Mississippi External Quality Review

ANNUAL COMPREHENSIVE TECHNICAL REPORT 2016

Submitted: May 26, 2017

Prepared on behalf of the
Mississippi Division of Medicaid

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EXECUTIVE SUMMARY

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

The purpose of the EQRs was to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. CCME accomplished this by conducting the following activities for the CAN and CHIP Programs: validate performance improvement projects (PIPs), performance measures (PMs), and surveys; determine compliance with state and federal regulations; and conduct access studies for each health plan. This report is an annual review findings compilation of each CCO's CAN and CHIP Programs conducted during June 1, 2016, through May 31, 2017.

A. Overall Findings

An overview of the findings for each section follows. Additional information regarding the reviews for United and Magnolia, including strengths, weaknesses, and recommendations are also included in the narrative of this report.

Administration

United and Magnolia have executive leadership teams and ample staff in place to ensure they can meet contract requirements. The medical directors in each of the plans are very involved with quality improvement (QI), utilization functions and processes, and developing criterion and guidelines for chronic and preventive health care services.

Both plans should ensure that all policies clearly indicate the line of business to which they apply. Claim processing by United and Magnolia meet or exceed contract goals and both plans have tested their disaster recovery plans within the past 12 months. Confidentiality is taken seriously by both plans as demonstrated by multiple policies and procedures, and required employee education.

Provider Services

The Provider Services review for United and Magnolia showed that overall both plans rely on established programs and/or processes to address review areas such as credentialing/recredentialing, provider education, network evaluation, medical record review, practice guidelines, and continuity of care. Common issues included insufficient or inconsistent information in program descriptions, *Provider Manuals*, policies, and/or the website; some credentialing and/or recredentialing files were missing information; both plans exhibited low results from their provider appointment and after-hours studies, and the *Provider Access Study* showed a decrease in successfully answered calls for both United and Magnolia CAN Programs from last year. The CHIP Programs were not evaluated for improvement, since this is the first year of review. Of concern is United's Credentialing Committee had no local representation as it makes credentialing/ recredentialing decisions for Mississippi providers. United did not conduct a medical record review for their CHIP Program and Magnolia had an uncorrected issue from their previous EQR. The *Provider Satisfaction Surveys* had low response rates, and lacked documentation regarding survey reliability and validity.

Member Services

United and Magnolia health plans take seriously their roles in providing quality information, education, and services to their members. The *Member Handbooks* contain very good information that is written in a language that is easy to understand; however, some important requirements were missing from both plans' CAN and CHIP *Member Handbooks*. United and Magnolia provide information on Preventive Health Guidelines and EPSDT/Well-Baby and Well-Child Programs in their *Member Handbooks* and on their websites.

Call Centers meet or exceed the goals for abandonment rate and speed of answer defined by DOM. Grievances were for the most part handled according to contract requirements for timeliness; however, United and Magnolia struggle to consistently document the definition of a grievance and the process for managing grievances across plan materials. United has improved its contracts documentation and the steps taken to resolve grievances. Magnolia's documentation also improved; however, there were gaps in a few files. The primary issue for the *Member Satisfaction Surveys* was the response rate. Although the minimum sample size met National Committee for Quality Assurance (NCQA) guidelines, the response rates were below the 40% target rate.

Quality Improvement

All of the health plans are required by contract and federal regulations to have an ongoing quality assessment and performance improvement program for the services furnished to its members. CCME's review found that both plans have a QI program in

place that actively involves the entire organization in improving care and services. Each health plan has a committee charged with providing direction for all QI activities. The committees meet regularly and most minutes are detailed and thorough. The only concern found during the review included the tracking of diagnoses identified during Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings, the Well-Baby and Well-Child assessments, and the treatments or referrals provided as a result of the assessments.

Performance Measures

Overall, performance measures were calculated accurately. United had software issues, which led to inaccurate data and rate reporting for the non-Healthcare Effectiveness Data and Information Set (HEDIS®) measures; moreover, United CAN's pre-and post-natal complications programming logic was incorrect.

Performance Improvement Projects

Regarding PIPs, an analysis and interpretation of each measure at each measurement period was not provided in the documentation. Additionally, the study results were inaccurately reported (e.g., numerator and denominator were switched).

Utilization Management

The Utilization Management (UM) review for United and Magnolia revealed that processes are in place for all UM activities including medical necessity determinations, care management, and appeals. Both plans' medical directors have significant involvement in developing, implementing, and overseeing the UM Programs. Issues common across United's and Magnolia's CAN and CHIP UM Programs include erroneous, insufficient, and/or inconsistent documentation in UM Program descriptions, policies, *Member Manuals*, and *Provider Manuals*, as well as lack of references to the medical necessity criteria or benefit provision used to determine the outcome of member appeals in appeal resolution letters. Areas of greatest concern include Magnolia's process of allowing pharmacists to issue medical necessity denials; United's practice of not acknowledging appeals for the CHIP population; and United's care management program descriptions and policies not addressing Mississippi-specific requirements.

Delegation

Delegation agreements used by United and Magnolia are thorough and address all contractually required elements; and policies define delegation and oversight processes. No issues were noted in United's delegation policies. Magnolia's delegated credentialing oversight policy erroneously states "NCQA Certified or Accredited delegates may not be subject to an annual oversight audit/evaluation," but review of oversight documentation confirmed Magnolia conducts appropriate oversight of all delegates. United's oversight

documentation did not provide evidence that all UM elements, such as authorization turnaround times, and standard/expedited appeal turnaround times are monitored; however, onsite discussion confirmed all performance standards are reviewed routinely for each delegate.

Figure 1, Overall Results for 2016 EQR, provides an overview of the percentage of "Met," "Partially Met," "Not Met," or "Not Applicable" scores by health plan and Medicaid Program.

Figure 1: Overall Results for 2016 EQR

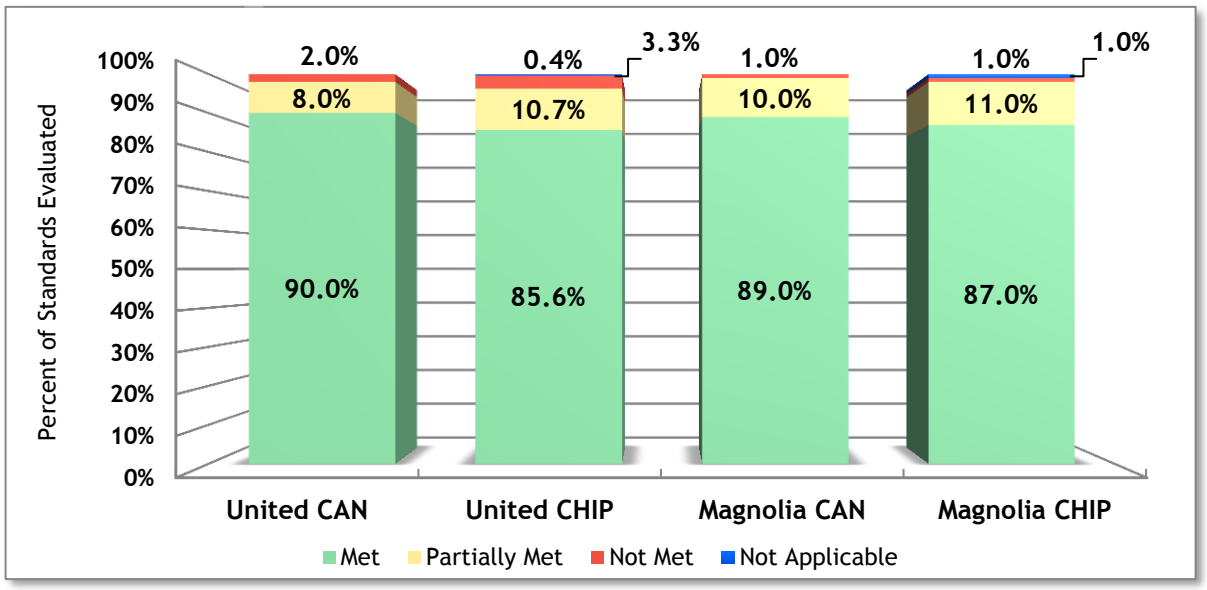


Table 1, CCO External Quality Reviews, shows the total percentage of standards scored as "Met" for the 2016 EQR. For the CAN Program, the percentages highlighted in green show an improvement in "Met" scores over the prior EQR results from 2015. While this table compares the CAN scores for 2015 and 2016, various factors such as changes in EQR standards due to CCO contract changes and revisions in CCO policies and/or processes as a result of CCO contract changes prevent a consistent year-to-year comparison. Since this is the first EQR for the CHIP Program, there is no prior year comparison data. Details of each review can be found in each CCO's Annual Technical Reports.

Table 1: CCO External Quality Reviews

REVIEW SECTIONS	UNITED			MAGNOLIA		
	2015 CAN	2016 CAN	2016 CHIP	2015 CAN	2016 CAN	2016 CHIP
Administration	96.55%	100.00%	100.00%	96.55%	96.00%	96.00%
Provider Services	85.06%	89.00%	80.00%	86.21%	89.00%	87.00%
Member Services	80.65%	91.00%	84.00%	77.42%	82.00%	81.00%
Quality Improvement	80.00%	90.00%	95.00%	73.33%	89.00%	95.00%
Utilization Management	79.25%	85.00%	85.00%	88.68%	91.00%	83.00%
Delegation	50.00%	100.00%	100.00%	50.00%	50.00%	50.00%
State-Mandated Services	80.00%	N/A	N/A	80.00%	N/A	N/A

The State-Mandated Services section included following up on deficiencies identified in the previous EQR to ensure corrective actions are implemented. Beginning in 2016, the State-Mandated Services section was eliminated, and follow up on deficiencies is now addressed in each individual review section.

B. Overall Scoring

To objectively compare the CCOs, CCME applied a numerical score (points) to each standard's rating within a section to be able to derive the overall score (percentage) for each plan and each Medicaid Program. Results of the scoring matrix are included in *Table 2: Scoring Matrix*. Using the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol1: Assessment of Compliance with Medicaid Managed Care Regulations*, the overall score was calculated based on the following method:

Overall Score for Plan

1. Points were assigned to each rating ("Met" = 2 points and "Partially Met" = 1 point), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.
2. The total number achieved was calculated by adding the earned points together.

3. The final section score was derived by dividing the section's total points (total number achieved) by the total possible points for that section.
4. The overall score (percentage) was then calculated by averaging the final section scores for the seven sections reviewed.

Table 2: Scoring Matrix

United		Magnolia	
CAN	CHIP	CAN	CHIP
94%	91%	94%	93%

BACKGROUND

The Division of Medicaid (DOM) contracted with two CCOs (United and Magnolia) to administer the MississippiCAN and the MississippiCHIP, Medicaid Managed Care Programs. The CCOs include United Healthcare Community Plan – Mississippi (United) and Magnolia Health Plan (Magnolia). The Balanced Budget Act of 1997 requires State Medicaid agencies that contract with Medicaid managed care organizations evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*.

As detailed in the *Executive Summary*, CCME as the EQRO conducts EQRs of the MississippiCAN (CAN) and MississippiCHIP (CHIP) Medicaid Managed Care Programs for each CCO on behalf of DOM. Federal regulations require that EQRs include three mandatory activities: validation of PIPs, validation of PMs, and an evaluation of compliance with state and federal regulations for each health plan.

In addition to the required mandatory activities, CCME validates consumer and provider surveys conducted by the CCOs, and performs telephonic *Provider Access Studies* for each CCO's CAN and CHIP Programs.

After completing the annual review of the required EQR activities, CCME submits a detailed technical report to DOM and the reviewed health plan. This report describes the data aggregation and analysis and the manner that conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; recommendations for improvement; and the degree to which the plan addressed the corrective action from the prior year's review. Annually, CCME prepares an annual comprehensive technical report for the State, which is a compilation of the individual annual review findings.

