
3. The QI Committee meets at regular intervals.	X					The Committee meets at least quarterly. A review of the committee minutes provided in the desk materials demonstrated this committee met regularly.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol “Validation of Performance Measures”.		X				<p>Magnolia was found to be fully compliant and met all the requirements for the HEDIS® measures. However, the non-HEDIS® measures did not meet the validation requirements. Two of the measures were <i>Substantially Compliant</i> and two measures were <i>Not Valid</i>. Issues with the way the numerators and denominators were calculated were of concern.</p> <p><i>Corrective Action: Correct the source codes for the non-HEDIS measures to comply with the State specifications and re-run the results.</i></p>
IV D. Quality Improvement Projects						
1. 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.	X					Topics for the projects included asthma, congestive heart failure, diabetes, hypertension, and obesity.
2. The study design for QI projects meets the requirements of the CMS protocol “Validating Performance Improvement Projects”.			X			<p>Three projects scored within the <i>Confidence</i> range and two in the <i>Low Confidence</i> range and failed to meet the validation protocol requirements. There were numerous issues identified with the projects. Details may be found in the <i>CCME EQR Validation Worksheets, Attachment 3</i>.</p> <p><i>Corrective Action: Correct the errors identified with the performance improvement projects.</i></p>
IV E. Provider Participation in Quality Improvement Activities						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The CCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Magnolia is working to establish standardized reports and benchmarks to send to individual physician practices at least once a year. Providers currently receive Care Gap reports to help identify where gaps in care are occurring amongst their members.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program is prepared annually.		X				<p>The 2014 Annual Quality Improvement Program Evaluation was received for review. The following issues were identified in the program evaluation:</p> <ul style="list-style-type: none"> •HEDIS is incorrectly listed as “The Health Effectiveness Data Information Systems” on page six. •The description on page six of the meeting frequency for the HEDIS Steering committee indicates the committee meets monthly and met 10 times in 2014. However, there was no documentation included to explain why the committee only met 10 times and not monthly. •It was noted on page 10 that the HEDIS rates were interim rates. However, the evaluation (interventions, barriers, etc.) should be based on final HEDIS rates. •Table 5 on page 33 does not include the Comparisons/Percentile Rank. •Preliminary results instead of final results are listed on page 47 for the C-Section Rate Reduction. •The section on page 57 discusses the monthly denial percentages; however, the table appears incomplete and does not include the percentages for each denial reason. There was no analysis presented and the last sentence is discussing appeals. This section is related to utilization denials. •Inter-rater reliability is included on page 62; however, the information is incomplete. It was missing details such as how many took the test, whether there were any new hires or physicians, and if there were, did any

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>reviewers not meet the 80% score.</p> <ul style="list-style-type: none"> •Opportunities for improvement listed on page 70 include publishing articles about asthma. However, the opportunities for improvement in this section should be related to diabetes and not asthma. •The table on page 74 does not list the delegated services for NurseWise. •In the annual audit table for Cenpatico (page 74) the overall audit score for credentialing is listed as 100%. However, it appears Cenpatico was placed on a corrective action plan for non-compliance with credentialing and recredentialing. The overall audit results for DentaQuest (page 75) in the area of Quality Improvement lists the score as 87.86%. However, there were no barriers identified for Quality Improvement. •Page 90 states “the Program Evaluation for 2013 has been reviewed and approved as follows.” This should read the 2014 Program Evaluation. <p><i>Corrective Action: The quality improvement program evaluation should be based on current HEDIS results and not interim results. Issues identified in the 2014 Annual Quality Improvement Program Evaluation should be addressed or corrected.</i></p>
2. The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The CCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The UM Program Description contains all required elements. In addition to the UM Program Description, policies and procedures are in place that define the processes in use by the UM department.
1.1 Structure of the program;	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Lines of responsibility and accountability;	X					
1.3 Guidelines/standards to be used in making utilization management decisions;	X					Policy MS.UM.02, Clinical Decision Criteria and Application, details the support tools used for decision making, including evidence based, nationally recognized clinical support tools (InterQual®); local/state regulatory guidelines; Magnolia’s Medical Management Guidelines for therapies and rehabilitation; Centene clinical policies; and other nationally-recognized support tools. Local practitioners advise on the adoption and application of UM criteria via membership on the Clinical Policy Committee.