The *Annual Comprehensive Technical Report* for contract year 2016 through 2017 contains data regarding results of the EQRs conducted for the CAN and CHIP Programs for United and Magnolia.

METHODOLOGY

The process used by CCME for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plans' office. After completing the annual review, CCME submits a detailed technical report to DOM and the health plan (covered in the preceding section titled, *Background*). For a health plan not meeting requirements, CCME requires the plan to submit a Corrective Action Plan for each standard identified as "Partially Met" or "Not Met." CCME also provides technical assistance to each health plan until all deficiencies are corrected.

FINDINGS

CCME conducted an annual review for United and Magnolia for the CAN and CHIP Programs during the reporting period. The CCOs were evaluated using the standards developed by CCME and summarized in the tables for each of the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "(Not Applicable)", or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR.

A. Administration

The *Annual Comprehensive Technical Report* combines the result of the reviews for the Administration sections for United and Magnolia CAN and CHIP Programs. This included a review of the health plans' policies and procedures, organizational structure and staffing, information systems, compliance, and confidentiality.

United and Magnolia have qualified staff performing the functions necessary to ensure they are able to meet enrollee needs and requirements of the contracts with DOM. Both plans have medical directors that are involved with the day-to-day utilization functions and pediatricians are available for meeting the utilization needs of CHIP enrollees. The health plans have large parent companies supporting a variety of functions.

The policies and procedures compiled by both plans for the CAN and CHIP Programs are developed in a consistent manner; however, some of Magnolia's and United's policies did not clearly indicate the line of business they applied to and United's adopted policies from Optum did not reflect last review dates or the date was out of compliance with internal policies.

Magnolia and United have Compliance and Fraud, Waste, and Abuse Plans. United's plan includes all federal and state requirements and indicates that adequate staff training is conducted. Magnolia's Compliance and Fraud, Waste, and Abuse Plan failed to address three federal requirements and no policy was found that defined Magnolias' understanding of the False Claims Act and associated training requirements. Magnolias' Compliance Committee minutes reflected poor attendance by two members. The charter indicates delegates can be sent in their place; however, the minutes did not reflect if a delegate was used. Both plans have hotlines for reporting Fraud, Waste, and Abuse; however, United's' CAN and CHIP *Provider Administrative Guides* provided a hotline number for providers that did not allow for anonymous reporting.

United received 100% "Met" scores and Magnolia received 96% "Met" scores for the standards in the Administration section for both CHIP and CAN lines of business.

Information Systems Capabilities Assessment

CCME performs an evaluation of the information systems capabilities for each plan as part of the annual review. The evaluation includes an examination of Information System Capabilities Assessment (ISCA) documents submitted as well as a number of other supporting documents. The aim is to ensure that the plans have the ability to manage their resources; meet state guidelines for the delivery of health care services; collect health care data securely and accurately; process claims appropriately and in a timely manner; and provide reports on those activities as required by DOM. CCME's review of the ISCA for each of the plans determined both plans have established guidelines for monitoring the timeliness and accuracy of claims processing and they consistently exceed targeted levels. Magnolia and United have Disaster Recovery/Business Continuity plans in place and tested these systems within the last year. Testing includes the use of various scenarios. United reported testing was successful but failed to submit documentation to support this claim. CCME requested additional information for United; however, the request was declined. CCME recommends United develop a method of providing adequate information for evaluating disaster recovery testing results. Both plans have information systems capable of collecting, tracking, and monitoring member demographics required by the CAN Contract.

An overview of the scores for the Administration section is illustrated in *Table 3: Administration Comparative Data*.

Table 3: Administration Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
General Approach to Policies and Procedures	The CCO has in place policies and procedures that impact the quality of care provided to Members, both directly and indirectly	Met	Met	Met	Met
Organizational Chart / Staffing	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. All staff must be qualified by training and experience. At a minimum, this includes designated staff performing in the following roles: • Full-Time Chief Executive Officer	Met	Met	Met	Met
	• Chief Operations Officer	Met	Met	Met	Met
	• Chief Financial Officer	Met	Met	Met	Met
	• Chief Information Officer: A professional who will oversee information technology and systems to support CCO operations, including submission of accurate and timely encounter data	Met	Met	Met	Met
	• Information Systems personnel	Met	Met	Met	Met
	• Claims Administrator	Met	Met	Met	Met
	• Provider Services Manager	Met	Met	Met	Met
	• Provider credentialing and education	Met	Met	Met	Met
	• Member Services Manager	Met	Met	Met	Met
	• Member services and education	Met	Met	Met	Met
	• Complaints/Grievance Coordinator: A dedicated person for the processing and resolution of complaints, grievances, and appeals	Met	Met	Met	Met
	• Utilization Management Coordinator: A designated health care practitioner to be responsible for utilization management functions	Met	Met	Met	Met
	• Medical/Care Management Staff	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Organizational Chart / Staffing	• Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities	Met	Met	Met	Met
	• Marketing and/or Public Relations	Met	Met	Met	Met
	• Medical Director: A physician licensed and actively practicing in the state of Mississippi, providing substantial oversight of the medical aspects of operation, including quality assurance activities, the functions of the Credentialing Committee, and serves as Chair of the Credentialing Committee	Met	Met	Met	Met
	• Fraud and Abuse/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	Met	Met	Met	Met
	• Operational relationships of CCO staff are clearly delineated	Met	Met	Met	Met
	• Operational responsibilities and appropriate minimum education and training requirements are identified for all CCO staff positions	Met	Met	Met	Met
	• A professionally staffed all service/Helpline/Nurse Line which operates 24 hours per day, 7 days per week	Met	Met	Met	Met
Management Information Systems	The CCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met
	The CCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met
	The CCO management information system is sufficient to support data reporting to the State and internally for CCO quality improvement and utilization monitoring activities	Met	Met	Met	Met
	The CCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Compliance/ Program Integrity	The CCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse	Met	Met	Partially Met	Partially Met
	The CCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Met	Met	Met
Confidentiality	The CCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met

Strengths

- Both plans have increased the percentage of "Met" standards in the Administration section of the review.
- Claims are processed in a timely fashion and consistently exceed internal goals and goals developed by DOM.

Weaknesses

- United and Magnolia have policies and procedures that do not indicate the line of business to which they apply, and United's adopted policies do not reflect last review dates or the date was out of compliance with internal policies.
- Magnolia's Compliance Plan was missing required elements and a policy that addressed the False Claims Act.

Recommendations

- United and Magnolia are encouraged to identify each policy and the line of business impacted by the policy.
- Ensure Compliance Plans meet all federal and state requirements.

B. Provider Services

CCME's review of the Provider Services section included a review of the health plans' materials related to their network providers, training and educational materials, network access and availability, practice guidelines, and credentialing/recredentialing files

Both United and Magnolia have established credentialing programs for assessing providers at initial credentialing/recredentialing. Processes are described in program descriptions and policies with specific Mississippi credentialing criteria detailed in riders or attachments. United received "Partially Met" scores in several standards due to missing information relating to facility credentialing/recredentialing and because their Optum Physical Health (behavioral health) credentialing program description did not address Mississippi-specific credentialing requirements.

The credentialing/recredentialing file review for both plans identified a few areas for improvement. The file review revealed that United was not collecting/verifying Clinical Laboratory Improvement Amendments (CLIA) Waivers when indicated on the application; and some facility files were missing information such as CLIA, proof of malpractice insurance, ownership disclosure form, and queries for the System for Award Management (SAM) or the National Plan & Provider Enumeration System (NPPES). Magnolia CAN received a "Not Met" score for the provider office site assessment credentialing standard due to an uncorrected issue from the previous EQR where the site assessment tool had incorrect appointment availability information. Also, site assessments were not received for three credentialing files. Magnolia CHIP received a "Partially Met" score for the same aforementioned issues.

At the time of the review, Magnolia's Credentialing Committee was chaired by Dr. Becky Waterer, Vice President of Medical Affairs. Dr. Waterer was formerly the chief medical director. CCME recommended that Magnolia consider having the chief medical director chair the Credentialing Committee and the plan was very receptive to implementing the change. United received a "Not Met" score because the National Credentialing Committee (NCC) is the decision-making committee and there is no representation of Mississippi licensed independent practitioners (LIPs) on the committee; the Mississippi chief medical director infrequently attends the meetings and has no voting privileges; and only 7 to 8 of the voting members are invited to the meetings with a majority quorum determined from those in attendance. This practice conflicts with the United Credentialing Plan 2015-2016 which requires at least 51% of the LIP NCC membership to be present.

Policies and processes are in place for United and Magnolia for measuring availability and accessibility of the provider networks. Both plans use quarterly GEO access reports in assessing network availability. Magnolia had inconsistencies in policies and the QI Program Evaluation regarding the primary care provider (PCP) member-to-provider ratio. For both plans, appointment accessibility standards are defined in policies, *Provider Manuals*, and *Member Handbooks*. The United CHIP Program and Magnolia CAN and CHIP received "Partially Met" scores for inconsistencies or insufficient information in documents regarding appointment standards. Recommendations were made to both plans to continue to focus on member access to providers because results of the annual review

for Magnolia showed access measures not meeting goals, and United's quarterly review for appointment availability and after-hours showed high percentages of provider non-compliance.

Both plans have comprehensive *Provider Manuals* for the CAN and CHIP Programs, and provider resource information listed on their website provider portals. At the time of the review, Magnolia did not have their CHIP *Provider Manual* loaded to their website, and both plans had updates that needed to be made to the *Provider Manuals* as a result of the EQR. Both United and Magnolia have paper and Web-searchable Provider Directories that contain appropriate information. United received a "Partially Met" score for CAN and CHIP because a policy needed to be updated and a sample chart in the paper directories contained inconsistent information.

United and Magnolia have processes in place to review and adopt preventive health and clinical practice guidelines. The guidelines are posted to the plan websites. Magnolia had insufficient information regarding the practice guidelines in their CAN and CHIP *Provider Manuals*; United did not appear to have all the adopted guidelines posted on their website, and the CHIP *Provider Manual* contained outdated practice guidelines information.

For practitioner medical record review, United's policy and medical record review tool did not address the Well-Baby and Well-Child care language related to the CHIP Program. In addition, United did not conduct a medical record review for their CHIP Program. Magnolia did not have their medical record review standards posted to their website as their policy had indicated.

Provider Access and Availability Study

As a part of the annual review process for all the plans, CCME performed a *Provider Access Study* focusing on primary care specialists. CCME requested and received a list of network providers and contact information with the desk materials for each of the health plans for the CAN and CHIP Programs. From this list, CCME defined a population of PCPs for each program and each plan, and selected a statistically relevant sample of providers from each plan's populations for the study. CCME attempted to contact these providers to ask a series of questions regarding the access that plan members have with their PCP.

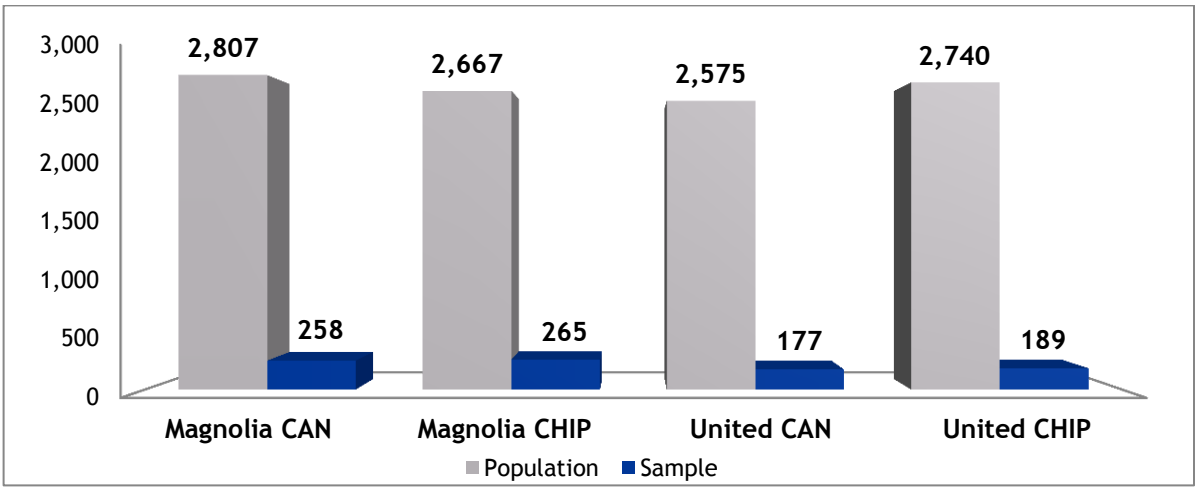
For the CAN Program, both of the plans received a score of "Not Met" for the standard requiring an improvement to the telephonic *Provider Access Study* conducted by CCME. For the CHIP Program, both plans received a score of "Not Applicable" for the standard requiring an improvement to the telephonic *Provider Access Study* conducted by CCME. Since this is the first time the study was completed for each plan's CHIP Program, results are considered a baseline for future reviews.

The following charts summarize CCME's survey findings and compare the four plans surveyed during the last review cycle.

Population and Sample Size

Figure 2, Population and Sample Sizes of Each Plan, displays population data CCME used to conduct the survey. From the four CCOs reviewed, CCME identified a total population of 10,789 unique PCPs. From each plan's population, CCME drew a random sample and selected a total of 889 providers.

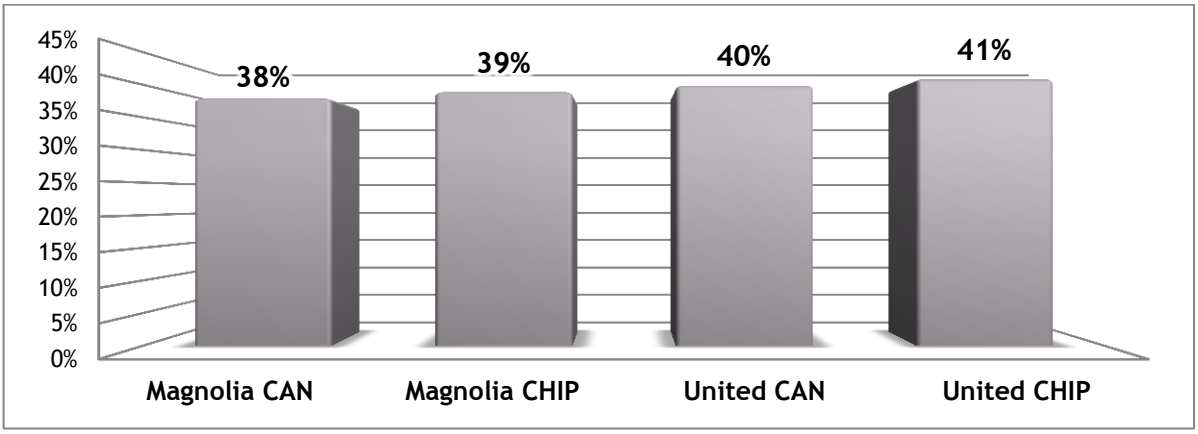
Figure 2: Population and Sample Sizes for Each Plan



Successfully Answered Calls

CCME used the telephone contact information provided by the plans and called each provider with a series of questions. In aggregate, the providers answered 39.5% of these calls successfully, as noted in *Figure 3: Percentage of Successfully Answered Calls*. Both CAN Programs decreased from the previous review cycle. Since the CHIP Programs were not reviewed last year, there is no comparison rate. The most common reason that a call was not answered continued to be that the physician was no longer at the number.

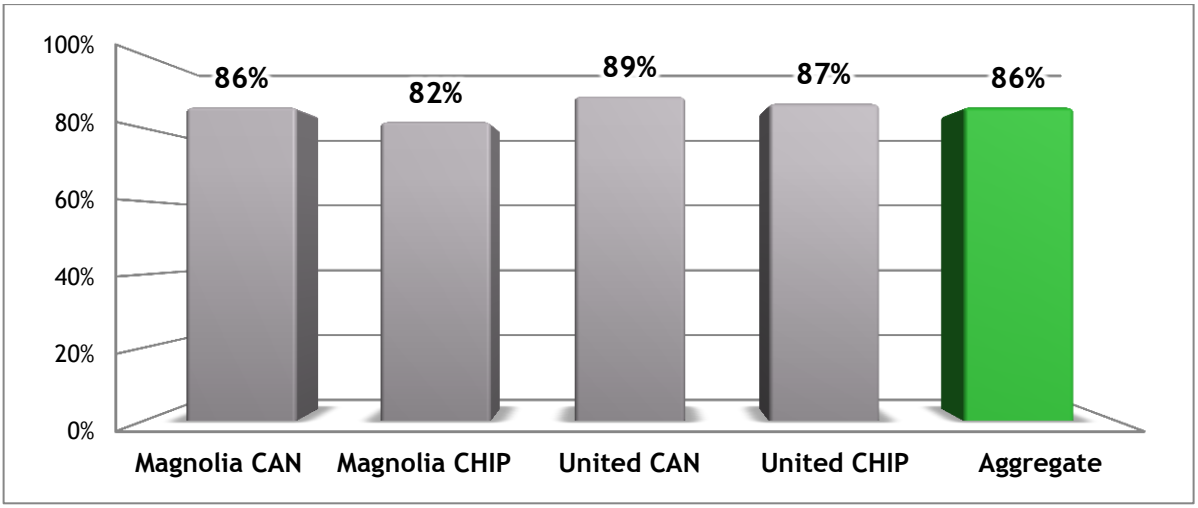
Figure 3: Percentage of Successfully Answered Calls



Currently Accepting the Plan

Of the calls successfully answered, 83% responded that the provider accepted the respective health plan. The percentages ranged from 82% for Magnolia CHIP to 89% for United CAN. In the aggregate, approximately 14% of the providers reported they do not accept the plan identified. *Figure 4, Percentage of Providers Accepting the Plan*, displays the percentage of providers that indicated they accept the plan.

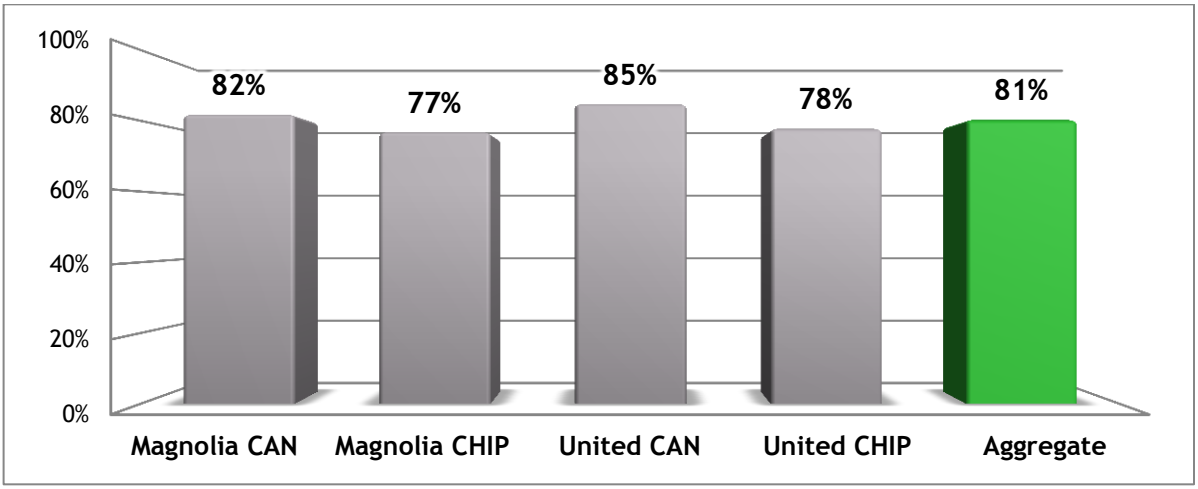
Figure 4: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

Of the providers accepting the plan, 81% responded they were accepting new Medicaid patients. The results range from Magnolia CHIP at 77% to United CAN at 85%.

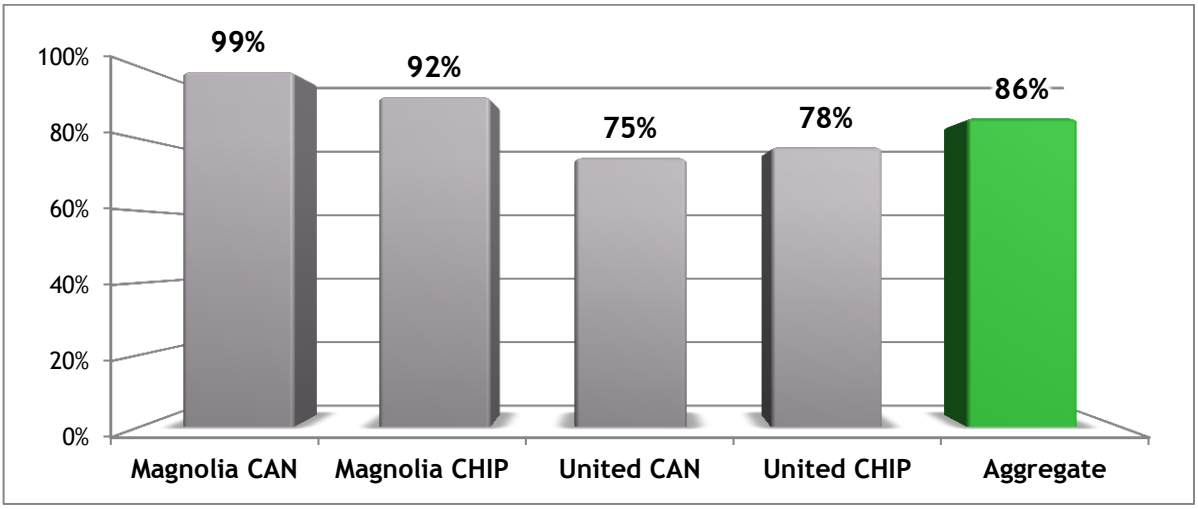
Figure 5: Percentage of Providers Accepting Medicaid Patients



Next Available Appointment

Of those accepting new Medicaid patients, when CCME asked for the next available, non-urgent appointment for the provider, 86% of all providers gave an appointment time that met the state timeframe requirements for a routine appointment. Magnolia CAN has the highest rate of 99% in this category, whereas United CAN has the lowest rate at 75%.

Figure 6: Percentage of Providers for which the Next Available Appointment Met Contract Requirements



Summary of Study Findings

For the two CAN plans, the overall access to providers did not improve from the previous cycle, as indicated by a decrease in the percentage of successfully answered calls in the *Provider Access Study*. The most common reason for unsuccessfully answered calls is that

the provider was not at the phone number listed or was no longer in the practice. Given these findings, the CAN plans do not meet the standard for Provider Access as defined by improvement from the previous year's rate. The CHIP Programs cannot be assessed for improvement, as there are no previous rates for comparison. Improvement will be assessed in the upcoming review for all plans. As an initial step to improve beneficiaries' access to providers, CCME recommended that all plans update provider contact information more often and create a process that updates and validates information at scheduled intervals.

Provider Satisfaction Survey

CCME conducted a validation review of the *Provider Satisfaction Surveys* using the protocol developed by CMS titled, *EQR Protocol 5: Validation and Implementation of Surveys - A Voluntary Protocol for External Quality Review*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid.

Magnolia and United used an NCQA-certified vendor to conduct the provider satisfaction surveys. Results of the validation found that the surveys "Partially Met" the CMS protocol requirements for Magnolia, but surveys did not meet the CMS protocol requirements for United. The response rate, sampling size, and how the survey was developed were some of the issues noted for the *Provider Satisfaction Surveys*. *Table 4, Provider Satisfaction Survey Validation Results,* that follows provides an overview of the provider survey validation results.