1.4 Timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				<p>Authorization timeframes are detailed in policy MS.UM.05, Timeliness of UM Decisions and Notifications; however, page nine of the policy does not address the requirement that when there is termination, suspension or reduction of a previously authorized service, notice must be given at least 10 days before the date of the action. Refer to <i>Federal Regulation § 431.211</i>.</p> <p>The Member Handbook, page 31, provides standard authorization timeframes, but does not include the timeframe for urgent authorization determinations.</p> <p><i>Corrective Action: Update policy MS.UM.05, page nine, to include that notice must be given at least 10 days before the date of the action when there is a termination, suspension, or reduction of a previously authorized service. Revise the Member Handbook, page 31, to include the determination timeframe for urgent authorization requests.</i></p>
1.5 Consideration of new technology;	X					Policy MS.UM.02.01, Medical Necessity Review, states requests for services for which there are no criteria are elevated to a medical director for Level II review.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 The appeal process, including a mechanism for expedited appeal;	X					
1.7 The absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 The absence of quotas establishing a number or percentage of claims to be denied.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					<p>Dr. Rebecca Waterer is the Chief Medical Director and Dr. Jeremy Erwin is the Medical Director. Dr. Waterer chairs the UM Committee.</p> <p>The chief medical director/medical director has operational responsibility for and supports the UM Program. A behavioral health (BH) practitioner is involved in the behavioral health aspects of the UM Program, and a pharmacist oversees the pharmacy services. Among the chief medical director's responsibilities are assisting with development and revision of UM policies and procedures; monitoring compliance with the UM Program; provision of clinical support to UM staff; assuring use and consistent application of appropriate medical necessity criteria; communication with practitioners as necessary to discuss UM issues; coordination and oversight of UM delegation activities; participation in and oversight of the Utilization Management Committee and other physician committees/subcommittees; and practitioner education.</p>
3. 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.	X					<p>The evaluation of the UM program is a component of Magnolia's annual Quality Improvement program evaluation. The UM evaluation includes documentation of actual performance related to authorization volume, turn-around times, denial rates, ER and provider visit utilization, and inter-rater reliability testing. The evaluation contains</p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation of improvements and declines in performance, along with associated barriers, interventions, and outcomes.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of UM approval files confirmed Level I reviews are conducted by prior authorization nurses and case managers utilizing established criteria and policies. The files contained evidence of requests for additional information and review by physician reviewers when appropriate.
3. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Physician (Level II) reviews utilize the established criteria while allowing for consideration of individual member needs.
4. Utilization management standards/criteria are consistently applied to all Members across all reviewers.	X					<p>Annual inter-rater reliability (IRR) testing is performed for all medical directors, nurses, and social workers involved in UM decision-making to ensure consistency. Onsite discussion confirmed that in addition to annual IRR testing, three monthly audits per nurse are performed. New employees are audited at a rate of five reviews per month.</p> <p>Per the UM Program Description, the benchmark for IRR scores is 80 percent. However, policy CC.UM.02.05, Interrater Reliability, states the benchmark is 90 percent. Onsite discussion confirmed the benchmark was increased in August 2015.</p> <p><i>Recommendation: When the UM Program Description is revised, ensure the IRR benchmark requirement is updated from 80 percent to 90 percent.</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Pharmacy Requirements						
5.1 The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List.	X					<p>The <i>DOM Contract, Section 5 (F)</i>, states the contractor must use the most current version of the Medicaid Program Preferred Drug List (PDL). Onsite discussion confirmed this change was effective 1/1/2015.</p> <p>The link to the PDL from Magnolia’s website directs the user to the Mississippi DOM Universal Preferred Drug list. However, the following documents have not been updated:</p> <ul style="list-style-type: none"> •The Provider Manual, page 40, contains a reference to the Magnolia PDL. •The UM Program Description, page 29, states, “The PDL is developed and maintained by the corporate P&T Committee, as well as the local Magnolia Health P&T Committee. The P&T Committee determines which drugs from the corporate PDL will be incorporated into the Plan PDL, and approves plan implementation of a Division of Medicaid PDL, if applicable.” •The Member Handbook, page 40, does not clearly indicate that Magnolia uses the Medicaid Program PDL. <p><i>Recommendation: Update the Provider Manual, UM Program Description, and Member Handbook to indicate that Magnolia uses the Medicaid Program PDL.</i></p>
5.2 The CCO has established policies and procedures for the prior authorization of medications.	X					<p>The UM Program Description, page 29, states the pharmacy benefit manager does not make denial decisions based on lack of medical necessity; however, policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, states when a request does not meet criteria it is forwarded to a PBM licensed clinical pharmacist for a determination. Onsite discussion confirmed the information in the UM Program Description is incorrect.</p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>Recommendation: Update the UM Program Description to correctly document the pharmacy authorization process when medical necessity criteria are not met.</i>
6. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
7. Utilization management standards/criteria are available to providers.	X					The Provider Manual, page 35, states providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department. Denial letters also inform of the availability of, and how to request, the criteria used for the determination.
8. Utilization management decisions are made by appropriately trained reviewers.	X					Policy MS.UM.04, Appropriate UM/UR Professionals, defines the qualifications of staff who perform Level I reviews or issue authorizations based on standard criteria. Only Medical directors have the authority to deny services.
9. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of UM approval files confirmed timely determinations.
10. Denials						
10.1 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.	X					Review of denial files confirmed appropriate requests were made for additional information when necessary. Determinations and notifications were timely.
10.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of denial files confirmed appropriate Level II reviewers issued the denial determinations.
10.3 Denial decisions are promptly communicated to the provider and Member and include the basis for the denial of service and the procedure for appeal.	X					
V C. Appeals						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. 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, including:	X					Policy MS.UM.08, Appeal of UM Decisions details Magnolia’s policy and process for handling appeals.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				<p>The terms “action” and “appeal” are appropriately defined in policy MS.UM.08, Appeal of UM decisions.</p> <p>The Member Handbook, page 52, defines an appeal as “a request for Magnolia to review a <u>Magnolia Notice of Adverse Action</u>”. This does not meet the definition of an appeal as found in <i>Federal Regulation § 438.400 (b)</i>, which defines an appeal as “a request for review of an action”. Magnolia reviews the decision in the notice of action, not the notice of action itself.</p> <p>The Member Handbook, page 52, defines an action but does not include the failure to act within timeframes and the denial of a member to obtain services outside the network. Refer to <i>Federal Regulation § 438.400 (b)</i>.</p> <p><i>Corrective Action: Revise the Member Handbook definitions of an action and an appeal to be compliant with the definitions as found in Federal Regulation § 438.400 (b).</i></p>
1.2 The procedure for filing an appeal;		X				<p>The <i>DOM Contract, Exhibit D, Section D</i>, defines the timeframe for requesting an appeal as within 30 calendar days of <u>receiving the Notice of Action</u>. Issues identified are:</p> <ul style="list-style-type: none"> •The Provider Manual does not document the timeframe for requesting an appeal. •The Member Handbook and denial letter templates incorrectly document the timeframe as within 30 days of <u>the date on the Notice of Action</u>. <p><i>Corrective Action: Update the Provider Manual to include the timeframe to request an appeal. Revise the</i></p>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>Member Handbook and the denial letters to reflect the correct timeframe to file an appeal.</i>
1.3 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;		X				Policy MS.UM.08, Appeal of UM Decisions, does not include that the review of the appeal must be made by a practitioner with the appropriate clinical expertise in treating the member's condition or disease. <i>Corrective Action: Revise policy MS.UM.08 to include that the review of the appeal must be made by a practitioner with the appropriate clinical expertise in treating the member's condition or disease.</i>
1.4 A mechanism for expedited appeal where the life or health of the Member would be jeopardized by delay;		X				The Provider Manual does not indicate that an oral request for an expedited appeal does not require a written follow-up. <i>Corrective Action: Update the Provider Manual to indicate that an oral request for an expedited appeal does not require a written follow-up.</i>
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					The Provider Manual does not include information on extensions of expedited appeal resolution timeframes. <i>Recommendation: Update the Provider Manual to include information on extensions of expedited appeal resolution timeframes.</i>
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.		X				Policy MS.UM.08, Appeal of UM Decisions, incorrectly states appeals are acknowledged within five <u>calendar</u> days. Onsite discussion confirmed the timeframe is five <u>business</u> days. The acknowledgement letter does not provide complete information on continuation of benefits. <i>Corrective Action: Correct the timeframe for appeal acknowledgement in policy MS.UM.08. Revise the</i>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>appeal acknowledgement letter to include complete information on continuation of benefits.</i>
2. The CCO applies the appeal policies and procedures as formulated.	X					
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Summaries of appeal actions, trends, and root causes are reported quarterly to the QIC. Reports are reviewed for opportunities to improve quality of care and/or service. Evidence of this is found in the QIC minutes.
4. Appeals are managed in accordance with the CCO confidentiality policies and procedures.	X					
V. D Care Management						
1. The CCO assess the varying needs and different levels of care management needs of its Member population.	X					The Care Management Program Description details Magnolia's Case Management Program. All Magnolia members receive care coordination including evaluation of risk factors; identification of special needs and barriers; and coordination of referrals, residential support services, and other assistance with accessing health care services. Members are categorized into low, moderate, and high complex or high transitional care.