Table 4: Provider Satisfaction Survey Validation Results

Reason	Recommendations
MAGNOLIA	
Information on reliability of the survey was not provided.	Include information and appropriate statistical values regarding reliability of the survey.
Information on validity of the survey was not provided in documentation.	Include information and appropriate statistical values regarding validity of the survey.
The initial sample (6.4%) had a low response rate and the latter sample had a response rate of 36.7%. This is just slightly below the NCQA target response rate for surveys of 40%.	Work to increase response rates to avoid biases and lack of generalizability of results. Solicit the help of your survey vendor.
Conclusions were supported by the data and analysis, but were based on a small sample size and need to be interpreted and generalized with caution.	Work to increase response rates to avoid biases and lack of generalizability of results.

Reason	Recommendations
UNITED	
Desk materials did not contain a report offering a statement of survey's purpose.	Provide program evaluation or other document with clearly stated study objectives.
Desk materials did not contain a report on study objectives. Study objective is not clearly defined in the *Provider Satisfaction Survey Results* document.	Provide program evaluation or other document with clearly stated study objectives.
No information on reliability was offered in the desk materials.	Provide documentation of reliability measures.
No information regarding validity was offered by the desk materials.	Provide documentation of validity measures.
Detailed information regarding the selection of the sample size was not included in the documentation.	Include in the survey documentation how the sample size was determined. Be sure to include the statistical assumptions such as acceptable margin of error and the level of certainty that was used in the sample size calculation.
The response rate was 6.8%. Sources were not documented for the non-response and bias as well as the implications of response rate for the generalizability of survey findings.	Provide information regarding non-response and bias, as well as how small sample can impact the generalizability of the results.

The two primary issues for both plans included low response rates and lack of information on the validity and reliability of the survey. United's documentation lacked information regarding the survey's objective and purpose. CCME recommended that the survey's objective and purpose be clearly stated in the documentation, as well as information regarding the reliability and validity of the survey. It was also recommended that the plans work with the vendor to increase *Provider Satisfaction Survey* response rates.

An overview of the scores for the Provider Services section is illustrated in *Table 5: Provider Services Comparative Data*.

Table 5: Provider Services Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	The CCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Partially Met	Partially Met	Met	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	Not Met	Met	Met
	The credentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met	Met	Met
	Verification of information on the applicant, including: • Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met
	• Valid DEA certificate and/or CDS Certificate	Met	Met	Met	Met
	• Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met
	• Work history	Met	Met	Met	Met
	• Malpractice claims history	Met	Met	Met	Met
	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Met	Met	Met
	Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	Query of the System for Award Management (SAM)	Met	Met	Met	Met
	Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met
	Query for Medicare and/or Medicaid sanctions [Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)]	Met	Met	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met
	Must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number	Met	Met	Met	Met
	Ownership Disclosure Form	Met	Met	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	Met	Met	Not Met	Partially Met
	Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met
	The recredentialing process includes all elements required by the contract and by the CCO's internal policies	Met	Met	Met	Met
	Recredentialing every three years	Met	Met	Met	Met
	Verification of information on the applicant, including: • Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	• Valid DEA certificate and/or CDS Certificate;	Met	Met	Met	Met
	• Board certification if claimed by the applicant	Met	Met	Met	Met
	• Malpractice claims since the previous credentialing event	Met	Met	Met	Met
	• Practitioner attestation statement	Met	Met	Met	Met
	Requery the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met
	Requery the System for Award Management (SAM)	Met	Met	Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event (State Board of Examiners for the specific discipline)	Met	Met	Met	Met
	Requery for Medicare and/or Medicaid sanctions since the previous credentialing event [Office of Inspector General (OIG) List of Excluded Individuals & Entities (LEIE)]	Met	Met	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	Met	Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met
	Ownership Disclosure Form	Met	Met	Met	Met
	Provider office site reassessment for complaints/grievances received about the physical accessibility, physical appearance and adequacy of waiting and examining room space, if the health plan established complaint/grievance threshold has been met	Met	Met	Met	Met
	Review of practitioner profiling activities	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Credentialing and Recredentialing	The CCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the CCO for serious quality of care or service issues	**Met**	**Met**	**Met**	**Met**
	Organizational providers with which the CCO contracts are accredited and/or licensed by appropriate authorities	**Partially Met**	**Partially Met**	**Met**	**Met**
Adequacy of the Provider Network	The CCO has policies and procedures for notifying primary care providers of the Members assigned	**Met**	**Met**	**Met**	**Met**
	The CCO has policies and procedures to ensure out-of-network providers can verify enrollment	**Met**	**Met**	**Met**	**Met**
	The CCO tracks provider limitations on panel size to determine providers that are not accepting new patients	**Met**	**Met**	**Met**	**Met**
	Members have two PCPs located within a 15-mile radius for urban or two PCPs within 30 miles for rural counties	**Met**	**Met**	**Partially Met**	**Partially Met**
	Members have access to specialty consultation from network providers located within the contract specified geographic access standards. If a network specialist is not available, the Member may utilize an out-of-network specialist with no benefit penalty	**Met**	**Met**	**Met**	**Met**
	The sufficiency of the provider network in meeting membership demand is formally assessed at least quarterly	**Met**	**Met**	**Met**	**Met**
	Providers are available who can serve Members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	**Met**	**Met**	**Met**	**Met**
	The CCO demonstrates significant efforts to increase the provider network when it is identified as not meeting member demand	**Met**	**Met**	**Met**	**Met**

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Adequacy of the Provider Network	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	**Met**	**Partially Met**	**Partially Met**	**Partially Met**
	The *Telephonic Provider Access Study* conducted by CCME shows improvement from the previous study's results	**Not Met**	**N/A**	**Not Met**	**N/A**
Provider Education	The CCO formulates and acts within policies and procedures related to initial education of providers	**Met**	**Met**	**Met**	**Partially Met**
	Initial provider education includes: • A description of the Care Management system and protocols, including transitional care management	**Met**	**Met**	**Met**	**Met**
	• Billing and reimbursement practices	**Met**	**Met**	**Met**	**Met**
	CAN - Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by DOM CHIP - Member benefits, including covered services, benefit limitations and excluded services, including appropriate emergency room use, a description of cost-sharing including co-payments, groups excluded from co-payments, and out of pocket maximums	**Partially Met**	**Partially Met**	**Met**	**Met**
	Procedure for referral to a specialist including standing referrals and specialists as PCPs	**Met**	**Met**	**Met**	**Met**
	Accessibility standards, including 24/7 access and contact follow-up responsibilities for missed appointments	**Met**	**Met**	**Met**	**Met**
	CAN - Recommended standards of care including EPSDT screening requirements and services CHIP - Recommended standards of care including Well-Baby and Well-Child screenings and services	**Met**	**Not Met**	**Met**	**Met**

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Provider Education	CAN - Responsibility to follow up with Members who are non-compliant with EPSDT screenings and services CHIP - Responsibility to follow up with Members who are non-compliant with Well-Baby and Well-Child screenings and services	Met	Met	Met	Met
	Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met
	Provider and Member complaint, grievance, and appeal procedures including provider disputes	Met	Met	Met	Met
	Pharmacy policies and procedures necessary for making informed prescription choices and the emergency supply of medication until authorization is complete	Met	Met	Met	Met
	Prior authorization requirements including the definition of medically necessary	Met	Met	Met	Met
	A description of the role of a PCP and the reassignment of a Member to another PCP	Met	Partially Met	Met	Met
	The process for communicating the provider's limitations on panel size to the CCO	Met	Not Met	Met	Met
	Medical record documentation requirements	Met	Met	Met	Met
	Information regarding available translation services and how to access those services	Met	Partially Met	Partially Met	Partially Met
	Provider performance expectations including quality and utilization management criteria and processes	Met	Met	Met	Met
	A description of the provider Web portal	Met	Met	Met	Met
	A statement regarding the non-exclusivity requirements and participation with the CCO's other lines of business	Met	Not Met	Met	Met
	The CCO regularly maintains and makes available a Provider Directory that is consistent with the contract requirements	Partially Met	Partially Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Provider Education	The CCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, Member benefits, standards, policies, and procedures.	**Met**	**Met**	**Met**	**Met**
Primary and Secondary Preventive Health Guidelines	The CCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	**Met**	**Partially Met**	**Met**	**Met**
	The CCO communicates the preventive health guidelines and the expectation that they will be followed for CCO members to providers	**Met**	**Met**	**Partially Met**	**Partially Met**
	The preventive health guidelines include, at a minimum, the following if relevant to member demographics: • CAN - Pediatric and Adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services • CHIP - Pediatric and Adolescent preventive care with a focus on Well-Baby and Well-Child services	**Met**	**Met**	**Met**	**Met**
	• Recommended childhood immunizations	**Met**	**Met**	**Met**	**Met**
	• Pregnancy care	**Met**	**Met**	**Met**	**Met**
	• Adult screening recommendations at specified intervals	**Met**	**N/A**	**Met**	**N/A**
	• Elderly screening recommendations at specified intervals	**Met**	**N/A**	**Met**	**N/A**
	• Recommendations specific to Member high-risk groups	**Met**	**Met**	**Met**	**Met**
	• Behavioral Health	**Met**	**Met**	**Met**	**Met**

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Clinical Practice Guidelines for Disease and Chronic Illness Management	The CCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	Partially Met	Partially Met	Met	Met
	The CCO communicates the clinical practice guidelines for disease and chronic illness management to providers with the expectation that they will be followed for CCO members	Met	Met	Partially Met	Partially Met
Practitioner Medical Records	The CCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Met	Partially Met	Partially Met	Partially Met
	The CCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Not Met	Met	Met
Provider Satisfaction Survey	A provider satisfaction survey performed and meets all requirements of the CMS Survey Validation Protocol	Not Met	Not Met	Partially Met	Partially Met
	The CCO analyzes data obtained from the provider satisfaction survey to identify quality problems	Met	Met	Met	Met
	The CCO reports to the appropriate committee on the results of the provider satisfaction survey and the impact of measures taken to address quality problems that were identified	Met	Met	Met	Met

Strengths

- Plan websites contain valuable resources and information for providers, including: newsletters, forms, practice guidelines, manuals and reference guides, training materials.

- Both plans have user friendly, Web-based searchable Provider Directories that contain appropriate search criteria.

Weaknesses

- United's behavioral health credentialing program description did not address Mississippi-specific credentialing requirements and their credentialing plan related to facility credentialing did not address all required elements.
- The process United follows for credentialing/recredentialing of Mississippi providers is of concern. There is no Mississippi provider representation on the NCC for credentialing/recredentialing decisions, the Mississippi chief medical director infrequently attends the meetings, and has no voting privileges. In addition, the NCC was not following the credentialing plan's established guidelines for determining a quorum. Magnolia's vice president of medical affairs was chairing the Credentialing Committee instead of the chief medical director.
- Credentialing and/or recredentialing files for both plans were missing some of the required information.
- Magnolia had an uncorrected issue from the previous EQR relating to incorrect appointment availability information in their site assessment tool.
- Magnolia had inconsistencies in policies and the QI program evaluation regarding the PCP member-to-provider ratio.
- Some appointment standards were inconsistent between documents, and both plans exhibited low results from their provider appointment and after-hours studies.
- Issues or insufficient information were identified in the CAN and CHIP *Provider Manuals* for both plans. At the time of the EQR, Magnolia did not have their CHIP *Provider Manual* loaded to their website.
- In regards to medical record review, United's medical record review materials lacked Well-Baby and Well-Child language and a medical record review was not conducted for the CHIP Program. Magnolia's review standards were not listed on their website as their policy had indicated.
- For United and Magnolia, results of the telephonic *Provider Access and Availability Study* performed by CCME for the CAN Program showed no improvement from the previous study.
- *Provider Satisfaction Surveys* had low response rates for both plans. United's report did not contain information on the reliability and validity of the survey that was used to assess provider satisfaction.