2. The CCO uses varying sources to identify and evaluate Members' needs for care management.	X					Magnolia uses various methods and sources to identify members who may need care management services. These include, but are not limited to, predictive modeling software; claims and encounter data; direct referral; hospital discharge data; pharmacy and laboratory data; UM data; ED utilization reports; readmission reports; State/CMS enrollment and other data; information provided by members or their care givers; health risk assessments; and information provided by practitioners, such as Notification of Pregnancy (NOP) forms.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. A health risk assessment is completed within 30 calendar days for Members newly assigned to the high or medium risk level.	X					
4. The detailed health risk assessment includes:						
4.1 Identification of the severity of the Member's conditions/disease state;	X					
4.2 Evaluation of co-morbidities or multiple complex health care conditions;	X					
4.3 Demographic information;	X					
4.4 Member's current treatment provider and treatment plan if available.	X					
5. 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.	X					
6. The risk level assignment is periodically updated as the Member's health status or needs change.	X					
7. The CCO utilizes care management techniques to insure comprehensive, coordinated care for all Members through the following minimum functions:	X					
7.1 Members in the high risk and medium risk categories are assigned to a specific Care Management Team Member and provided instructions on how to contract their assigned team;						
7.2 Member choice of primary care health care professional and continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the Member requests otherwise;						

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.3 Appropriate referral and scheduling assistance for Members needing specialty health care services, including behavioral health and those identified through EPSDT;						
7.4 Documentation of referral services and medically indicated follow-up care in each Member's medical record;						
7.5 Monitoring and treatment of Members with ongoing medical conditions according to appropriate standards of medical practice;						The Start Smart for Your Baby program includes perinatal management of normal pregnancies. The Start Smart for Your Baby program, along with Case Management staff, provide high-risk case management services.
7.6 Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care;						
7.7 Coordination of discharge planning;						Policy MS.UM.01.09 Discharge Planning, details the process Magnolia uses to initiate discharge planning and follow-up.
7.8 Determination of the need for non-covered services and referral of Members to the appropriate service setting, utilizing assistance as needed from the Division;						Policy MS.UM.24, Continuity and Coordination of Services, details referral to external providers, transition if a provider is not in the network and assistance when available benefits end.
7.9 Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA), the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;						
7.10 Ensuring that when a provider is no longer available through the Plan, the Contractor allows Members who are undergoing an active course of treatment to have continued access to that provider for 60 calendar days;						Policy MS.UM.24, Continuity and Coordination of Services, states to ensure appropriate continuity and transition of care, Magnolia will allow continuation of such services for up to 90 calendar days or until the member is reasonably transferred to a network provider without interruption of care.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7.11 Procedure for maintaining treatment plans and referral services when the Member changes PCPs;						
7.12 The Contractor shall provide shall provide for a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network, at no cost to the Member;						
7.13 If the Network is unable to provide necessary medical services covered under the contract to a particular Member, the Contractor must adequately and timely cover these services out of network for the Member, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment;						
7.14 The Contractor must produce a treatment plan for Members determined to need a course of treatment or regular care monitoring. The Member and/or authorized family Member or guardian must be involved in the development of the plan;						
7.15 Monitor and follow-up with Members and providers including regular mailings, newsletters, or face-to-face meetings as appropriate.						
8. 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.	X					
9. 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.	X					

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. The CCO has policies and procedures that address continuity of care when the Member disenrolls from the health plan.	X					
11. 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.	X					Nurtur provides disease management services for asthma, diabetes, hypertension, cardiac disorders, and weight management. Transplant members are managed in complex case management by Magnolia.
V E. Evaluation of Over/ Underutilization						
1. The CCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Magnolia has a policy in place to evaluate over- and under-utilization at least annually with issues reported to the UM, Credentialing, or Peer Review Committee.
2. The CCO monitors and analyzes utilization data for under and over utilization.	X					Magnolia analyzes data on the following topics in regards to utilization: •Pharmacy •Authorizations •Additional listings in policy MS.UM.01.03, Monitoring Utilization
V. F Annual Evaluation of the Utilization Management Program						
1. A written summary and assessment of the effectiveness of the UM program is prepared annually.	X					
2. The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM.	X					
VI. DELEGATION						
1. 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.	X					Magnolia has delegation contracts with Cenpatico; Dental Health and Wellness (DHW); National Imaging Associates; Medical Transportation Management, Inc.; NurseWise; Nurtur; Opticare; and US Script. In addition, credentialing delegation agreements are in place with Mississippi Physicians Care Network; University of Mississippi Medical Center; Hattiesburg Clinic; RUSH Health Systems; LeBonheur; and St. Jude’s Children’s Research Center.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>The Master Services Agreement and its Attachment B, Delegated Services Agreement, were received and reviewed. The agreements have areas to specify the delegated activities and information on requirements for corrective action plans for substandard or non-performance, up to and including termination of the contract.</p> <p>Exhibit X of the Delegated Services Agreement details credentialing and recredentialing responsibilities for delegated credentialing entities and appropriately addresses credentialing requirements specific to Mississippi.</p>
<p>2. 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.</p>		X				<p>Policy MS.QI.14, Oversight of Delegated Vendor Services, defines Magnolia’s processes for monitoring and oversight of delegated entities.</p> <p>The <i>DOM Contract, Exhibit D, Item (A) (12)</i>, states additional provider office site visits must be conducted within 45 calendar days when a complaint, grievance, or appeal threshold has been met against a specific provider related to the provider’s office. However, the Centene Corporate Standardized Credentialing Audit Tool 2015/2016, page nine, references conducting site visits of offices <u>within 60 calendar days</u> of determining that the complaint threshold was met. There is no addendum or notation in the tool that the MS requirement for these site visits is within 45 days.</p> <p>Additional issues related to oversight of Cenpatico include:</p> <ul style="list-style-type: none"> •The 2015 Cenpatico Tracking Grid for Magnolia Health Plan includes a standard that for member/provider complaints and appeals, <u>98% or 100%</u> are to be resolved within state required timeframes. Also, the timeframes for resolution of complaints/grievances are not specified.

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>•The 2015 Cenpatico Performance Summary Report does not address turn-around times for member and provider complaints/grievances and appeals.</p> <p>•The 2015 Cenpatico Tracking Grid does not specify timeliness requirements for authorization determinations.</p> <p>•The 2015 Cenpatico Performance Summary Report does not have an area for monitoring expedited authorization turn-around times.</p> <p>The 2015 NIA Tracking Grid states, “Medical Necessity appeals are not delegated to Vendor (<u>with the exception of 1st level Medical Necessity appeals</u>).” However, onsite discussion confirmed that NIA does not process appeals—they are all handled by Magnolia.</p> <p><i>Corrective Action:</i></p> <ul style="list-style-type: none"> •<i>Revise the Centene Corporate Standardized Credentialing Audit Tool 2015/2016, page nine, to be consistent with the DOM Contract requirement that provider office site visits must be conducted within 45 calendar days when a complaint, grievance, or appeal threshold has been met against a specific provider related to the provider’s office. Alternatively, develop an addendum or notation in the tool that the MS requirement for these site visits is within 45 days.</i> •<i>Update the 2015 Cenpatico Tracking Grid to specify the timeframes for resolution of complaints/grievances Update the percentage of member/provider complaints and appeals that are to be resolved within timeliness requirements.</i> •<i>Revise the 2015 Cenpatico Tracking Grid to specify timeliness requirements for authorization determinations.</i> •<i>The 2015 Cenpatico Performance Summary Report should be updated to include monitoring expedited authorization turn-around times in addition to standard authorization turn-around times.</i>

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Because onsite discussion confirmed that NIA does not process appeals, the 2015 NIA Tracking Grid should be revised to remove the statement that “Medical Necessity appeals are not delegated to Vendor (with the exception of 1st level Medical Necessity appeals).”
VII. STATE-MANDATED SERVICES						
1. The CCO tracks provider compliance with:						
1.1 Initial visits for newborns;	X					Magnolia monitors for provider compliance with preventive health and clinical practice guidelines, including those for well-care for newborns/children via claims and encounter data, and medical record reviews. Physicians receive an annual profile report for each individual measure, including an individual practitioner score and a weighted composite score.
1.2 EPSDT screenings and results;	X					Magnolia has processes for monitoring compliance with EPSDT program requirements. QI and/or Provider Relations staff intervene to educate providers on timely provision of services and to promote sustained improvement over time.
1.3 Diagnosis and/or treatment for children.	X					
2. Core benefits provided by the CCO include all those specified by the contract.	X					The findings of this EQR indicate Magnolia provides all core benefits required by the <i>DOM Contract</i> .
3. The CCO addresses deficiencies identified in previous independent external quality reviews.			X			The following issues were noted in the previous EQR and have not been corrected: •Errors in the performance improvement projects were not corrected and failed to meet the validation requirements. •Recredentialing files did not contain ownership disclosure forms. The previous EQR CAP response indicated that ownership disclosure forms would be collected at recredentialing.

CCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD 2015	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<i>Corrective Action: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.</i>