Recommendations

- The plans should make sure they are following contract requirements regarding the Credentialing Committees and ensure credentialing/recredentialing files contain all required documentation.
- The plans need to work on updating policies, *Provider Manuals*, program descriptions, and the website to ensure information is detailed and consistent.
- Magnolia needs to make sure all updates from their previous EQR Corrective Action Plan are implemented.
- United needs to include the CHIP Program in provider medical record reviews.
- United and Magnolia should continue to focus on member access to providers.
- The plans need to work with the vendor to increase response rates for *Provider Satisfaction Surveys*.
- *Provider Satisfaction Survey* validity and reliability information needs to be reported as per CMS protocol requirements.

C. Member Services

The Member Services review included policies and procedures, member rights, member orientation and educational materials, member satisfaction, and the processes for handling grievances and practitioner changes. The reviews included the CAN and CHIP lines of business for both Magnolia and United. Each plan has comprehensive *Member Handbooks* for CAN and CHIP that are easily understood and appear to comply with contract reading comprehension requirements. The CHIP and CAN *Member Handbooks* and websites for Magnolia and United provide useful information regarding Preventive Health Guidelines and EPSDT/Well-Baby and Well-Child Programs.

The *Member Handbooks* for each plan includes very good information; however Magnolia and United CAN and CHIP *Member Handbooks* contained errors and omissions that required correction. United's CAN and CHIP *Member Handbooks* lacked complete information on advance directives, second opinions, a member's right to disenroll for cause, and the WIC Program. The CHIP *Member Handbook* also lacked a form on which to report grievances, failed to include the grievance expedited resolution timeframe or 14 day timeframe extensions, lacked a complete list of member rights, and member appointment scheduling requirements, to name a few. Magnolia's CAN and CHIP *Member Handbooks* did not include all member rights and the appropriate timeframe for notifying members when a physician leaves the network. The CHIP *Member Handbook* also lacks information on direct access to care for females, discrepancies in benefit information, and the definition of a grievance. Both plans have handbooks and written materials for members available in alternate formats and Spanish.

During the onsite visits for Magnolia and United we were provided actual recorded member calls to listen to and assess compliance to plan policies and procedures regarding the handling of member phone calls. Both plans refer to scripts and have the ability to advise members about needed health screenings or immunizations. The health plans also meet or surpass contract requirements for speed of answer and abandonment rates. At United, calls featured mandatory identification, Health Insurance Portability and Accountability Act of 1996 (HIPAA) checks, courteous interactions, and a desire to meet the callers' needs. Calls to Magnolia's Call Center revealed a few examples of incomplete HIPAA checks and staff appearing to be rushed resulting in the perception of disrespectful conduct. Both plans conduct training with Call Center staff; however, United had not documented in a policy or procedure, the contract requirements to conduct training on a quarterly basis.

The grievance processes used by both United and Magnolia for CAN or CHIP members was inconsistently documented in *Member Handbooks* (CAN and CHIP), *Provider Manuals* (CAN and CHIP), and policies and procedures and websites. United and Magnolia have processes in place to tally and analyze grievances for patterns and areas in need of improvement; however, United has not included the process in a policy or procedure. Grievance file reviews for United and Magnolia CHIP and CAN Programs indicate grievances are acknowledged and resolved timely. United CAN grievance files indicated some staff handling grievances did not clearly understand the process and CHIP grievance resolution letters contained medical terms not easily understood by members receiving the notice. United has not clearly documented grievances that require involvement of the medical director as part of the resolution. Magnolia was encouraged to fully document the investigation and resolution process for CAN and CHIP grievances and address the high percentage of CAN grievances related to non-urgent Medicaid transportation.

Member Satisfaction Survey

As required by the contract, both health plans conducted *Member Satisfaction Surveys*. As part of the annual EQR of both health plans, CCME conducted a validation review of the *Member Satisfaction Surveys* using the protocol developed by CMS titled, *EQR Protocol 5: Validation and Implementation of Surveys – A Voluntary Protocol for External Quality Review*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol is broken down into seven activities:

1. Review survey purpose(s), objective(s) and intended use
2. Assess the reliability and validity of the survey instrument
3. Review the sampling plan
4. Assess the adequacy of the response rate

5. Review survey implementation
6. Review survey data analysis and findings/conclusions
7. Document evaluation of the survey

Validation results are displayed in Table 6: Results of the Validation of CCO Satisfaction Surveys.

Table 6: Results of the Validation of CCO Satisfaction Surveys

Enrollee Satisfaction Survey Validation			
Magnolia CAN	**Magnolia CHIP**	**United CAN**	**United CHIP**
The responses met the minimum number of responses considered by NCQA to be necessary for a valid survey but fell below the response rate targets set by AHRQ or NCQA at 24.2% for the Adult survey and 20.9% for the Child survey.	The results met the minimum number of responses considered by NCQA to be necessary for a valid survey but fell below the response rate targets set by AHRQ or NCQA at 20.0%.	The results met the minimum number of responses considered by NCQA to be necessary for a valid survey but fell below the response rate targets set by AHRQ or NCQA at 25.7% for the Adult survey and 25.26% for the Child survey.	The results met the minimum number of responses considered by NCQA to be necessary for a valid survey but fell below the response rate targets set by AHRQ or NCQA at 31.47%.

Magnolia and United used an NCQA-certified vendor to conduct their *Member Satisfaction Surveys*. The surveys met all but one of the validation requirements due to low response rates. This could lead to response bias and results that do not represent the entire member population. CCME recommended that both plans solicit the help of the survey vendors to increase the response rates for next year's survey, incorporate reminders into the Call Center script, use the website to announce the survey, and use over-sampling for survey send-outs.

An overview of the scores for the Member Services section is illustrated in *Table 7: Member Services Comparative Data*.

Table 7: Member Services Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Member Rights and Responsibilities	The CCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met
	All member rights included	Met	Partially Met	Partially Met	Partially Met
	All member responsibilities included	Met	Met	Met	Met
Member CCO Program Education	Members are informed in writing within 14 calendar days from CCO's receipt of enrollment data from the Division and prior to the first day of month in which their enrollment starts, of all benefits to which they are entitled	Partially Met	Partially Met	Partially Met	Partially Met
	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Met	Partially Met	Partially Met
	Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract	Met	Met	Met	Met
	The CCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the CCO, including the availability of free oral translation services for all languages	Met	Met	Met	Met
	Member complaints/grievances, denials, and appeals are reviewed to identify potential Member misunderstanding of the CCO program, with reeducation occurring as needed	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Member CCO Program Education	Materials used in marketing to potential members are consistent with the state and federal requirements applicable to members	**Met**	**N/A**	**Met**	**N/A**
Call Center	The CCO maintains a toll-free dedicated Member Services and Provider Services Call Center to respond to inquiries, issues, or referrals	**Met**	**Met**	**Met**	**Met**
	Call Center scripts are in-place and staff receives training as required by the contract	**Met**	**Met**	**Met**	**Met**
	Performance monitoring of the Call Center activity occurs as required and results are reported to the appropriate committee	**Met**	**Met**	**Met**	**Met**
Member Disenrollment	Member disenrollment is conducted in a manner consistent with contract requirements	**Met**	**Met**	**Met**	**Met**
Preventive Health and Chronic Disease Management Education	The CCO enables each member to choose a PCP upon enrollment and provides assistance as needed	**Met**	**Met**	**Met**	**Met**
	The CCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits	**Met**	**Met**	**Met**	**Met**
	The CCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program	**Met**	**Partially Met**	**Met**	**Met**

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Preventive Health and Chronic Disease Management Education	CAN - The CCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits CHIP - The CCO tracks children eligible for recommended Well-Baby and Well-Child visits and immunizations and encourages Members to utilize these benefits	Met	Met	Met	Met
	The CCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met
Member Satisfaction Survey	The CCO conducts a formal annual assessment of member satisfaction that meets all the requirements of the CMS' Survey Validation Protocol	Met	Met	Met	Met
	The CCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Met
	The CCO reports the results of the member satisfaction survey to providers	Met	Met	Met	Met
	The CCO reports to the appropriate committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met	Met	Met
Complaints/ Grievances	The CCO formulates reasonable policies and procedures for registering and responding to member complaints/grievances in a manner consistent with contract requirements including, but not limited to	Met	Met	Met	Met
	Definition of a complaint/grievance and who may file a complaint/grievance	Met	Met	Partially Met	Partially Met
	The procedure for filing and handling a complaint/grievance	Partially Met	Partially Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Complaints/ Grievances	Timeliness guidelines for resolution of the complaint/grievance as specified in the contract	Met	Met	Partially Met	Partially Met
	Review of all complaints/grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Partially Met	Partially Met	Met	Met
	Maintenance of a log for oral complaints/grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Met	Partially Met	Partially Met
Complaints/ Grievances	The CCO applies the complaint/ grievance policy and procedure as formulated	Met	Met	Met	Met
	Complaints/Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met
	Complaints/Grievances are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met	Met
Practitioner Changes	The CCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction	Met	Met	Met	Met
	Practitioner changes due to dissatisfaction are recorded as complaints/grievances and included in complaint/grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee	Met	Met	Met	Met

Strengths

- Magnolia and United CAN and CHIP *Member Handbooks* include useful information on Preventive Health Guidelines and EPSDT/Well-Baby and Well-Child.

- Magnolia and United CHIP and CAN grievance file review indicates both plans consistently acknowledge and resolve grievances within the timeframes required by the DOM Contract.
- Magnolia and United CHIP and CAN Programs use an NCQA-certified vendor to conduct the *Member Satisfaction Surveys*.

Weaknesses

- Magnolia and United CAN and CHIP *Member Handbooks* lack complete information in several areas, including patient rights.
- The definition of a grievance and the processes used by Magnolia and United to resolve CHIP and CAN grievances are inconsistent in policies, handbooks, and provider information.
- *Member Satisfaction Survey* response rates were below the NCQA target rate of 40% for Magnolia and United CAN and CHIP Programs.

Recommendations

- Although both plans conduct grievances according to contract guidelines for timeliness, plans still do not document the grievance process consistently across plan materials, websites, and member and provider information.
- The plans have a responsibility to continue monitoring and auditing calls received from members and any plans developed for reeducation and additional training. Ensure the calls are managed according to HIPAA guidelines and the quality of information provided to members is consistent.

D. Quality Improvement

All of the health plans are required by contract and federal regulations to have an ongoing Quality Assessment and Performance Improvement Program for the services furnished to its members. CCME's review found that both plans have a QI program in place that actively involves the entire organization in improving care and services. Each health plan has a committee charged with providing direction for all QI activities. The committees meet regularly and most minutes are detailed and thorough. The only concern found during the review included the tracking of diagnoses identified during EPSDT screenings, the Well-Baby and Well-Child assessments, and the treatments or referrals provided as a result of the assessments. There were some minor documentation errors found in the PIPs; however, all projects scored within the high confidence or confidence range. Details of the PM and PIP follow.

Performance Measure Validation

Health plans are required to have an ongoing improvement program and report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the performance measures (PMs) reported, CCME uses the CMS's *EQR Protocol 2: Validation of Performance Measures Managed Care Organization Version 2.0* (September 2012). This validation balances the subjective and objective parts of the review, provides a review that is fair to the plans, and provides the State information about how each plan is operating. *Table 8, HEDIS® Performance Measure Data for CAN Programs,* displays the most recent measurement year rates for the Magnolia and United CAN Programs.

Table 8: HEDIS® Performance Measure Data for CAN Programs

	Magnolia CAN	United CAN
PREVENTION AND SCREENING		
1. Adult BMI Assessment (aba)	69.47%	73.22%
2. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)		
• BMI Percentile	24.04%	34.06%
• Counseling for Nutrition	25.48%	39.90%
• Counseling for Physical Activity	22.84%	39.90%
3. Childhood Immunization Status (cis)		
• DTaP	85.10%	76.64%
• IPV	95.43%	90.51%
• MMR	93.03%	90.75%
• HiB	93.03%	87.83%
• Hepatitis B	96.15%	90.27%
• VZV	93.03%	91.00%
• Pneumococcal Conjugate	83.17%	79.08%
• Hepatitis A	80.05%	80.54%
• Rotavirus	63.46%	65.21%
• Influenza	25.00%	20.92%
• Combination #2	83.17%	75.18%
• Combination #3	78.85%	72.02%
• Combination #4	67.79%	64.96%
• Combination #5	56.73%	56.45%
• Combination #6	23.08%	17.76%
• Combination #7	46.88%	51.58%
• Combination #8	22.12%	16.79%

	Magnolia CAN	United CAN
• Combination #9	15.87%	12.90%
• Combination #10	14.90%	12.41%
4. Immunizations for Adolescents (ima)		
• Meningococcal	48.56%	47.93%
• Tdap/Td	73.32%	79.81%
• Combination #1	47.36%	47.20%
5. Human Papillomavirus Vaccine for Female Adolescents (hpv)	12.06%	11.53%
6. Lead Screening in Children (lsc)	68.87%	65.45%
7. Breast Cancer Screening (bcs)	55.18%	47.78%
8. Cervical Cancer Screening (ccs)	59.14%	60.00%
9. Chlamydia Screening in Women (chl)		
• 16-20 Years	49.14%	45.57%
• 21-24 Years	62.39%	66.58%
• Total	58.25%	58.71%
RESPIRATORY CARE		
1. Appropriate Testing for Children with Pharyngitis (cwp)	51.62%	54.36%
2. Appropriate Treatment for Children With URI (uri)	NR	62.04%
3. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	NR	34.75%
4. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.34%	30.06%
5. Pharmacotherapy Management of COPD Exacerbation (pce)		
• Systemic Corticosteroid	39.30%	35.34%
• Bronchodilator	74.51%	63.15%
6. Medication Management for People With Asthma (mma)		
• 5-11 Years - Medication Compliance 50%	44.52%	64.32%
• 5-11 Years - Medication Compliance 75%	17.42%	35.24%
• 12-18 Years - Medication Compliance 50%	43.57%	58.06%
• 12-18 Years - Medication Compliance 75%	17.14%	31.34%
• 19-50 Years - Medication Compliance 50%	46.42%	62.77%
• 19-50 Years - Medication Compliance 75%	22.87%	36.80%
• 51-64 Years - Medication Compliance 50%	66.10%	66.67%
• 51-64 Years - Medication Compliance 75%	41.53%	45.10%
• Total - Medication Compliance 50%	48.73%	62.12%
• Total - Medication Compliance 75%	23.65%	35.26%
7. Asthma Medication Ratio (amr)		

	Magnolia CAN	United CAN
• 5-11 Years	73.29%	NR
• 12-18 Years	62.18%	NR
• 19-50 Years	39.90%	NR
• 51-64 Years	44.74%	NR
• Total	50.54%	NR
CARDIOVASCULAR CARE		
1. Controlling High Blood Pressure (cbp)	32.23%	43.07%
2. Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	59.52%	53.85%
3. Statin Therapy for Patients With Cardiovascular Disease (spc)		
• Received Statin Therapy - 21-75 years (Male)	61.65%	NR
• Statin Adherence 80% - 21-75 years (Male)	72.38%	NR
• Received Statin Therapy - 40-75 years (Female)	58.17%	NR
• Statin Adherence 80% - 40-75 years (Female)	61.16%	NR
• Received Statin Therapy - Total	59.81%	NR
• Statin Adherence 80% - Total	66.62%	NR
DIABETES		
1. Comprehensive Diabetes Care (cdc)		
• Hemoglobin A1c (HbA1c) Testing	85.65%	78.59%
• HbA1c Poor Control (>9.0%)	65.97%	67.64%
• HbA1c Control (<8.0%)	26.62%	26.76%
• HbA1c Control (<7.0%)	NR	NR
• Eye Exam (Retinal) Performed	65.74%	71.05%
• Medical Attention for Nephropathy	92.13%	93.19%
• Blood Pressure Control (<140/90 mm Hg)	40.97%	45.99%
MUSCULOSKELETAL CONDITIONS		
1. Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	71.43%	NR
BEHAVIORAL HEALTH		
1. Antidepressant Medication Management (amm)		
• Effective Acute Phase Treatment	36.91%	56.19%
• Effective Continuation Phase Treatment	23.07%	41.55%
2. Follow-Up Care for Children Prescribed ADHD Medication (add)		
• Initiation Phase	55.98%	49.19%
• Continuation and Maintenance (C&M) Phase	68.29%	67.65%
3. Follow-Up After Hospitalization for Mental Illness (fuh)		
• 30-Day Follow-Up	39.06%	60.83%

	Magnolia CAN	United CAN
• 7-Day Follow-Up	20.73%	38.96%
• Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	NR	NR
• Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NR	NR
• Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NR	NR
• Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	NR	NR
4. Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)		
• 1-5 Years	NR	NR
• 6-11 Years	NR	NR
• 12-17 Years	NR	NR
• Total	NR	NR
MEDICATION MANAGEMENT		
1. Annual Monitoring for Patients on Persistent Medications (mpm)		
• ACE Inhibitors or ARBs	87.38%	87.07%
• Digoxin	50.37%	50.00%
• Diuretics	87.36%	86.48%
• Total	86.93%	86.42%
OVERUSE/APPROPRIATENESS		
1. Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	4.45%
2. Appropriate Treatment for Children With URI (uri)	63.25%	62.04%
3. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	31.44%	34.75%
4. Use of Imaging Studies for Low Back Pain (lbp)	73.14%	71.82%
5. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)		
• 1-5 Years	NR	NR
• 6-11 Years	NR	NR
• 12-17 Years	NR	NR
• Total	NR	NR
ACCESS/AVAILABILITY OF CARE		
6. Adults' Access to Preventive/Ambulatory Health Services (aap)		
• 20-44 Years	86.04%	85.44%
• 45-64 Years	92.29%	91.55%
• 65+ Years	76.47%	87.18%

	Magnolia CAN	United CAN
• Total	88.34%	87.49%
7. Children and Adolescents' Access to Primary Care Practitioners (cap)		
• 12-24 Months	96.04%	96.37%
• 25 Months - 6 Years	88.89%	92.06%
• 7-11 Years	89.21%	92.36%
• 12-19 Years	83.49%	89.06%
8. Annual Dental Visit (adv)		
• 2-3 Years	41.43%	35.13%
• 4-6 Years	67.82%	64.27%
• 7-10 Years	67.20%	70.28%
• 11-14 Years	59.09%	63.86%
• 15-18 Years	49.33%	54.92%
• 19-20 Years	33.40%	37.37%
• Total	56.34%	59.61%
9. Prenatal and Postpartum Care (ppc)		
• Timeliness of Prenatal Care	88.21%	69.85%
• Postpartum Care	62.26%	53.35%
UTILIZATION		
1. Frequency of Ongoing Prenatal Care (fpc)		
• <21 Percent	11.27%	9.78%
• 21-40 Percent	4.74%	5.21%
• 41-60 Percent	7.33%	7.00%
• 61-80 Percent	13.94%	12.24%
• 81+ Percent	62.72%	65.76%
2. Well-Child Visits in the First 15 Months of Life (w15)		
• 0 Visits	6.03%	2.92%
• 1 Visit	5.76%	2.43%
• 2 Visits	6.94%	4.38%
• 3 Visits	8.32%	7.54%
• 4 Visits	13.76%	10.95%
• 5 Visits	21.66%	21.41%
• 6+ Visits	37.53%	50.36%
• Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	50.94%	56.51%
• Adolescent Well-Care Visits (awc)	28.54%	41.61%

NR= Not Reported.

Table 9, HEDIS® Performance Measure Data for CHIP Programs, displays the most recent measurement year rates for the Magnolia and United CHIP Programs.

Table 9: HEDIS® Performance Measure Data for CHIP Programs

	Magnolia CHIP	United CHIP
PREVENTION AND SCREENING		
1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)		
• BMI Percentile	36.54%	30.66%
• Counseling for Nutrition	37.98%	40.63%
• Counseling for Physical Activity	35.58%	36.74%
2. Childhood Immunization Status (cis)		
• DTaP	80.00%	79.72%
• IPV	90.00%	86.36%
• MMR	90.00%	91.61%
• HiB	83.33%	83.92%
• Hepatitis B	90.00%	86.36%
• VZV	86.67%	91.61%
• Pneumococcal Conjugate	86.67%	80.42%
• Hepatitis A	73.33%	71.68%
• Rotavirus	60.00%	72.73%
• Influenza	33.33%	36.36%
• Combination #2	73.33%	75.87%
• Combination #3	73.33%	74.13%
• Combination #4	63.33%	59.79%
• Combination #5	53.33%	64.69%
• Combination #6	30.00%	32.87%
• Combination #7	46.67%	52.80%
• Combination #8	26.67%	28.32%
• Combination #9	20.00%	30.42%
• Combination #10	16.67%	26.22%
3. Immunizations for Adolescents (ima)		
• Meningococcal	50.00%	47.93%
• Tdap/Td	82.26%	88.56%
• Combination #1	50.00%	47.93%

	Magnolia CHIP	United CHIP
• Human Papillomavirus Vaccine for Female Adolescents (hpv)	16.67%	9.89%
• Lead Screening in Children (lsc)	66.67%	39.16%
4. Chlamydia Screening in Women (chl)		
• 16-20 Years	35.20%	37.51%
• Total	35.20%	37.51%
RESPIRATORY CONDITIONS		
1. Appropriate Testing for Children with Pharyngitis (cwp)	60.28%	57.71%
2. Medication Management for People with Asthma (mma)		
• 5-11 Years - Medication Compliance 50%	NA	66.81%
• 5-11 Years - Medication Compliance 75%	NA	32.75%
• 12-18 Years - Medication Compliance 50%	NA	53.17%
• 12-18 Years - Medication Compliance 75%	NA	29.27%
• 19-50 Years - Medication Compliance 50%	NA	100.00%
• 19-50 Years - Medication Compliance 75%	NA	100.00%
• 51-64 Years - Medication Compliance 50%	NA	NA
• 51-64 Years - Medication Compliance 75%	NA	NA
• Total - Medication Compliance 50%	NA	60.55%
• Total - Medication Compliance 75%	NA	31.42%
DIABETES		
1. Comprehensive Diabetes Care (cdc)		
• Hemoglobin A1c (HbA1c) Testing	NQ	100.00%
• HbA1c Poor Control (>9.0%)	NQ	50.00%
• HbA1c Control (<8.0%)	NQ	40.00%
• HbA1c Control (<7.0%)	NQ	NR
• Eye Exam (Retinal) Performed	NQ	70.00%
• Medical Attention for Nephropathy	NQ	90.00%
• Blood Pressure Control (<140/90 mm Hg)	NQ	90.00%
BEHAVIORAL HEALTH		
1. Antidepressant Medication Management (amm)		
• Effective Acute Phase Treatment	NQ	26.32%
• Effective Continuation Phase Treatment	NQ	23.68%
2. Follow-Up Care for Children Prescribed ADHD Medication (add)		
• Initiation Phase	NA	49.62%
• Continuation and Maintenance (C&M) Phase	NA	65.38%
3. Follow-Up After Hospitalization for Mental Illness (fuh)		

	Magnolia CHIP	United CHIP
• 30-Day Follow-Up	NB	76.02%
• 7-Day Follow-Up	NB	54.59%
OVERUSE/APPROPRIATENESS		
1. Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NQ	2.55%
2. Appropriate Treatment for Children With URI (uri)	NR	52.99%
ACCESS/AVAILABILITY OF CARE		
1. Children and Adolescents' Access to Primary Care Practitioners (cap)		
• 12-24 Months	98.02%	98.96%
• 25 Months - 6 Years	82.19%	91.15%
• 7-11 Years	NA	94.31%
• 12-19 Years	100.00%	91.89%
2. Annual Dental Visit (adv)		
• 2-3 Years	45.28%	53.45%
• 4-6 Years	61.63%	75.23%
• 7-10 Years	66.14%	79.14%
• 11-14 Years	58.62%	73.29%
• 15-18 Years	47.73%	64.00%
• 19-20 Years	35.42%	67.02%
• Total	57.13%	71.62%
3. Initiation and Engagement of AOD Dependence Treatment (iet)		
• Initiation of AOD Treatment: 13-17 Years	NQ	53.13%
• Engagement of AOD Treatment: 13-17 Years	NQ	3.13%
• Initiation of AOD Treatment: 18+ Years	NQ	55.88%
• Engagement of AOD Treatment: 18+ Years	NQ	14.71%
• Initiation of AOD Treatment: Total	NQ	54.08%
• Engagement of AOD Treatment: Total	NQ	7.14%
4. Prenatal and Postpartum Care (ppc)		
• Timeliness of Prenatal Care	80.00%	66.67%
• Postpartum Care	60.00%	77.78%
• Call Answer Timeliness (cat)	NQ	97.30%
UTILIZATION		
1. Frequency of Ongoing Prenatal Care (fpc)		
• <21 Percent	NA	NR
• 21-40 Percent	NA	NR
• 41-60 Percent	NA	NR

	Magnolia CHIP	United CHIP
• 61-80 Percent	NA	NR
• 81+ Percent	NA	NR
2. Well-Child Visits in the First 15 Months of Life (w15)		
• 0 Visits	4.55%	2.19%
• 1 Visit	2.27%	1.46%
• 2 Visits	3.41%	1.46%
• 3 Visits	3.41%	6.57%
• 4 Visits	10.23%	5.11%
• 5 Visits	25.00%	18.25%
• 6+ Visits	51.14%	64.96%
• Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	43.18%	58.29%
• Adolescent Well-Care Visits (awc)	27.76%	40.15%

NA = Not Applicable; NB = No Benefit; NR = Not Reported; NQ = Not Required.

To validate non-HEDIS® measures, CCME reviewed 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

Table 10, DOM Measure Rates for CAN Program, displays the most recent measurement rates for the Magnolia and United CAN Programs.

Table 10: DOM Measure Rates for CAN Programs

DOM Measure	Magnolia CAN	United CAN
1. Asthma Related Readmissions	129	25*
2. Asthma Related ER Visits	305	0*
3. CHF Rehospitalizations	64	204*
4. Pre Post Natal Complications		
• Low Birth Weight	.90%	.02%
• Very Low Birth Weight	1.31%	.02%
• Large for Gestational Age	.15%	0.0%

** Rates not reported per 1,000 member months*

For Magnolia CAN, three of the four non-HEDIS® measures were found to be "Fully Compliant" and one measure was "Substantially Compliant" (Pre/Post Natal Complications). For United CAN, three of the four non-HEDIS® measures were found to be "Fully Compliant" and one measure was "Substantially Compliant" (Asthma Related Emergency Room (ER) Visits). United reported they were having issues with their software used to abstract the data for the non-HEDIS® measure and results could not be reported as per specifications. The 2015 annual rates for Asthma Related Readmissions, Asthma Related ER Visits, and CHF Hospitalizations are not available per 1,000 member months. The rates noted above include the numbers per member count, not per 1,000 member months.

Table 11, DOM Measure Rates for CHIP Program, displays the most recent measurement rates for the Magnolia and United CAN Programs.

Table 11: DOM Measure Rates for CHIP Programs

	Magnolia CHIP	United CHIP
CHIPRA MEASURES (NON-HEDIS MEASURES)		
1. Behavioral Health Risk Assessment (BHRA)		
• Depression Screening	0.00%	NR
• Alcohol Use Screening	0.00%	NR
• Tobacco Use Screening	0.00%	NR
• Drug Use	0.00%	NR
• Intimate Partner Violence	0.00%	NR
• Total	0.00%	NR
2. Developmental Screening in the first Three Years of Life (DEV)		
• Age 12 months	0%	NR
• Age 24 months	3.50%	NR
• Age 36 months	1.58%	NR
• Total (All Ages)	2.07%	NR

NR= Not Reported.

For Magnolia CHIP, all of the non-HEDIS® measures for the CHIP Program met the protocol guidelines and were considered "Fully Compliant." For United CHIP, data were not available for accurate reporting of the measures. There were noted problems with the data, so non-HEDIS® measures were unable to be measured accurately. It was recommended that United continue working with the appropriate department to fix software issues related to abstracting data to ensure accuracy and reporting on the non-HEDIS performance measures rates.

Performance Improvement Project Validation

Each health plan is required to submit to CCME their PIPs for review annually. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The 16 projects reviewed for the CAN and CHIP Programs for the two plans are displayed in *Table 12: Results of the Validation of PIPs*.

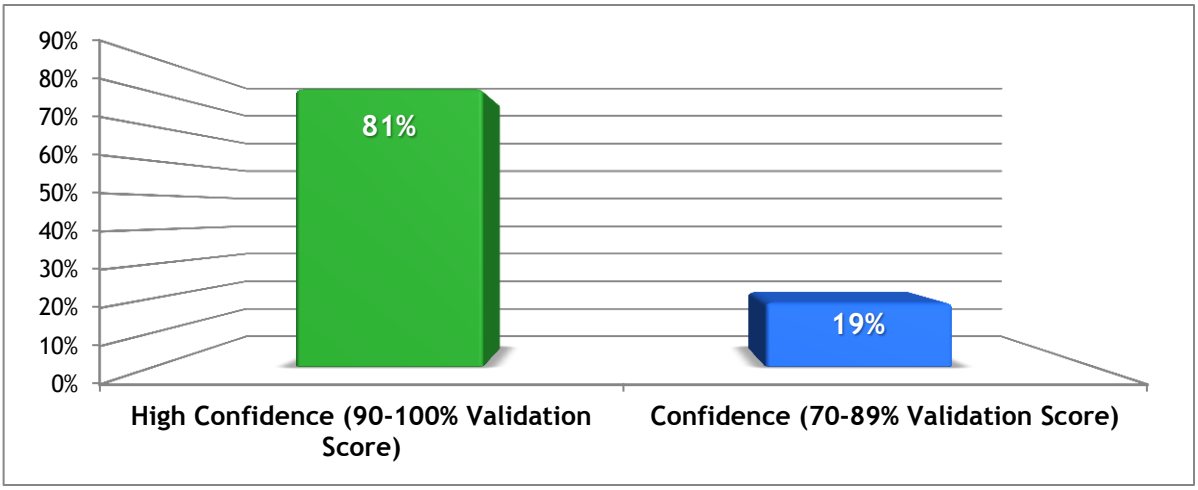
Table 12: Results of the Validation of PIPs

Project	Validation Score
United CAN	
Use of Appropriate medications for People with Asthma	**90% High Confidence in Reported Results**
Reducing Adult, Adolescent, and Childhood Obesity	**89% Confidence in Reported Results**
Comprehensive Diabetes Care	**91% High Confidence in Reported Results**
Annual Monitoring for Patients on Ace/ARB Inhibitors	**90% High Confidence in Reported Results**
United CHIP	
Use of Appropriate Medications for People with Asthma	**90% High Confidence in Reported Results**
Adolescent Well Care	**100% High Confidence in Reported Results**
Reducing Adolescent and Childhood Obesity	**100% High Confidence in Reported Results**
Follow-up after Hospitalization for Mental Illness	**94% High Confidence in Reported Results**
Magnolia CAN	
Congestive Heart Failure Readmissions	**80% Confidence in Reported Results**
Obesity	**100% High Confidence in Reported Results**
Diabetes	**100% High Confidence in Reported Results**
Asthma	**86% Confidence in Reported Results**
Magnolia CHIP	
EPSDT	**100% High Confidence in Reported Results**
Obesity for Children	**100% High Confidence in Reported Results**
ADHD	**100% High Confidence in Reported Results**
Asthma	**100% High Confidence in Reported Results**

Figure 7, Percent of Performance Improvement Projects, displays the percentage of projects that scored in either the "High Confidence," "Confidence," and "Low Confidence" validation range categories. Of the 16 projects submitted, 13 (81%) are in

the "High Confidence" range and three (19%) are in the "Confidence Range." Scores range from 80% to 100%.

Figure 7: Percent of Performance Improvement Projects



Issues for Performance Improvement Projects

The most common issue with PIPs for the current reviews is presenting the findings clearly. There were issues with correct reporting of the numerator and denominator in the Findings tables, as well as a lack of analysis and interpretation of the results. Other noted issues included lack of information regarding the qualification of the personnel that are collecting and analyzing data, as well as a lack of a clearly stated research question.

Table 13, Quality Improvement Comparative Data, provides an overview of how each health plan's standard for quality is scored.

Table 13: Quality Improvement Comparative Data

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
The Quality Improvement (QI) Program	The CCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met
	The scope of the QI program includes monitoring of services furnished to Members with special health care needs and health care disparities	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
The Quality Improvement (QI) Program	The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met
	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Met
Quality Improvement Committee	The CCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met
	The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met
	The QI Committee meets at regular quarterly intervals	Met	Met	Met	Met
	Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met
Performance Measures (PMs)	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met	Met	Met
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population or as directed by DOM	Met	Met	Met	Met
	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met	Partially Met	Met
Provider Participation in Quality Improvement Activities	The CCO requires its providers to actively participate in QI activities	Met	Met	Met	Met
	Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Provider Participation in Quality Improvement Activities	The scope of the QI program includes monitoring of provider compliance with CCO practice guidelines	Met	Met	Met	Met
	CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Initial visits for newborns CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Initial visits for newborns	Met	Met	Met	Met
	CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: EPSDT screenings and results CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Well-Baby and Well-Child screenings and results	Met	Met	Met	Met
	CAN - The CCO tracks provider compliance with EPSDT service provision requirements for: Diagnosis and/or treatment for children CHIP - The CCO tracks provider compliance with Well-Baby and Well-Child service provision requirements for: Diagnosis and/or treatment for children	Not Met	Not Met	Not Met	Not Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met	Met	Met
	The annual report of the QI program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	Met

Both health plans were not tracking diagnoses identified during EPSDT screenings, the Well-Baby and Well-Child assessments, and the treatments or referrals provided as a result of these assessments. This represented the "Not Met" scores. The "Partially Met" scores were related to the PIP validation.

Strengths

- Methodology for PIPs was sound.
- For most of the DOM performance measures, programming logic was accurate.
- PIP documentation was well-organized and formatted.

Weaknesses

- Both health plans are not tracking any diagnoses identified during EPSDT screenings, Well-Baby and Well-Child assessments and treatments, or the referrals provided as a result of these assessments.
- Data was not available for United DOM performance measures due to software issues, which impacts reporting and ability to validate measures.
- PIP documentation did not include all elements as required by the CMS protocol, including qualification of personnel working with the data, a clearly stated research question, and a documented analysis and interpretation of the findings for each measurement period.

Recommendations

- Develop a system for tracking any diagnoses identified during an EPSDT screening, Well-Baby and Well-Child assessment, and the treatment and/or referrals provided.
- Include qualification of personnel working with data on PIPs.
- Offer an analysis and interpretation of the findings for each measurement period of PIPs.
- Ensure PIPs have a clearly stated research question.

E. Utilization Management

CCME's EQR of the Utilization Management section includes reviews of UM program descriptions and policies, as well as documentation in other sources such as *Member Handbooks* and *Provider Manuals*, letter templates, committee minutes, and file reviews of approval, denial, appeal, and case management files.

The CCOs have established program descriptions and policies which describe UM requirements and guide staff in the performance of UM processes. Both CCOs include most of the necessary information in various information sources; however, some issues were noted. United does not specify the criteria used for medical necessity determinations in UM policies or in the UM program descriptions (CAN and CHIP). Discrepancies were noted in Magnolia's CAN *Member Handbook* and CAN *Provider Manual* regarding the required timeframe for notification of a member's admission. Magnolia's

CHIP *Member Handbook* does not define the determination timeframe or provide information on extensions for urgent pre-service outpatient requests.

Policies for pharmacy authorization processes are in place for United CAN and CHIP and Magnolia CAN, but not for Magnolia's CHIP product. Magnolia staff indicated the CAN policy had not been updated to indicate it applies to both the CAN and CHIP products.

UM approval and denial files for United and Magnolia provided evidence of attempts to obtain additional information when necessary, timely determinations and provision of determination notices within appropriate timeframes. Onsite discussion regarding pharmacy authorization processes revealed that Magnolia allows pharmacists to render denial determinations, and pharmacy denial files confirmed this practice. However, the *CAN Contract*, *CHIP Contract*, and Magnolia's policy defining the requirements for reviewers who issue denial determinations require denial determinations to be issued only by a Mississippi-licensed physician.

United and Magnolia have implemented appropriate processes for consideration of requests for which there are no established criteria, including mandatory review by a medical director. In addition, United's Executive Medical Policy Committee and Magnolia's Corporate Clinical Policy Committee develop internal medical policy and clinical criteria for new technologies or new applications of existing technologies. Both committees consider input from relevant specialists and professionals who have expertise in the technology being considered.

To ensure consistency in medical necessity determinations, both United and Magnolia employ annual inter-rater reliability (IRR) testing. United's IRR procedure describes the IRR process for CAN and CHIP and addresses when remediation is required, but does not describe the remediation process. Magnolia's IRR policy defines all components of the IRR process but applies only to the CAN product; there was no IRR policy for the CHIP product. Notably, passing scores for initial IRR testing were achieved by all of United's staff. Several Magnolia staff members required retesting due to initial scores below the benchmark of 90%.

Both United and Magnolia thoroughly define coverage requirements for emergency care and post-stabilization services in policies. Information on post-stabilization coverage requirements and processes is included in Magnolia's CAN and CHIP *Provider Manuals* but not found in United's *Provider Manuals*. CCME recommended United's CAN and CHIP *Provider Manuals* be revised to include the information.

As in previous EQRs, the area of appeals is the most problematic for both United and Magnolia. Issues common to both United and Magnolia include:

- Errors and/or discrepancies in definitions of the terms "action" and "appeal" and in who can file an appeal
- Errors or omissions of pertinent information regarding appeal filing procedures (such as requirements for acknowledging appeals, information that members may present evidence and examine documents related to an appeal, the timeframe to file an appeal)
- Errors or omissions in appeal resolution timeframes and/or extension of resolution timeframes

United's CHIP Addendum to the UM program description addresses provider appeals but does not address member appeals, and discrepancies were noted in the timeframe to request continuation of benefits in United's CAN documentation. Both plans analyze appeal data appropriately to improve quality of care and service.

No issues were noted in United's CAN appeal files, but United's CHIP appeal files do not include written acknowledgement of receipt of the appeal. Also, United CHIP appeals handled by Dental Benefit Providers, a delegated vendor, did not reference the benefit provision or criteria set used to review the appeal. Two of Magnolia's CAN and CHIP appeal files did not reference the benefit provision or criteria set used to review the appeal in the appeal resolution letter, but no other issues were found.

Both plans have care management programs that ensure comprehensive, coordinated care for CAN and CHIP members as evidenced by care management file review. United's person centered care model program description and care management policies are all national documents and do not contain riders and/or addenda to address Mississippi-specific requirements. In addition, policies address only high-risk care management. This resulted in several United CAN and CHIP care management standards being scored as "Partially Met."

Annual evaluations of the overall effectiveness of United's CAN and CHIP UM Programs are conducted and include data for UM metrics along with the goals, barriers, interventions, and recommendations for the next year. The *Utilization Management Evaluation* for 2015 was presented to appropriate committees for approval. Magnolia's *2015 Utilization Management Program Evaluation* for CAN identifies the UM Program's status, barriers, opportunities for improvement, recommendations for further action, and was reviewed and approved by appropriate committees. Magnolia did not provide a *Utilization Management Program Evaluation* for CHIP to CCME; this resulted in one standard being scored as "Not Met" and a corresponding standard scored as "Not Applicable."

An overview of all scores for the Utilization Management section is illustrated in *Table 14: Utilization Management Services Comparative Data*.

Table 14: Utilization Management Services Comparative Data

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

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Partially Met
	The CCO uses the most current version of the Mississippi Medicaid Program Preferred Drug List	Met	Met	Met	Met
	The CCO has established policies and procedures for the prior authorization of medications	Met	Met	Met	Partially Met
	Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met
	Utilization management standards/criteria are available to providers	Met	Met	Met	Met
	Utilization management decisions are made by appropriately trained reviewers	Met	Met	Partially Met	Partially Met
	Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met
	A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met
	All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Partially Met	Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Met	Met	Met
Appeals	The CCO formulates and acts within policies and procedures for registering and responding to Member and/or provider appeals of an action by the CCO in a manner consistent with contract requirements, including	Met	Met	Met	Met
	• The definitions of an action and an appeal and who may file an appeal	Partially Met	Partially Met	Partially Met	Partially Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Appeals	• The procedure for filing an appeal	Partially Met	Partially Met	Partially Met	Partially Met
	• Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met
	• A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met
	• Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Partially Met	Partially Met	Partially Met
	• Written notice of the appeal resolution as required by the contract	Met	Met	Met	Met
	• Other requirements as specified in the contract	Partially Met	Met	Met	Met
	The CCO applies the appeal policies and procedures as formulated	Met	Partially Met	Met	Met
	Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met
	Appeals are managed in accordance with the CCO confidentiality policies and procedures	Met	Met	Met	Met
Care Management	The CCO assesses the varying needs and different levels of care management needs of its member population	Partially Met	Partially Met	Met	Met
	The CCO uses varying sources to identify and evaluate members' needs for care management	Met	Met	Met	Met
	A health risk assessment is completed within 30 calendar days for members newly assigned to the high or medium risk level	Partially Met	Partially Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Care Management	The detailed health risk assessment includes: • Identification of the severity of the Member's conditions/disease state	Met	Met	Met	Met
	• Evaluation of co-morbidities or multiple complex health care conditions	Met	Met	Met	Met
	• Demographic information	Met	Met	Met	Met
	• Member's current treatment provider and treatment plan if available	Met	Met	Met	Met
	The health risk assessment is reviewed by a qualified health professional and a treatment plan is completed within 30 days of completion of the health risk assessments	Partially Met	Partially Met	Met	Met
	The risk level assignment is periodically updated as the member's health status or needs change	Met	Met	Met	Met
	The CCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met
	The CCO provides members assigned to the medium risk level all services included in the low risk and the specific services required by the contract	Partially Met	Partially Met	Met	Met
	The CCO provides members assigned to the high risk level all the services included in the low risk and the medium risk levels and the specific services required by the contract including high risk perinatal and infant services	Met	Met	Met	Met
	The CCO has policies and procedures that address continuity of care when the member disenrolls from the health plan	Met	Met	Met	Met

Section	Standard	United CAN	United CHIP	Magnolia CAN	Magnolia CHIP
Care Management	CAN - 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 CHIP - The CCO has disease management programs that focus on diseases that are chronic or very high cost, including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.	Met	Met	Met	Met
Transitional Care Management	The CCO monitors continuity and coordination of care between the PCPs and other service providers	Met	Met	Met	Met
	The CCO formulates and acts within policies and procedures to facilitate transition of care from institutional clinic or inpatient setting back to home or other community setting	Met	Met	Met	Met
	The CCO has an interdisciplinary transition of care team that meets contract requirements, designs and implements a transition of care plan, and provides oversight to the transition process	Met	Met	Met	Met
Annual Evaluation of the UM Program	A written summary and assessment of the effectiveness of the UM program is prepared annually	Met	Met	Met	Not Met
	The annual report of the UM program is submitted to the QI Committee, the CCO Board of Directors, and DOM	Met	Met	Met	N/A

Strengths

- Plan medical directors actively participate in UM development, implementation, and oversight.
- The plans' websites are a good resource for providers as well as members to obtain useful information regarding UM processes and requirements.
- UM files provided evidence that individual member circumstances are considered when determining medical necessity.

Weaknesses

- Errors, discrepancies, and/or insufficiencies were noted in information in policies, program descriptions, *Member Handbooks*, and *Provider Manuals*.
- Magnolia does not have a policy defining IRR testing processes and requirements for staff who issue medical necessity determinations for the CHIP product.
- Magnolia permits pharmacists to issue denial determinations for medications without referring the review to a medical director.
- United does not acknowledge receipt of appeals for the CHIP population.
- Appeal resolution letters for United CHIP and Magnolia CAN and CHIP do not always include a reference to the criterion or benefit provision used to render the appeal determination.
- United's CAN and CHIP care management program descriptions and policies are national documents that do not address all case management requirements specific to Mississippi.
- Evidence of a written evaluation for the Magnolia CHIP UM Program was not provided.

Recommendations

- The plans should review and revise documentation to ensure UM, appeals, and case management requirements and processes are documented completely, correctly, and consistently across all information sources.
- Magnolia should develop a policy addressing IRR testing requirements and processes for CHIP staff.
- Magnolia needs to ensure all denials are issued by a Mississippi-licensed physician, as required by the CAN and CHIP Contracts and Magnolia policy.
- United needs to implement processes to acknowledge receipt of appeals for the CHIP population.
- Both CCOs should ensure that all appeal resolution letters include a reference to the criterion or benefit provision used to decide the outcome of appeals.
- United should develop riders and/or addenda to CAN and CHIP UM Program descriptions and policies to address Mississippi-specific care management requirements.
- Magnolia should implement measures to ensure formal documentation of the CHIP UM Program evaluation.

F. Delegation

CCME's review of Delegation includes contracts and agreements with delegated entities and the processes for pre-assessment, ongoing monitoring, and annual assessments.

United and Magnolia execute complete delegation agreements with each entity. The delegation agreements contain all contractually required elements, including the functions to be delegated; terms of the contract; responsibility to abide by state and federal regulations; and a process for corrective action if the delegate's performance does not meet established expectations.

Both plans have policies that define delegation and oversight processes. United's policies are thorough and adequately address all requirements. Magnolia's policy addressing oversight of delegated credentialing incorrectly states that for delegates who are NCQA certified or accredited, Magnolia may omit the annual audit or evaluation. During discussion with Magnolia staff, it was confirmed that Magnolia does conduct annual oversight for NCQA-certified or accredited entities, and evidence of appropriate oversight for each of Magnolia's delegates was provided.

Oversight documentation for United's delegates did not indicate that authorization turnaround times are monitored for OptumHealth, and did not clearly indicate that both standard and expedited appeal turnaround times are monitored for Dental Benefit Providers; however, onsite discussion confirmed all performance standards are reviewed routinely with each delegate.

For the Delegation section, United achieved 100% "Met" scores and Magnolia Health Plan received scores of "Met" for 50% of the standards. *Table 15, Delegation Services Comparative Data*, illustrates the scoring for each standard reviewed.

Table 15: Delegation Services Comparative Data

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

Strengths

- United and Magnolia have adequate agreements in place with each delegated entity which specify the delegated functions; requirements for Corrective Action Plans for performance falling below established expectations; and contain appropriate Mississippi-specific requirements.

Weaknesses

- United's delegation oversight documentation does not include evidence that all performance elements are monitored.
- Magnolia's credentialing delegation oversight policy includes incorrect information that the health plan may omit the annual audit/oversight for delegates who have achieved NCQA certification or accreditation.

Recommendations

- The plans should ensure that delegation policies contain correct information regarding delegation requirements and that documentation of delegation oversight addresses all required performance elements.